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A Systematic Review Study on Sexual Reproductive Health (SRH) Services Received on Ethnic Minority Women in the UK

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Abstract

Aims: To identify and appraise existing literature on SRH services for ethnic minority women in the UK. The study examines four dimensions: service provision for ethnic minority women for their Sexual and Reproductive Health (SRH) needs in the UK; the challenges ethnic minority women face with healthcare service providers; factors that contribute to inequality; and strategies implemented to improve access to SRH services in the UK.

Design: A systematic literature review.

Data Sources: The search was conducted across Amed, CINAHL and Medline/Pubmed examining studies conducted between 2013 and 2023.

Review Method: The methodological quality of the included studies was appraised using the Scottish Intercollegiate Guidelines Network (SIGN,2014) quality assessment tool.

Results: Data from nineteen studies met the criteria for inclusion.

Conclusion: This report finds that whilst the UK has made progress in addressing the needs of ethnic minority women in this space, much still can be done: tailoring care to better address needs; increasing cultural knowledge and understanding among healthcare staff; provision of service in multiple languages; fostering partnerships with community organisations; and involving ethnic minatory women more in service design.

Impact: This study acknowledges that this field would benefit from further research. Addressing this will contribute to a more comprehensive understanding of the challenges, barriers, and strategies for improving SRH services for ethnic minority women in the UK. It is hoped that this knowledge can further inform evidence-based interventions and policies that promote health equity and ensure equitable access to culturally sensitive SRH services for all women.

1. INTRODUCTION

1.1 Study Background

Sexual and reproductive health (SRH) encompasses various aspects of sexuality and reproduction throughout a person's life, such as access to contraception, prevention and treatment of sexually transmitted infections (STIs), safe pregnancies, safe abortion services, comprehensive sexuality education, and the right to make autonomous decisions about one's own body and reproductive choices (Li et al., 2020). It acknowledges that sexual and reproductive rights are fundamental human rights and emphasises the importance of gender equality, equity, and the abolition of discrimination and violence in the context of SRH. The notion of SRH originated in the 1990s, drawing on previous initiatives in reproductive health.

The International Conference on Population and Development (ICPD) in Cairo in 1994 was essential in the development of the SRH framework. The ICPD Programme of Action recognised that reproductive health should involve more than only fertility and should include sexual health and rights (Li et al., 2020). The Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994 emphasised numerous key principles and goals linked to sexual and reproductive health (SRH). Universal reproductive rights; reproductive health as part of overall health; gender equality and empowerment; comprehensive sexuality education; and access to safe and legal abortion services are among the ideas and goals. Other global and regional conferences and frameworks have underlined the relevance of SRH and sexual and reproductive rights since the ICPD. The Beijing Declaration and Platform for Action (1995) and the United Nations Sustainable Development Goals (SDGs) adopted in 2015, for example, have continued to affect policies and programmes around the world, pushing for the realisation of sexual and reproductive rights for all individuals (Bearak et al., 2020).

These frameworks and conferences have been critical in promoting and advancing SRH around the world. They have emphasised the significance of guaranteeing access to complete SRH services, supporting gender equality and empowerment, and recognising reproductive health as a critical component of overall health and well-being. By emphasising these principles and goals, the ICPD and subsequent frameworks have led to the establishment of policies and programmes aimed at improving SRH outcomes and promoting individuals' rights to make informed reproductive decisions.

Ethnic minority women are women who belong to a society's or country's minority or non-dominant racial or ethnic groupings. Because of their overlapping identities of gender, race, and ethnicity, these women encounter unique problems and experiences. Ethnic minority women frequently face inequities and discrimination in a variety of areas of their lives, including healthcare, education, work, housing, and resource access. Racial and ethnic inequities in healthcare exist in a variety of settings. Breastfeeding rates among racial and ethnic minority mothers, for example, are lower than those among white women. Jones and colleagues (2015). They also have disparities in maternal morbidity and mortality, with black women being three to four times more likely than white women to die from pregnancy-related reasons (Howell, 2018). Furthermore, ethnic minority women may face difficulties to receiving cervical cancer screening, as well as inequities in breast cancer incidence and outcomes (Yedjou et al., 2019). Another area where inequities exist is mental health, with ethnic minority women facing distinct problems and hurdles to accessing perinatal mental health care (Watson et al., 2019).

Ethnic minority women in the United Kingdom (UK) are a diverse group of people with different racial, ethnic, and cultural backgrounds. They are an essential element of the country's multicultural fabric and come from diverse backgrounds, including South Asian, Black, East Asian, Middle Eastern, and other ethnic communities. Ethnic minority women in the United Kingdom frequently encounter unique obstacles and experiences that can have a negative influence on their lives, particularly their sexual and reproductive health (SRH) requirements. The foregoing indicates that services for sexual and reproductive health (SRH services) which encompass a broad range of healthcare interventions and support related to sexual and reproductive well-being, are critical for improving the well-being and autonomy of all individuals, especially ethnic minority women. As earlier stated, access to sexual and reproductive health (SRH) services is essential for ethnic minority women in the United Kingdom (UK) in order to protect their reproductive rights, promote healthy pregnancies, prevent and treat sexually transmitted infections (STIs), and make informed contraception and family planning decisions (Budhwani et al., 2018; Marlow et al. 2015; Tuddenham et al. 2022).

1.2 Rationale for the Study

The United Kingdom (UK) understands the need of and has made efforts towards providing equitable and accessible SRH services so that all women, regardless of ethnicity, can make informed decisions about their sexual and reproductive lives. However, ethnic minority women in the UK still frequently encounter distinct barriers and inequities when it comes to accessing and receiving appropriate SRH care (Badu et al., 2018; Ivanova et al., 2018). Studies have shown that ethnic minority women in the UK may face barriers to accessing SRH services, including cultural beliefs, language barriers, lack of awareness, and discrimination. For example, a qualitative study found that ethnic minority women may have limited knowledge of cervical cancer screening and face cultural barriers that prevent them from attending screenings (Marlow et al., 2015). This highlights the need for culturally sensitive and targeted interventions to improve access to cervical cancer screening among ethnic minority women.

In terms of STI prevention and treatment, ethnic minority women may also face disparities. A study conducted in the UK found that ethnic minority women had higher rates of STIs compared to white women (Sonnenberg et al., 2015). This may be due to various factors, including limited access to SRH education, cultural norms, and barriers to healthcare services. It is important to address these disparities through targeted interventions that address the specific needs and challenges faced by ethnic minority women. Additionally, studies have highlighted the challenges faced by visually impaired women and refugee and migrant women in accessing SRH services in the UK. Visually impaired women may face structural, financial, physical, social, and attitudinal barriers to accessing SRH services and care (Badu et al., 2018). Refugee and migrant women may also face barriers related to language, cultural differences, and limited knowledge of SRH services (Ivanova et al., 2018). It is crucial to address these barriers and provide inclusive and accessible SRH services for these populations.

To improve access to SRH services for ethnic minority women in the UK, it is important to implement culturally sensitive and inclusive healthcare practices. This includes providing language support, addressing cultural beliefs and practices, and promoting diversity and inclusivity in healthcare settings (Marlow et al., 2015). It is also important to involve ethnic minority women in the design and delivery of SRH services to ensure that their specific needs and experiences are taken into account (Schouteden et al., 2015). The need to address current disparities and problems experienced by this specific demographic is therefore what spurred the study on sexual and reproductive health (SRH) services for ethnic minority women in the UK. This study seeks to generate evidence that can drive policy changes, enhance healthcare practises, and ultimately promote health equity for this population by performing a systematic review on SRH services for ethnic minority women in the UK. It will add to the existing knowledge base, highlight research gaps, and lay the groundwork for future research and interventions addressing the specific SRH needs of ethnic minority women in the UK.

1.3 Research Questions

This study poses the following questions:

1. What are the service provisions for ethnic minority women for their SRH needs in the UK?
2. What are the challenges ethnic minority women face with healthcare service providers relating to their SRH in the UK??
3. What are the contributing factors to inequality in SRH for ethnic minority women in the UK?
4. What are strategies implemented for ethnic minority women to access SRH services in the UK?

1.4 Aim

To identify and appraise existing literature on SRH services for ethnic minority women in the UK.

1.5 Objectives

Specifically, the study hopes to examine;

1. the service provision for ethnic minority women for their Sexual and Reproductive Health needs in the UK.
2. the challenges ethnic minority women face with healthcare service providers relating to their Sexual and Reproductive Health in the UK.
3. the contributing factors to inequality in Sexual and Reproductive Health for ethnic minority women in the UK.
4. the strategies implemented for ethnic minority women to access Sexual and Reproductive Health services in the UK.

1.6 Underpinning Public Health Theories

The Social Determinants of Health (SDH) hypothesis and the Health Equity hypothesis are two public health ideas that effectively underpin this study on SRH services for ethnic minority women in the UK.

1.6.1 Social Determinants of Health (SDH) Theory

The social determinants of health (SDH) theory emphasises the impact of social, economic, and environmental factors on health outcomes in individuals (Nagata et al., 2013). It acknowledges that larger social variables such as income, education, employment, housing, and access to healthcare services impact health disparities and inequalities (Nagata et al., 2013; Walker et al., 2016). The SDH theory is useful in explaining the discrepancies and difficulties that ethnic minority women confront while seeking sexual and reproductive health (SRH) services (Dahab & Sakellariou, 2020; Badu et al., 2018). Cultural views, language barriers, discrimination, and a lack of awareness can all have a substantial impact on their ability to access and use SRH services (Badu et al., 2018). Through the SDH theory, the study explores the social determinants that contribute to inequalities in SRH services for ethnic minority women in the UK (Germain & Yong, 2020).

1.6.2 Health Equity Theory

The Health Equity Theory focuses on achieving equitable health outcomes for all individuals, regardless of their social or demographic characteristics. It recognizes that health disparities are not solely due to individual choices or behaviours but are also influenced by structural and systemic factors (Brown et al., 2019). In the context of the study on ethnic minority women's access to sexual and reproductive health (SRH) care, the Health Equity Theory provides a framework for understanding and addressing the inequalities in SRH services experienced by these women (Pellowski et al., 2013; Brown et al., 2019). It highlights the importance of ensuring equitable access to SRH services and addressing the underlying structural and systemic factors that contribute to disparities. The application of the theory therefore aids to identify strategies and interventions that can promote health equity and improve SRH outcomes for ethnic minority women in the UK (Brown et al., 2019).

1.7 Thesis Structure

This study begins with an introduction where a general background is provided on the study and the aims and objectives as well as rationale of the study are provided. The second chapter deals with the literature review where relevant literature are examined in an attempt to peruse existing literature on the current area of study. The third chapter deals with the methodology where the researcher presents the how of the study

conduct. The fourth chapter presents the results of the systematic literature review and discusses important findings. The fifth and final chapter proposes recommendations and concludes the research,

2. LITERATURE REVIEW

2.1 Concept of Sexual and Reproductive Health

Sexual and reproductive health (SRH) is a fundamental aspect of overall well-being that includes access to contraception, prevention, and treatment of sexually transmitted infections (STIs), safe pregnancies, safe abortion services, comprehensive sexuality education, and the right to make autonomous reproductive choices Karp et al. (2020). As the prevalence of premarital sexual intercourse among young people has increased globally (Wang et al., 2020), the United Nations Global Strategy for Women's, Children's, and Adolescents' Health recognises the importance of addressing the sexual and reproductive health needs of young unmarried people. This highlights the importance of comprehensive SRH education and contraception access in order to prevent unintended pregnancies and promote healthy sexual behaviours.

Adolescents have unique SRH needs, regardless of their sexuality or marital status. Adolescent SRH interventions have yielded positive results, including increased sexual knowledge, contraceptive use, and lower rates of adolescent pregnancy (Das et al., 2016). Comprehensive sexuality education, counselling, and contraceptive provision have proven to be effective strategies for meeting these needs (Das et al., 2016). Sexual and reproductive health education is critical in encouraging women to use contraception. According to studies, sex education increases the use of contraception during the first coitus (Seidu et al., 2022). However, various factors, including cultural values and beliefs, influence the effectiveness of SRH education. As providers of SRH education, teachers may face conflicts between their cultural values and comprehensive approaches to sexuality education (Haas & Hutter, 2018). It is critical for effective SRH education to resolve these conflicts and provide culturally sensitive education.

Contraceptive counselling and services are critical for women's SRH. Midwives play an important role in contraceptive counselling, especially in Sweden, where they are the primary providers of such services. Unmet SRH needs are common among immigrant women in Sweden, and successful contraceptive counselling by midwives can improve their SRH outcomes (Kolak et al., 2022). In the counselling process, trust and effective communication between healthcare providers and immigrant women are critical (Kolak et al., 2022). Women with substance use disorders (SUD) face unique SRH challenges. They frequently face stigma, lack social capital, and may be coerced or pressured into SRH decisions (Gibson et al., 2022). As such, access to essential SRH services, such as contraception, safe abortion, and STI prevention and treatment, is critical for this population.

The perspectives of parents on reproductive and sexual health education are also important in shaping adolescents' SRH outcomes. Many parents consider comprehensive reproductive and sexual health education to be essential. There is a need for improved comprehensive SRH education that is medically accurate, unbiased, and culturally appropriate in South Carolina for instance, where teenage pregnancy rates are high (Cameron et al., 2020). Adult and adolescent SRH knowledge and attitudes are important factors in promoting positive SRH outcomes. Adults' knowledge of SRH topics such as genital anatomy, contraceptive use, and sexually transmitted infections is often low, according to studies (Khajehei et al., 2013). Similarly, adolescents' knowledge levels vary, with a need for additional education to improve their understanding of SRH (Putri et al., 2022). Addressing knowledge gaps and encouraging positive attitudes towards SRH can help improve SRH outcomes. Contraceptive services are an important component of SRH because they allow individuals to control their desired family size and birth spacing. However, there

are barriers to adolescents using contraception services, such as embarrassment, ill-treatment by healthcare workers, and a lack of nonjudgmental and kind healthcare providers (Ezenwaka et al., 2020). It is critical to remove these barriers and ensure access to contraceptive services in order to promote SRH.

2.2 Women and Sexual and Reproductive Health (SRH)

As earlier stated, sexual and reproductive health (SRH) is a vital part of overall health and well-being. This statement is especially true for women. It covers a wide range of issues concerning women's sexual activity, reproductive processes, and access to healthcare services that support sexual and reproductive rights. Contraception, family planning, pregnancy, childbirth, sexually transmitted infections (STIs), and access to comprehensive healthcare services are all examples of SRH (Mitchell et al., 2023). The COVID-19 pandemic has had a significant global and regional impact on sexual and reproductive health. According to studies, the pandemic hampered access to SRH services such as contraception, and antenatal care (Mitchell et al., 2023; Shaikh et al., 2021; Leon-Larios et al., 2022). During the pandemic, deprioritization of essential SRH services exacerbated existing disparities in access to care, particularly for marginalised populations (Shaikh et al., 2021; Arnott et al., 2022). Refugee women, for example, face multiple barriers to accessing SRH services, and the pandemic added a new barrier to in-person care (Bocanegra et al., 2022). Similarly, women living in humanitarian settings frequently have limited access to comprehensive adolescent sexual and reproductive health services (Arnott et al., 2022).

Gender inequality has a significant impact on women's reproductive health outcomes. Gender inequalities, such as limited decision-making power and lack of autonomy, have been shown in studies to contribute to reproductive health problems in women (Roy et al., 2022; Darteh et al., 2019). Gender inequality can exacerbate disparities in reproductive health outcomes in rural areas where access to healthcare services is limited (Roy et al., 2022). Furthermore, gender minorities, including sexual and gender minorities, frequently face disparities in SRH outcomes, including higher rates of substance use and misuse (Kaniuka & Marks, 2021; Mereish, 2018). Access to sexual and reproductive health services is a critical component of ensuring women's sexual and reproductive rights. However, studies have revealed a variety of barriers to accessing these services. Lack of awareness and information, stigma and discrimination, limited availability of services, and structural factors such as poverty and geographic location are examples of these barriers (Mahmood et al., 2020; Ireland et al., 2021; Kura et al., 2013).

Efforts to address these barriers and promote women's SRH have taken a variety of forms. Telehealth and digital technologies have emerged as critical tools for providing SRH services, especially during the pandemic (Shaikh et al., 2021; Bocanegra et al., 2022). Integrating child rights standards into contraceptive and abortion care for minors has been proposed as a way to ensure adolescent access to SRH services while respecting their autonomy (Kangaude et al., 2022). A rights-based approach to SRH also emphasises the importance of recognising and enforcing women's sexual and reproductive rights as outlined in international legal instruments (Tanira et al., 2019).

2.3 SRH Services for Ethnic Minority Women

Socioeconomic status, cultural and language barriers, legal barriers, disability, and migration status can all have an impact on ethnic minority women's access to sexual and reproductive health (SRH) services. Several studies have found disparities in SRH service access among various populations, including ethnic minorities, migrants, and refugees. Socioeconomic factors influence access to SRH services significantly. Poorer rural women and adolescents, ethnic minorities, and rural-urban migrants are less likely to have access to sexual and reproductive health services (Qiao et al., 2021). In-depth national assessments have revealed significant differences in SRH service access based on social disadvantages such as place of

residence, education, and wealth (Kapilashrami, 2019). Women with disabilities, including visually impaired women, face multiple barriers to accessing SRH services and care, including structural, financial, physical, social, and attitudinal barriers (Badu et al., 2018; Shiwakoti et al., 2021).

Cultural and linguistic barriers can also prevent ethnic minority women from accessing SRH services. According to women, support services are rarely provided by professionals from ethnic minority backgrounds, resulting in a lack of understanding of their religion and culture (Watson et al., 2019). When information is not provided in their first language and interpreters are not available, language problems arise (Watson et al., 2019). These barriers can lead to a lack of knowledge and understanding of SRH services, as well as a decrease in their utilisation. Legal barriers can make it difficult for migrant women to access healthcare. The Immigration Act of 2014 in England has created legal barriers to healthcare access for migrant women (Germain & Yong, 2020). These barriers can intersect with ethnic minority characteristics, exacerbating the difficulties that ethnic minority migrant women face. Discrimination against migrant women, including white migrant women, has been documented, especially in light of recent events such as Brexit (Germain & Yong, 2020).

Refugee and migrant women also face unique challenges in obtaining SRH services. They may face displacement, loss of livelihood, increased disease transmission risk, and disruptions in vital services, including SRH (Cherri et al., 2017). The COVID-19 pandemic has highlighted the difficulties that underserved populations, such as racial/ethnic or sexual minorities, immigrants, and those with intersectional identities, face in accessing and utilising SRH services (Khan et al., 2021). According to studies, refugee and migrant women have limited access to SRH services, including family planning, due to barriers such as language barriers, a lack of awareness, and cultural stigma (Ivanova et al., 2018; Vu et al., 2022).

Intersectionality, which considers the interconnected nature of social identities and oppressive systems, is an important framework for understanding the barriers to SRH services faced by ethnic minority women. It recognises that multiple intersecting factors shape the experiences of ethnic minority women, such as race, ethnicity, gender, socioeconomic status, and migration status (Kapilashrami, 2019). Intersectionality emphasises the need for tailored and inclusive approaches to SRH services that address the specific needs and challenges faced by ethnic minority women.

2.4 Literature Gaps

Despite efforts to improve sexual and reproductive health (SRH) services for ethnic minority women in the UK, the existing literature has significant gaps. These gaps highlight areas where additional research is required to address the specific needs and challenges that this population faces. Among the gaps in the literature are as follows. Firstly, many studies on SRH services and ethnic minority women in the UK have concentrated on specific ethnic groups, such as South Asian or Black women, while ignoring the experiences of other ethnic minority groups. To capture the diversity of this population and understand the unique challenges they face, there is a need for research that includes a broader range of ethnic minority women. Secondarily, intersectionality recognises that individuals have multiple intersecting social identities that interact and shape their experiences. There has been little research into the intersecting experiences of ethnic minority women in relation to SRH services. Further research is required to understand how factors such as ethnicity, gender, socioeconomic status, and migration status interact to influence access to and experiences with SRH services.

Moreso, while some qualitative studies have examined the experiences and perspectives of ethnic minority women regarding SRH services, there is still a need for more in-depth qualitative research. Qualitative

research can provide valuable insights into ethnic minority women's nuanced experiences, cultural beliefs, and barriers, as well as their preferences and suggestions for improving SRH services. Existing research has found health inequities and disparities in SRH outcomes for ethnic minority women in the United Kingdom. However, more research is required to understand the underlying causes of these inequities, which include structural, cultural, and healthcare system-related factors. Furthermore, more research is required to determine the long-term effects of these disparities on the reproductive health and overall well-being of ethnic minority women.

While some studies have looked into the importance of culturally sensitive care in SRH services for ethnic minority women, there hasn't been much research into the effectiveness of such interventions. There is a need for studies that assess the impact of culturally sensitive approaches, language support, and community engagement on improving access, utilisation, and outcomes of SRH services for ethnic minority women. Further, there has been little research on the health literacy and communication barriers faced by ethnic minority women in the context of SRH services. More research is required to understand the health literacy levels of ethnic minority women, their access to health information, and the communication strategies that effectively address their informational needs and preferences.

Finally, longitudinal studies that track the needs, experiences, and outcomes of ethnic minority women over time are critical for assessing changes in SRH needs, experiences, and outcomes. Longitudinal research can provide insights into the dynamic nature of SRH services and capture the impact of interventions and policies on ethnic minority women's reproductive health trajectories. Addressing these gaps in the literature through rigorous research can aid in the development of evidence-based interventions, policies, and programmes that better meet the SRH needs of ethnic minority women in the UK and promote health equity in this population.

3. MEHODS

3.1 Research Design

This study used a systematic literature review research design. Munn et al. (2018) define a systematic literature review as a rigorous and transparent methodological approach for synthesising and analysing existing literature on a specific topic. It entails a systematic and predefined search strategy to identify relevant studies, followed by a thorough analysis and synthesis of their findings. The systematic literature review approach is a strong and popular research design for synthesising and analysing existing literature on a specific topic and it ensures that the review process is transparent, reproducible, and reliable. The review follows the 'Preferred Reporting Items for Systematic Review and MetaAnalysis' (PRISMA) standard and has been pre-approved by the researcher's supervisor.

3.2 Inclusion and Exclusion Criteria

Inclusion Criteria:

1. Studies published between 2013 and the present (to capture the most recent research).
2. Studies conducted in the United Kingdom (UK) or specifically focused on the UK context.
3. Studies that examine sexual and reproductive health (SRH) services received by ethnic minority women.
4. Studies that include ethnic minority women as the target population or have a specific focus on their experiences and perspectives.
5. Studies employing various research designs, including quantitative, qualitative, and mixed-methods approaches.

6. Studies available in the English language.

Exclusion Criteria:

1. Studies published before 2013 (to maintain focus on recent research).
2. Studies conducted outside the UK or not relevant to the UK context.
3. Studies that do not specifically address SRH services or focus on ethnic minority women.
4. Studies with a primary focus on populations other than ethnic minority women.
5. Studies that do not provide sufficient information or full-text availability for review.
6. Studies not available in the English language.

These inclusion and exclusion criteria aim to ensure that the systematic review focuses on recent studies conducted in the UK, specifically examining SRH services for ethnic minority women. The criteria help to maintain the relevance and scope of the review, ensuring that the selected studies provide valuable insights into the experiences and challenges faced by ethnic minority women in accessing and receiving SRH services in the UK.

Table 3.1 Inclusion and exclusion criteria summary table

Search Results	Studies included	Studies Excluded	Inclusion Criteria	Exclusion Criteria
652	23	By deduplication = 1 By date = 44 By relevance = 573 Not enough info = 2 Not in region = 4 Full text unavailable = 5	1. Relevance 2. Not earlier than 2013 3. English Language	1. Studies published before 2013 (to maintain focus on recent research). 2. Studies conducted outside the UK or not relevant to the UK context. 3. Studies that do not specifically address SRH services or focus on ethnic minority women. 4. Studies with a primary focus on populations other than ethnic minority women. 5. Studies that do not provide sufficient information or full-text availability for review. 6. Studies not available in the English language.

3.3 Search Strategy

The literature search strategy in this work followed a systematic process. A search string was used on PubMed to generate relevant literature to the current study. The search string made use of relevant keywords such as sexual and reproductive health, sexual health, reproductive health, ethnic minority, ethnicity, race, women, females, and United Kingdom which were combined in different ways to generate a search string for the database search. Boolean operators 'AND' and 'OR' were also used to further refine the search and abbreviations such as SRH and UK for sexual and reproductive health and United Kingdom

respectively were used to include all relevant results. The search turned up 651 papers with dates ranging from 1989 to 2023. To further narrow the search, a date filter was used to eliminate all studies that were older than 10 years (i.e all studies before 2013 were excluded from the review). By the date of publication, 44 results were excluded and the search was left with only 607 results. Next, the researcher carefully screened the titles of the papers that turned up in the search for relevance. Through this, another 573 papers were eliminated leaving the researcher with only 34 papers. These 34 papers were then screened for abstract and full text contents upon which 5 were excluded for the unavailability of full texts, 2 were excluded due to lack of enough information for review, and 4 were excluded due to their being in a different region. At the end of the screening, 23 studies were left, and these were included in the systematic literature review (see fig. 3.1).

Fig. 3.1. Summary of literature search strategy

3.4 Data Extraction and Analysis Process

The abstract and full texts of the 23 included literature were screened to identify and extract the following info from the papers: Aim, Methods, Results/Analysis, and Conclusions. A data extraction sheet was created through Microsoft Excel to extract relevant data from the studies. The extracted data were then analysed systematically and thematically to identify relevant common themes and topics of discussion to the current study.

3.5 Quality Assessment

Most of the included studies were peer reviewed and so they had a high level of credibility. Moreso, the researcher personally screened all the included studies to ensure that the methods employed and the procedures involved were of an acceptable standard of quality. As earlier stated, the study follows the PRISMA.

4. RESULTS AND DISCUSSION

4.1 Results

Paper 1:

Women with mental illness are more likely to experience recurrent miscarriage, termination, gynecological diseases, sexually transmitted infections, and reproductive cancers.

Women with mental illness are less likely to attend for cervical screening.

Women with mental illness have unmet sexual and reproductive health needs and require better engagement and support in primary care and mental health services.

Paper 2:

Muslim women have poor sexual and reproductive health (SRH) knowledge and negative attitudes.

Barriers to SRH services and education for Muslim women stem from religious, cultural, and family influences.

Interventions addressing these barriers are needed to improve SRH education and services for Muslim women.

Paper 3:

Earlier age at menarche, earlier age at first birth, and higher number of live births are associated with higher levels of body adiposity in women.

No evidence of an association between age at menopause and body adiposity.

Reproductive health factors, such as age at menarche and first birth, as well as parity, are associated with body adiposity in women.

Paper 4:
Migrant women in Malaysia face limited access to sexual and reproductive health (SRH) services.
Barriers to access include insufficient information, barriers to contraception use, reliance on abortions as the only option, delays in care-seeking during pregnancy, and additional barriers for gender-based violence services.
There is a need to address and expand SRH services for migrant women in Malaysia.

Paper 5:
Emergency contraception, condoms, and STI self-sampling kits are the most requested pharmacy-based SRH services.
Contraceptive injection, oral contraception, and chlamydia treatment have lower uptake.
Understanding healthcare utilization can inform the improvement of service delivery and address barriers to access for pharmacy-based SRH services.

Paper 6:
Childhood development plays a crucial role in determining variation in ovarian reserve across different ethnic groups.
Bangladeshi migrants who moved to the UK as children and European women have larger ovarian reserve compared to migrants who moved to the UK as adults or Bangladeshi women still living in Bangladesh.
Early life developmental factors should be considered when evaluating inter-group differences in response to assisted reproductive technology.

Paper 7:
Insufficient evidence exists to fully support or reject sexual health interventions for people with severe mental illness.
Further research and well-designed UK-based trials are needed, along with training and support for staff implementing sexual health interventions.

Paper 8:
Sexual activity decreases with age, with women less likely than men to report being sexually active at all ages.
Poorer health is associated with lower levels of sexual activity and higher prevalence of problems with sexual functioning.
Sexual health concerns vary by gender and age, with men reporting higher levels of concern and dissatisfaction.

Paper 9:
Sources of fertility information include school education, healthcare professionals, internet and social media, family and friends, books and magazines, fertility products, workplaces and communities, and sexual health clinics/centers.
Participants reported varying levels of access, reliability, and trust in these sources.
Improvements can be made by utilizing underexploited sources such as workplaces and communities, along with training for providers.

Paper 10:
Being young, unmarried, rural, and female contributes to inequities in sexual and reproductive health and rights (SRHR) in the Maldives.
Attitudes towards non-marital sexual activity, marriage, relationships, abstinence, abortion, access to services, and religion influence SRHR outcomes.

Targeted interventions and policies are needed to address the unique challenges faced by young, unmarried, rural, and female individuals in accessing SRHR services in the Maldives.

Paper 11:

Female condoms (FCs) are considered unacceptable to many women due to stigma, design, negative visual appeal, insertion difficulties, and lack of familiarity.

Perceived unavailability and higher cost of FCs compared to male condoms are major barriers to their use.

Healthcare professionals are reluctant to promote FCs due to perceived social stigma, highlighting the need for further education and promotion.

Paper 12:

Vaccine-induced seropositivity for HPV16 and HPV18 decreases with age among women attending sexual health clinics in England.

Lower vaccine-induced seropositivity is associated with being born outside the UK, residing in more deprived areas, and having a history of chlamydia diagnosis.

The study did not find evidence supporting the cross-protective effect of HPV16/18 vaccine against genital warts.

Paper 13:

Many recently arrived migrants in Sweden have incorrect knowledge regarding the legality of induced abortion.

Lack of knowledge is associated with religious beliefs, lack of previous sexual health education, coming from countries with restrictive abortion laws, low education level, and having a temporary residence permit.

SRHR-related programs and comprehensive sexual health education are needed for recently arrived migrants to increase knowledge of legal and safe abortions and other laws concerning SRHR.

Paper 14:

Differences in sexual partnerships and mixing exist between Black Caribbean (BC) and White British/Irish (WBi) individuals attending sexual health clinics in England.

Acute sexually transmitted infection (STI) diagnoses are higher among BC women compared to WBi women, and these differences persist even after adjusting for partnerships and mixing.

The study suggests the need for better characterization of "high transmission networks" to understand influences beyond individual-level factors and reduce population-level STI transmission.

Paper 15:

UK-born individuals of Black Caribbean (BC) ethnicity attending sexual health services in England have higher odds of being diagnosed with STIs compared to Caribbean-born BC individuals.

Differences in STI diagnoses persist even after adjusting for sexual orientation, place of residence, HIV status, area-level deprivation, and STI diagnosis in the last year.

Targeted interventions are needed to address STI disparities among BC individuals attending sexual health services.

Paper 16:

Female sex workers (FSWs) in England have access to high-quality care, but there are geographical inequalities in accessing services.

FSWs are at increased risk of certain STIs, such as gonorrhea.

Migrant FSWs have better sexual health outcomes but are more likely to experience non-STI outcomes, such as pelvic inflammatory disease.

Paper 17:
Women living with HIV in England aged 45-60 are more likely to have low overall sexual function and experience sexual problems compared to HIV-negative women.
Postmenopausal women living with HIV have a higher prevalence of low sexual function.
Routine assessment of sexual function is recommended for women living with HIV.

Paper 18:
Uptake of the HPV vaccination program among young women attending sexual health services (SHS) in England is lower compared to national data.
Factors such as location, ethnicity, age, smoking status, and previous STIs are associated with lower offer and completion rates of HPV vaccination among SHS attendees.
Interventions targeting high-risk individuals and improving HPV vaccination rates among young women attending SHS are needed.

Paper 19:
African women living with HIV in the UK face challenges in decision-making about infant feeding.
Factors such as cultural expectations, stigma, fear of transmission, and healthcare provider advice influence their decision.
Support and guidance tailored to the specific needs and experiences of African women living with HIV are crucial in the decision-making process.

Paper 20:
Female Chinese asylum seekers in the UK appreciate the increased autonomy provided by the UK system for family planning.
Cultural beliefs and values influence their choice of contraceptive methods.
Lack of knowledge about contraception upon arrival in the UK and influence from friends with a similar background are identified factors.
Unwanted pregnancies have occurred among unmarried women due to missed sex education in China.

Paper 21:
Limited information on HIV test refusal among black Africans attending sexual health clinics (SHCs) in England.
The study emphasizes the need for increased HIV test uptake among black Africans attending SHCs.

Paper 22:
Evaluation of a media campaign to increase chlamydia testing among young people aged 15-24 in England.
Overall testing coverage did not change significantly during or after the campaign.
Testing patterns varied among different socio-demographic groups.
The positivity rate increased during the campaign and further increased in the post-campaign phase.
The campaign was associated with increased testing of high-risk individuals and increased detection of chlamydia infections.

Paper 23:
Muslim women worldwide generally have poor knowledge about sexually transmitted infections (STIs) and various misconceptions.
Negative attitudes towards people infected with HIV/AIDS are common and influenced by misconceptions and insufficient knowledge.
Infected women face blame and judgment more than men.

Culturally sensitive sexual health education is needed for Muslim women, addressing barriers and providing accurate information.

4.2 Discussion

4.2.1 Service Provisions for Ethnic Minority Women's SRH Needs in the UK

In recent years, there has been a growing recognition of the importance of addressing ethnic minority women's sexual and reproductive health (SRH) needs in the UK. Loganathan et al. (2020) shed light on the barriers that migrant women face in accessing SRH services in Malaysia, and it is critical to investigate whether similar issues exist in the UK context. Alomair et al. (2020) emphasise the importance of culturally sensitive sexual health education for Muslim women worldwide, which also applies to the UK's diverse Muslim population. However, considering the findings of Harb et al. (2020), Tariq et al. (2016), Verran et al. (2014), Mohammed et al. (2016), and Aicken et al. (2019), it is important to critically assess the service provisions for ethnic minority women's SRH needs in the UK.

On the one hand, there have been positive steps towards addressing the SRH needs of ethnic minority women in the UK. Cultural competence has been recognised as important by service providers, who have made efforts to provide culturally sensitive care. Verran et al. (2014) highlight the increased autonomy afforded to Chinese asylum-seeking women in the UK system, allowing them to make informed family planning decisions. This suggests that service provisions have evolved to better meet the needs of women of ethnic minorities. Furthermore, initiatives like targeted sexual health campaigns, as demonstrated by Aicken et al. (2019), have shown promise in raising awareness and testing for sexually transmitted infections (STIs) among specific ethnic groups, with the goal of reducing health disparities.

Despite these positive steps, service provision for ethnic minority women's SRH needs in the UK faces significant challenges. Harb et al. (2020) report disparities in STI diagnoses among Black Caribbean individuals born in the UK and Caribbean, indicating the presence of inequities in access to and quality of SRH services. This suggests that service provisions may be inadequate in meeting the specific needs of this population. Furthermore, Tariq et al. (2016) identify a lack of knowledge about infant feeding options among African women living with HIV in the UK, indicating gaps in education and support for this vulnerable group. According to Mohammed et al. (2016), there is little data on HIV test refusal among black Africans attending sexual health clinics in England, indicating potential barriers to accessing and utilising SRH services. It is pertinent to note that providing culturally sensitive SRH services is a difficult task. Despite efforts to improve service provision, challenges such as language barriers, limited cultural competence among healthcare providers, and varying cultural norms and beliefs remain. These obstacles can stymie effective communication and understanding between service providers and ethnic minority women, resulting in suboptimal care.

4.2.2 Challenges Faced by Ethnic Minority Women with Healthcare Service Providers Regarding SRH

Sexual and reproductive health (SRH) services for ethnic minority women present significant challenges for healthcare providers. Drawing on the works of Hope et al. (2022), Loganathan et al. (2020), Begum et al. (2015), Hameed (2019), Grace et al. (2023), Aicken et al. (2019), Harb et al. (2020), Verran et al. (2014), Mohammed et al. (2016), and Alomair et al. (2020), the researcher critically examines the issues faced by healthcare service providers and ethnic minority women in the context of SRH. It can be argued that healthcare providers face difficulties in meeting the specific SRH needs of ethnic minority women. According to Hope et al. (2022), women with mental illnesses, including those from ethnic minorities,

have unmet sexual and reproductive health needs. Recurrent miscarriages, termination, gynaecological diseases, and sexually transmitted infections may be more common in these women. Furthermore, Loganathan et al. (2020) discovered that migrant women frequently have limited access to SRH services, resulting in insufficient information, barriers to contraception use, and reliance on abortions as the only option. The cultural, linguistic, and religious differences that exist between healthcare providers and ethnic minority women exacerbate the difficulties in providing appropriate and culturally sensitive SRH care.

Healthcare providers, on the other hand, work hard to provide inclusive and effective SRH services to ethnic minority women. Begum et al. (2015) and Hameed (2019) conducted studies on the impact of ethnicity and migration on reproductive health. Understanding the effects of migration on ovarian reserve, as demonstrated by Begum et al. (2015), enables healthcare providers to take early life developmental factors into account when assessing differences in SRH outcomes. Similarly, the experiences of young, unmarried, rural, and female individuals, as highlighted by Hameed (2019), call for targeted interventions and policies to address inequities in SRH access and outcomes. Healthcare providers are working to close these gaps and tailor their services to the specific needs of ethnic minority women.

Furthermore, healthcare providers recognise the importance of cultural competence in providing effective SRH care. Verran et al. (2014) stress the importance of culturally competent strategies in ensuring that Chinese immigrant women receive full access to family planning services. Similarly, Alomair et al. (2020) emphasise the importance of culturally sensitive sexual health education for Muslim women, taking into account their distinct beliefs, values, and attitudes towards STIs. Healthcare providers can improve the accessibility and acceptability of SRH services for ethnic minority women by acknowledging and accommodating cultural practises and beliefs.

Despite this, challenges remain in effectively meeting the SRH needs of ethnic minority women. Mohammed et al. (2016) highlight the issue of HIV test refusal among black Africans attending sexual health clinics. There is little information available about the factors associated with test refusal, which hampers efforts to increase HIV testing rates among this population. Furthermore, Grace et al. (2023) show that individuals, including ethnic minority women, have varying levels of access, reliability, and trust in various sources of fertility information. Healthcare providers must overcome barriers such as language barriers, limited resources, and cultural differences in order to disseminate accurate and trustworthy information.

4.2.3 Contributing Factors to Inequality in SRH for Ethnic Minority Women in the UK

Ethnic minority women frequently face socio-cultural barriers that contribute to SRH inequality. Loganathan et al. (2020) highlight the barriers to reproductive health discussions among Malaysian migrant women due to limited access to SRH services, insufficient information, and cultural norms. These factors can lead to a lack of information, limited contraceptive use, and a reliance on unsafe abortion as the only option. Begum et al. (2015), on the other hand, contend that childhood development and the quality of early environments play an important role in determining ovarian reserve and reproductive ageing in different ethnic groups. This implies that cultural practises and social environments can have a positive impact on reproductive health. Disparities in access to and utilisation of SRH services contribute to inequality. Harb et al. (2020) discovered that UK-born Black Caribbean women were more likely than Caribbean-born women to be diagnosed with sexually transmitted infections (STIs), implying potential barriers to timely and appropriate care. However, Alomair et al. (2020) highlight Muslim women's worldwide lack of knowledge and misconceptions about STIs. This lack of awareness, when combined

with cultural influences, may influence help-seeking behaviour and result in delayed or insufficient utilisation of SRH services.

Knowledge gaps and inadequate sexual health education also contribute to SRH inequality. Mohammed et al. (2016) discuss HIV testing refusal among black Africans in England, identifying potential barriers such as cultural beliefs, stigma, and fear of test results. Aicken et al. (2019) investigate ethnic differences in sexual partnerships and mixing, implying that differences in sexual behaviour patterns between ethnic groups contribute to disparities in STI diagnoses. This implies that knowledge and education may not be sufficient to explain the complexities of SRH inequality, and that cultural and behavioural factors must also be considered.

Media and information campaigns can both contribute to and mitigate SRH inequality. Gobin et al. (2013) assess the impact of a media campaign on chlamydia testing among young people in England and find that testing and positivity rates increased during the campaign. This implies that well-designed campaigns can raise awareness and increase testing rates, potentially reducing disparities. Verran et al. (2014), on the other hand, investigate the experiences of family planning among Chinese asylum seekers in the United Kingdom, emphasising the influence of cultural beliefs on contraceptive choices. To effectively reach ethnic minority women, media campaigns must consider cultural practises and address knowledge gaps. It is pertinent to note that addressing SRH inequality solely through knowledge and education initiatives may overlook systemic factors, such as structural barriers and economic inequalities, that contribute to disparities. A comprehensive approach that combines knowledge dissemination, improved access to services, and targeted interventions is therefore necessary to address the complex web of factors influencing SRH outcomes.

4.2.4 Strategies Implemented for Ethnic Minority Women to Access SRH Services

Access to sexual and reproductive health (SRH) services is critical for all women's well-being and autonomy, including those from ethnic minorities. Several strategies have been implemented to ensure that ethnic minority women have effective access to SRH services. Loganathan et al. (2020), Begum et al. (2015), Harb et al. (2020), and Verran et al. (2014) demonstrated some of these strategies. One strategy in place is the provision of culturally sensitive services. Loganathan et al. (2020) highlight the difficulties that migrant women face in accessing SRH services in Malaysia. Culturally sensitive services aim to address ethnic minority women's specific needs and cultural practises by creating an environment that respects and understands their cultural beliefs and values. This approach has the potential to increase trust and acceptability of services among ethnic minority women. However, there are drawbacks to this approach, as such services may unintentionally reinforce cultural stereotypes and perpetuate inequalities. By focusing solely on cultural differences, there is a risk of essentialising and homogenising ethnic minority communities, ignoring their diversity and individual agency. Furthermore, providing separate services based on cultural backgrounds can result in segregation and unequal access to resources, undermining the goal of providing equitable healthcare for all.

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ethnic minority communities. By focusing solely on ethnicity, other intersecting factors such as socioeconomic status and level of education may be overlooked, exacerbating inequalities. It is critical to strike a balance between culturally sensitive information and a holistic approach that recognises ethnic minority women's diverse experiences and identities.

Another strategy identified by Harb et al. (2020) is to improve access to SRH services. They investigate the relationship between birth region and STI diagnoses among Black Caribbean ethnicity individuals seeking sexual health services in England. Efforts to improve access include the creation of outreach programmes, mobile clinics, and community partnerships. By bringing services closer to ethnic minority communities, barriers to access and utilisation of SRH services such as transportation, language, and cultural unfamiliarity can be reduced. The disadvantage of focusing solely on improving access is that it may overlook the underlying structural and systemic factors that contribute to healthcare disparities. Ethnic minority women face a variety of intersecting barriers, including racism, discrimination, and socioeconomic disadvantages that extend beyond physical access. Without addressing these structural barriers, improved access may not result in equitable health outcomes. To address both the proximal and distal determinants of access and health disparities therefore, comprehensive strategies are required.

4.3 Relating the SDH Theory to SRH Services for Ethnic Minority Women in the UK

The SDH theory has been widely applied in a variety of research to investigate the impact of socioeconomic determinants on health outcomes. A systematic review, for example, found that social determinants of health, such as income, education, and employment, affected seasonal influenza vaccination uptake in individuals aged 65 and older (Nagata et al., 2013). Another study found that social determinants of health, such as race, ethnicity, and socioeconomic status, have an impact on diabetes outcomes (Walker et al., 2016). Access to maternity care was found to be influenced by social determinants such as transportation difficulties, economic factors, and cultural attitudes in low-income African nations (Dahab & Sakellariou, 2020). Disparities in vision health and eye care utilization were also found to be affected by social determinants of health, including economic stability, education, healthcare access, neighborhood environment, and social context (Williams & Sahel, 2022).

Furthermore, during the COVID-19 pandemic, the SDH theory was used to investigate discrepancies in access to healthcare treatments. A study that looked at interruptions to healthcare, economic activity, and housing during the pandemic discovered that pre-pandemic mental health was connected with these disruptions, underscoring the effect of social determinants on mental health outcomes (Gessa et al., 2021). The COVID-19 pandemic has also exposed inequities in healthcare access, notably for ethnic minority and migrant women, exacerbating previously existing hurdles to healthcare services (Germain & Yong, 2020). Specific hurdles to healthcare access for these women were identified as racialized medical beliefs, gendered cultural norms, information barriers, and stigma (Germain & Yong, 2020).

In the context of sexual and reproductive health, Badu et al. (2018) used the SDH theory to investigate barriers to receiving SRH services among visually impaired women in Ghana. Barriers to SRH services and care were characterised as structural, financial, physical, social, and attitudinal (Badu et al., 2018). Similarly, a systematic review on barriers to breast and cervical cancer screening uptake among Black, Asian, and Minority Ethnic women in the United Kingdom discovered that social determinants of health, such as income, education, employment, and housing, played a significant role in cancer screening low uptake (Bolarinwa & Holt, 2023).

The SDH theory has also been used to better understand health disparities in a variety of health conditions.

In chronic liver disease, for example, the syndemic of dangerous alcohol consumption, opioid use, and obesity has exacerbated health inequities, particularly among socially disadvantaged people (Kardashian et al., 2022). Income, education, and neighbourhood socioeconomic status have all been recognised as risk factors for cardiovascular disease and have led to health disparities (Vinter et al., 2022). Social determinants of health have been identified as major factors impacting health outcomes in multiple sclerosis, and addressing social determinants of health could enhance health and healthcare in this illness (Dobson et al., 2022).

Ultimately, the SDH theory provides a framework for comprehending the impact of social, economic, and environmental factors on individuals' health outcomes. It recognises that broader social variables such as income, education, employment, housing, and access to healthcare services shape health disparities and inequalities. The idea has been widely used in many research to investigate the impact of socioeconomic determinants on health outcomes, such as inequities in access to healthcare, maternal health, vision health, chronic diseases, and mental health. The study on ethnic minority women's access to SRH care use SDH theory to identify and comprehend the socioeconomic determinants that lead to inequities in SRH services for these women in the UK.

4.4 Relating the Health Equity Theory to SRH Services for Ethnic Minority Women in the UK

The Health Equity Theory is based on the recognition that social determinants of health, or the conditions under which people are born, grow, live, work, and age, influence health disparities (Brown et al., 2019). According to research, social determinants play an important role in shaping health outcomes and contributing to health disparities (Gutiérrez et al., 2019; Kardashian et al., 2022; Boyd et al., 2022; Häfliger et al., 2023; Leung et al., 2022; Hubach et al., 2022; Adsul et al., 2022; Gaias et al., 2022; Honda et al., 2022; Khan et al., 2021; Nguliefem et al., 2022; Benoit et al., 2022; Mhyre, 2022; Lince-Deroche et al., 2019).

For example, studies have found that social determinants of health, such as income, education, and employment, are associated with disparities in access to healthcare services, including sexual and reproductive health services (Gutiérrez et al., 2019; Hubach et al., 2022). Social disadvantage and marginalisation have contributed to health disparities in the context of the US HIV epidemic, with higher rates of HIV infection among sexual minorities and communities of colour (Pellowski et al., 2013). Similarly, research has shown that social determinants of health, such as poverty and education, are associated with disparities in maternal health outcomes (Gutiérrez et al., 2019). Social determinants of health have played a significant role in exacerbating health disparities in the COVID-19 pandemic, particularly among vulnerable populations (Häfliger et al., 2023).

Structural interventions addressing the underlying social determinants of health have been identified as critical strategies for reducing health disparities and promoting health equity (Brown et al., 2019). These interventions seek to address systemic factors that contribute to health disparities, such as poverty, discrimination, and limited access to healthcare (Brown et al., 2019; Kardashian et al., 2022). Policies and programmes that address income inequality, improve educational opportunities, provide affordable housing, and ensure access to healthcare services are examples of structural interventions (Brown et al., 2019; Kardashian et al., 2022).

The Health Equity Theory can inform interventions that aim to address the barriers and disparities faced by ethnic minority women in the context of this study (Pellowski et al., 2013; Brown et al., 2019). Culturally sensitive and linguistically appropriate healthcare services, community outreach and education

programmes, and policies that promote equitable access to SRH services are examples of such interventions (Pellowski et al., 2013; Brown et al., 2019). These interventions can help improve SRH outcomes for ethnic minority women in the UK by addressing social determinants of health and promoting health equity. Finally, the Health Equity Theory provides a framework for understanding, addressing, and promoting health equity. It recognises that structural and systemic factors, rather than individual choices or behaviours, influence health disparities. The Health Equity Theory can guide the identification of strategies and interventions that promote equitable access to SRH services and address the underlying social determinants of health in the context of the study on ethnic minority women's access to SRH care. The study aims to improve SRH outcomes for ethnic minority women in the UK by employing the Health Equity Theory.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Key Findings

Service provisions for ethnic minority women's SRH needs in the UK have made progress in recognizing the importance of cultural competence and tailoring care to specific populations. However, there are still notable challenges in ensuring equitable access and quality of care. Efforts should be made to address these challenges by investing in cultural competence training for healthcare providers, improving language services, and fostering partnerships with community organizations. By doing so, the UK can strive towards providing inclusive and comprehensive SRH services that meet the diverse needs of ethnic minority women. The provision of SRH services to ethnic minority women presents both challenges and opportunities for healthcare service providers. While efforts are made to deliver inclusive and culturally sensitive care, obstacles such as unmet needs, limited access, cultural disparities, and communication barriers persist. Addressing these challenges requires ongoing efforts to improve cultural competence, increase awareness and knowledge among healthcare providers, and develop targeted interventions that consider the specific needs and experiences of ethnic minority women. By addressing these challenges, healthcare service providers can strive towards achieving equitable and accessible SRH care for all women, irrespective of their ethnic background.

The issue of inequality in SRH for ethnic minority women in the UK is multifaceted, with various contributing factors that warrant critical examinationfrom multiple angles. Socio-cultural factors, including limited access to services, cultural norms, and the quality of early environments, can either hinder or positively influence SRH outcomes. Disparities in health service access and utilization also play a role, with potential barriers affecting timely and appropriate care. Knowledge gaps and inadequate sexual health education contribute to inequality, but cultural beliefs and behavioral patterns must also be considered. Information campaigns and media influence can both contribute to and mitigate SRH inequality, highlighting the need for culturally sensitive approaches. In addressing SRH inequality for ethnic minority women in the UK, it is crucial to recognize the interplay of these factors and their varying impacts. Policies and interventions should consider the cultural practices, beliefs, and values of different ethnic groups to ensure inclusivity and effectiveness. Culturally competent health strategies that provide accurate information, address knowledge gaps, and respect diverse cultural backgrounds are essential.

However, it is important to note that addressing SRH inequality solely through knowledge and education initiatives may overlook systemic factors, such as structural barriers and economic inequalities, that contribute to disparities. A comprehensive approach that combines knowledge dissemination, improved access to services, and targeted interventions is necessary to address the complex web of factors

influencing SRH outcomes. While socio-cultural factors, health service access, knowledge, and media influence contribute to inequality in SRH for ethnic minority women in the UK, a critical analysis reveals the nuanced nature of this issue. By recognizing the complexities and adopting a multi-faceted approach, policymakers and healthcare providers can work towards reducing SRH disparities and promoting equitable access to comprehensive and culturally sensitive SRH services for all women, regardless of their ethnic background.

Ethnic minority women's access to SRH services strategies aim to address their specific needs while also promoting equitable healthcare. Among the strategies used are culturally sensitive services, targeted education and information, and improved access. While these strategies have merit, it is critical to assess their potential limitations, which include the risk of perpetuating stereotypes, ignoring individual agency, reinforcing cultural biases, and ignoring structural determinants of health disparities. A balanced and nuanced approach is required to ensure that strategies are inclusive, empowering, and address complex and intersecting factors that influence ethnic minority women's SRH experiences. In essence, addressing the SRH needs of ethnic minority women in the UK requires a multifaceted approach that takes into account cultural sensitivity, language access, targeted interventions, collaboration, and addressing structural inequalities. By implementing the key implications and recommendations outlined above, policymakers and healthcare providers can work towards reducing SRH inequalities and improving the overall health and well-being of ethnic minority women.

5.2 Implications and Recommendations for Policy and Practice

The discussion on service provisions for ethnic minority women's sexual and reproductive health (SRH) needs, challenges faced by healthcare service providers, contributing factors to SRH inequality, and strategies implemented to help ethnic minority women access SRH services reveals important policy and practise implications and recommendations. These implications and recommendations aim to close existing gaps in service provision, improve service delivery, and promote equitable SRH outcomes for ethnic minority women in the UK.

1. **Improving cultural competence and sensitivity:** When providing SRH services to ethnic minority women, healthcare providers must develop cultural competence and sensitivity. Cultural competency training programmes and workshops that increase healthcare providers' understanding of different cultural norms, beliefs, and practises can help achieve this. In order to better meet the needs of ethnic minority women, healthcare institutions should ensure diverse representation on their staff.
2. **Improving access to and communication in foreign languages:** Language barriers can make it difficult for healthcare providers and ethnic minority women to communicate and understand each other. To facilitate better communication, healthcare institutions should prioritise the provision of professional interpreters or multilingual healthcare staff. Furthermore, providing informational materials in multiple languages can assist ethnic minority women in gaining access to accurate SRH information.
3. **Tailoring SRH education and outreach programmes:** SRH education and outreach programmes should be culturally sensitive, taking into account the unique beliefs, values, and attitudes of different ethnic minority groups. These programmes should address specific cultural concerns, dispel myths, and provide accurate information about contraception, STDs, and reproductive health.
4. **Improving data collection and research:** To effectively address SRH inequality, policymakers and researchers should prioritise collecting disaggregated data on SRH outcomes and experiences of ethnic

minority women. This will aid in identifying specific areas of concern, assessing the efficacy of interventions, and informing evidence-based policy decisions.

5. **Targeted interventions and support:** Policymakers should develop targeted interventions and support services that address the specific SRH needs and challenges faced by ethnic minority women. This can include providing culturally appropriate family planning services, increasing access to contraception, encouraging regular STI testing, and providing tailored support to vulnerable groups such as young unmarried women or women with mental health issues.
6. **Collaboration and partnership:** Effective SRH programmes and services require collaboration between healthcare institutions, community organisations, and ethnic minority community leaders. Engaging community members in the design, implementation, and evaluation of SRH initiatives can ensure that they are culturally relevant, acceptable, and accessible.
7. **Addressing structural inequalities:** SRH disparities among ethnic minority women are frequently rooted in larger structural issues, such as economic disparities and social determinants of health. Policymakers should address these structural factors by enacting policies that promote economic equity, expand access to education and employment, and reduce social inequalities.
8. **Health promotion and media campaigns:** Media campaigns can help raise awareness, encourage positive SRH behaviours, and reduce stigma. These campaigns should be created with the help of ethnic minority communities and tailored to their unique cultural contexts and needs. Media campaigns can dispel myths, encourage SRH-seeking behaviour, and provide information about available services.

5.3 Limitations of the study

While this systematic literature review on sexual and reproductive health (SRH) services for ethnic minority women in the United Kingdom (UK) provides useful information, there are some limitations to be aware of. These limitations should be considered when interpreting and generalising the findings. First, the study's inclusion and exclusion criteria may have influenced study selection and potentially introduced bias. Some relevant older studies, which could have provided valuable historical perspectives and insights into the development of SRH services for ethnic minority women in the UK, may have been excluded by focusing on recent studies published between 2013 and the present. Furthermore, the study only included studies that were available in English, which could have resulted in the exclusion of relevant research conducted in other languages.

Second, while the search strategy used in this study was systematic, it was limited to a single database (PubMed). Despite efforts to use relevant keywords and Boolean operators to generate a comprehensive search string, it is possible that some relevant studies were omitted. Additional databases and other sources, such as grey literature or unpublished studies, could have produced more diverse and comprehensive results. Third, the researcher assessed the quality of the included studies using their own judgement and the PRISMA guidelines. Despite efforts to ensure the credibility of the included studies, the subjective nature of the assessment process may introduce some bias. Exclusion of studies due to a lack of sufficient information or the unavailability of full texts may also have hampered the review's comprehensiveness.

Furthermore, the findings may have limited generalizability. Because the review concentrated on SRH services for ethnic minority women in the United Kingdom, the findings may not be directly applicable to other countries or contexts. Because the experiences and challenges faced by ethnic minority women in

the United Kingdom may differ from those in other regions, caution should be exercised when extrapolating the findings to other populations. Finally, while systematic and rigorous, thematic analysis of the extracted data is subjective to some extent. The researcher's perspectives and biases may influence theme identification and interpretation. Despite these limitations, this systematic review provides useful information about the current state of SRH services for ethnic minority women in the United Kingdom. The findings can help policymakers, healthcare providers, and researchers develop targeted interventions and strategies to improve access, address barriers, and promote health equity for ethnic minority women's sexual and reproductive health.

5.4 Suggestions for future research

Several suggestions for future research in the field of sexual and reproductive health (SRH) services for ethnic minority women in the United Kingdom (UK) can be made based on the study's findings and limitations:

Longitudinal research: Conducting studies that track changes in SRH service access, utilization, and outcomes over time to understand the long-term effects on ethnic minority women's health.

Intersectional approach: Taking into account the multiple intersecting identities and experiences of ethnic minority women to better understand how factors like race, ethnicity, gender, socioeconomic status, and immigration status interact to shape SRH outcomes and access to services.

Mixed-methods research: Combining quantitative and qualitative methods to gain a comprehensive understanding of ethnic minority women's experiences and perspectives on SRH services.

Comparative research: Comparing SRH services and outcomes for ethnic minority women between different countries or regions to identify best practices and areas for improvement.

Participatory research: Involving ethnic minority women as active participants and collaborators in research to ensure their voices and perspectives are heard and valued.

Evaluation of interventions: Conducting rigorous evaluations of interventions aimed at improving SRH services for ethnic minority women to determine their effectiveness and impact.

Focus on specific ethnic minority groups: Investigating the unique challenges and needs of specific ethnic minority communities to develop tailored interventions.

Health literacy and education: Examining the role of health literacy and comprehensive sexuality education in improving SRH outcomes for ethnic minority women.

Policy evaluation: Researching the impact of policies and guidelines on the provision of SRH services to ethnic minority women to identify gaps and barriers and inform policy changes.

Long-term health outcomes: Investigating the relationship between SRH service access and broader health outcomes, such as maternal health, STI rates, and reproductive cancers, among ethnic minority women.

Addressing these areas of research will contribute to a comprehensive understanding of the challenges, barriers, and strategies for improving SRH services for ethnic minority women in the UK. This knowledge can inform evidence-based interventions and policies that promote health equity and ensure equitable access to culturally sensitive SRH services for all women.

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