Anghydraddoldebau mynediad at wasanaethau gofal iechyd:

Adroddiad Cwmpasu Ystwyth

Lluniwyd gan:

Amy Hookway, Prif Ddadansoddwr Tystiolaeth a Gwybodaeth

Anamica Patel, Uwch Ddadansoddwr Tystiolaeth a Gwybodaeth

Jordan Everitt, Dadansoddwr Tystiolaeth a Gwybodaeth

Toby Ayres, Dadansoddwr Tystiolaeth a Gwybodaeth

Cynnwys

Crynodeb Gweithredol

Cefndir:

Mae'r adroddiad hwn yn drosolwg o'r dystiolaeth ar anghydraddoldebau o ran mynediad at wasanaethau iechyd. Mae'n cynnwys gwybodaeth am y math o grwpiau poblogaeth a'u demograffeg neu eu nodweddion economaidd-gymdeithasol a nodwyd mewn llenyddiaeth ymchwil eilaidd fel sydd yn gysylltiedig ag anghydraddoldeb o ran mynediad at amrywiaeth o leoliadau gofal iechyd gwahanol.[1] Lle y bo'n bosibl, gwnaed ymgais i nodi nodweddion poblogaeth gydag oedi o ran diagnosis ac oedi o ran cysylltu â gofal arbenigol ar ôl diagnosis (h.y., atgyfeirio) yn ogystal ag echdynnu data sy'n berthnasol i leoliad y DU.

Amcan:

Cynnal adolygiad cwmpasu i nodi nodweddion y boblogaeth sydd yn llai tebygol o gael mynediad at wasanaethau iechyd.

Yn benodol, aethpwyd i'r afael â'r cwestiynau canlynol:

- Pwy (nodweddion poblogaeth) sydd yn llai tebygol o gael mynediad at wasanaethau iechyd?
- Pa wasanaethau iechyd y mae'r nodweddion poblogaeth hyn yn llai tebygol o gael mynediad atynt?
- Pa rwystrau (strwythurol) sydd yn gysylltiedig â llai o ymgymeriad yn y gwasanaethau iechyd o fewn y nodweddion poblogaeth hyn?

Dulliau:

Oherwydd natur eang y testun, roedd y chwiliad yn gyfyngedig i adolygiadau a gynhyrchwyd gan ddefnyddio dulliau chwilio systematig penodol y gellir eu hatgynhyrchu, arfarnu beirniadol o ansawdd a chyfosod y brif lenyddiaeth ar y testun. Gyda'r nod yma, chwiliwyd un ar bymtheg o ffynonellau sydd yn glynu wrth egwyddorion adolygu systematig cadarn, dwy gronfa ddata, Google scholar a briffiau Tystiolaeth Llyfrgell Asiantaeth Diogelwch Iechyd y DU am lenyddiaeth wedi ei chyhoeddi a llenyddiaeth lwyd. Dim ond adolygiadau a gynhyrchwyd gan ddefnyddio methodoleg systematig (yn cynnwys arfarnu beirniadol) gafodd eu hasesu ar gyfer eu cynnwys. Sgriniodd dau adolygydd yr adolygiadau yn annibynnol am berthnasedd gan echdynnu data perthnasol. Gan fod yr adroddiad hwn yn ymwneud yn bennaf â nodi grwpiau poblogaeth, ni chafodd unrhyw un o'r adolygiadau gafodd eu cynnwys eu harfarnu'n feirniadol am eu hansawdd.

[1] O hyn ymlaen, cyfeirir ato fel "nodweddion poblogaeth".

Lle y bo'n bosibl, cafodd data yn adrodd ar fynediad gan nodweddion poblogaeth gwahanol, cyfeiriad yr anghydraddoldeb a'r math o wasanaeth iechyd, ei echdynnu.

Canlyniadau:

Roedd pedwar deg pedwar o adolygiadau'n bodloni'r meini prawf ar gyfer eu cynnwys. O'r rhain, roedd dau ar bymtheg o adolygiadau yn canolbwyntio ar wasanaeth gofal iechyd penodol, gan nodi unrhyw nodweddion poblogaeth â mynediad/atgyfeirio annheg i'r gwasanaeth iechyd hwnnw, neu unrhyw grŵp oedd yn profi oedi wrth gael diagnosis. Canolbwyntiodd y saith ar hugain o adolygiadau oedd yn weddill ar nodwedd poblogaeth wedi ei rhagddiffinio gyda'r nod o gadarnhau neu wrthbrofi anghydraddoldeb yn y grŵp hwnnw, neu archwilio a oes amrywiad pellach mewn anghydraddoldebau yn y grŵp hwnnw. Nododd deunaw o adolygiadau rwystrau a allai fod yn cyfrannu at lai o fynediad ac atgyfeirio at wasanaethau iechyd gan y grwpiau a nodwyd.

Nodweddion poblogaeth

Nodwyd saith o grwpiau a nodweddion poblogaeth trosfwaol:

- Oed
- Lefel addysg
- Ethnigrwydd neu statws mewnfudo
- Rhywedd
- Risg (risgiau meddygol a ffordd o fyw)
- Gwledigrwydd neu amddifadedd cymdeithasol a
- Statws economaidd-gymdeithasol

Daeth y rhain o dan bum categori eang o wasanaethau iechyd:

- Gwiriadau iechyd y GIG
- Gwasanaethau sgrinio
- Gwasanaethau brechu
- Gwasanaethau gofal sylfaenol
- Gwasanaethau gofal eilaidd / arbenigol

Canfyddiadau ar anghydraddoldebau o ran mynediad at ofal iechyd

Mae'r canfyddiadau o'r adroddiad hwn yn ***awgrymu presenoldeb anghydraddoldebau o ran mynediad, ymgymeriad ac atgyfeirio at wasanaethau iechyd o fewn pob nodwedd poblogaeth***. Fodd bynnag, mae ***cyfeiriad yr anghydraddoldeb hwn yn cael ei*** ddylanwadu gan nifer o ffactorau yn cynnwys y math o nodwedd poblogaeth, ei anghenion penodol, grŵp cymhariaeth ac ati. Felly, gallai nodwedd poblogaeth fod yn llai tebygol o gael mynediad at un gwasanaeth iechyd tra'n fwy tebygol o gael mynediad at wasanaeth arall. E.e. nodwyd bod

henaint (65+) yn fwy tebygol o gael mynediad at wiriadau iechyd y GIG ond bod cyfraddau defnydd is wedi eu hadrodd yn y grŵp oedran hwn o ran gofal arbenigol. Yn yr un modd, roedd mynediad at therapi lleferydd ac iaith yn amrywio ar draws chwe grŵp lleiafrifoedd ethnig, gyda'r uchaf ar gyfer y grŵp Dwyrain Canol/Arabaidd wedi ei ddilyn gan Ewropeaid gwyn a grŵp ethnig cymysg/ grwpiau ethnig eraill ac isaf ar gyfer grwpiau du.

Rhwystrau o ran ymgymeriad gwasanaethau iechyd gan y nodweddion poblogaeth a nodwyd

Roedd y rhwystrau y canfuwyd eu bod yn gysylltiedig ag ymgymeriad is o'r gwasanaethau iechyd yn gyffredinol yn gysylltiedig â ffactorau sy'n effeithio ar hygyrchedd a fforddiadwyedd. Nododd grwpiau lleiafrifol, poblogaethau mudwyr, Sipsiwn, Roma a theithwyr ac oedolion hŷn eu bod yn profi'r rhwystrau mwyaf. Y rhwystrau pennaf a nodwyd, oedd yn ymwneud ag hygyrchedd oedd rhwystrau cyfathrebu; llythrennedd iechyd isel yn cynnwys peidio bod yn gyfarwydd â darpariaeth gofal iechyd lleol a hawl; ansicrwydd ynghylch statws cyfreithiol; teimlad o wahaniaethu; diffyg gwasanaethau priodol yn ddiwylliannol, allgau digidol a diffyg hygyrchedd daearyddol. Roedd costau uniongyrchol gwasanaethau iechyd penodol a chostau anuniongyrchol yn deillio o amser i ffwrdd o'r gwaith, darpariaethau gofal iechyd, costau teithio a chwblhau blaenoriaethau fel gofal plant ac ymrwymiadau teuluol yn cyfrannu at ddiffyg fforddiadwyedd y gwasanaethau yn y grwpiau hyn.

Nododd pobl hŷn sawl mater yn ymwneud â'r teulu hefyd o ran atgyfeirio i gael gofal lliniarol yn cynnwys gwrthdaro teuluol am y camau gweithredu gorau i'r claf, credoau diwylliannol neu grefyddol teulu a'u methiant i dderbyn prognosis y claf. Yn ogystal, nodwyd ***sawl rhwystr penodol i ddarparwr gofal iechyd*** hefyd ar draws y nodweddion grŵp. Roedd y rhain yn cynnwys diffyg dealltwriaeth ddiwylliannol, amrywioldeb lleol o ran ymagwedd ac ymarfer yn cynnwys arferion presgripsiynu a thrin, gweithlu a gallu gwasanaeth isel oherwydd argaeledd isel staff, rhestrau aros hir a diffyg dyrannu adnoddau o fewn gwasanaethau/ ardaloedd penodol.

Roedd nodweddion poblogaeth eraill yn adrodd ffactorau oedd yn cyfrannu at ymgymeriad is o ran gwasanaethau iechyd yn cynnwys pobl ifanc ar y cyrion, menywod o leiafrifoedd rhywiol ac oedolion digartref. Roedd y rhwystrau a nodwyd amlaf o fewn y grwpiau hyn yn cynnwys methu fforddio gwasanaethau penodol oherwydd costau uniongyrchol ac anuniongyrchol yn ogystal â diffyg dealltwriaeth a gwybodaeth am ddarparwyr gofal iechyd yn ymwneud â rhywedd a phoblogaethau amrywiol yn rhywiol a diffyg defnydd o iaith gynhwysol gan ddarparwyr y gwasanaethau. Yn ogystal, adroddodd menywod o leiafrifoedd rhywiol eu bod yn profi teimlad o wahaniaethu a dadrymuso, gwrthod gwasanaethu a chamwybodaeth gan ddarparwr y gwasanaeth; ac adroddodd oedolion digartref eu bod yn profi anawsterau yn cofrestru am gymorth gan y llywodraeth.

Camau ac ystyriaethau pellach:

Briff gwreiddiol yr adroddiad hwn oedd cynnal chwiliad cwmpasu eang ar gyfer adolygiadau wedi eu cynhyrchu gan ddefnyddio methodoleg systematig i nodi'r nodweddion poblogaeth sydd yn llai tebygol o gael mynediad at/ymgymryd â gwasanaethau iechyd. Mae ymchwil helaeth yn ***cymharu*** mynediad yn ôl ***nodweddion poblogaeth*** ac yn adrodd nodweddion sydd yn fwy tebygol o gael mynediad at ***wasanaeth iechyd penodol*** mewn cymhariaeth ag un arall yn hytrach na gwasanaethau iechyd yn gyffredinol. Gallai hyn fod oherwydd natur eang y cwestiwn. Felly, er mai'r prif ganlyniad o ddiddordeb oedd nodi nodweddion poblogaeth oedd yn llai tebygol o gael mynediad at wasanaethau iechyd, cafodd data, lle'r oedd ar gael, ar nodweddion poblogaeth oedd yn llai tebygol o gael mynediad at wasanaethau o'u cymharu ag un arall, eu casglu hefyd o'r adolygiadau oedd wedi eu cynnwys.

Nodwyd saith nodwedd poblogaeth trosfwaol yn yr adolygiad cwmpasu hwn. Fodd bynnag, oherwydd natur eang y cwestiwn a'r ffactorau lluosog sydd yn dylanwadu ar gyfeiriad yr anghydraddoldeb, mae'n bwysig ystyried canfyddiadau'r adroddiad hwn wrth ddylunio ymchwil bellach. Argymhellir edrych ar ddata Cymru ar y nodweddion poblogaeth a nodwyd yn yr adroddiad hwn, er mwyn nodi'r anghydraddoldebau a brofir gan y grwpiau hyn yn lleoliad Cymru.

Mae awgrymiadau ar gyfer gwaith pellach gan y Gwasanaeth Tystiolaeth yn cynnwys:

1. Archwilio'r dulliau a ddefnyddir i nodi anghydraddoldebau mewn mynediad at wasanaethau iechyd mewn gwledydd eraill a'r ffordd y gellid eu cymhwyso i ddata yng Nghymru

Neu

2. Cynhyrchu crynodeb tystiolaeth testun yn canolbwyntio ar:

(i) Nodi anghydraddoldebau o ran mynediad at wasanaethau iechyd mewn poblogaeth (e.e., lleiafrifoedd ethnig) neu nodwedd (e.e., statws economaidd-gymdeithasol), gwasanaeth gofal iechyd penodol (e.e., gwasanaethau sgrinio), neu gyfuniad o sawl ffactor. Gallai hyn hefyd gynnwys archwilio rhwystrau penodol i'r nodwedd poblogaeth neu'r gwasanaeth. Er ei fod yn debyg i'r hyn a wnaed ar gyfer yr adolygiad cwmpasu presennol, gallai hyn fod yn ddefnyddiol i ddarparu archwiliad manylach i unrhyw fylchau a nodwyd gan yr adolygiad cwmpasu hwn, trwy archwilio llenyddiaeth sylfaenol mewn maes ffocws.

Neu

(ii) Ymyriadau i wella mynediad at wasanaeth iechyd penodol mewn nodwedd poblogaeth benodol.

Mae crynodeb tystiolaeth testun yn cael ei gynhyrchu gan ddilyn methodoleg gynhwysfawr ac yn mynd i'r afael â chwestiwn ymchwil â ffocws. Mae'r fethodoleg yn cynnwys chwiliad systematig ar gyfer llenyddiaeth sylfaenol mewn amrywiaeth ehangach o gronfeydd data, arfarnu ansawdd yn ogystal â graddio a chyfosod y dystiolaeth a nodwyd. Ei gyfnod cyflawni yw 10-12 wythnos/testun.

Cyflwyniad

Mae'r adroddiad hwn yn rhoi trosolwg o'r dystiolaeth a nodwyd o adolygiad cwmpasu byr a gynhaliwyd gan Wasanaeth Tystiolaeth Iechyd Cyhoeddus Cymru i nodi'r sail dystiolaeth ar nodweddion poblogaeth sydd yn llai tebygol o gael mynediad at wasanaethau gofal iechyd.

Dulliau

Gan fod hwn yn destun eang, roedd yr ymchwil yn gyfyngedig i gynnwys adolygiadau a gynhyrchwyd gan ddefnyddio dulliau penodol y gellir eu hatgynhyrchu o chwilio systematig, arfarnu ansawdd yn feirniadol a chyfosod y llenyddiaeth sylfaenol am y testun yn unig. Mae hon yn ffordd dderbyniol o gael mynediad cyflym at y rhan fwyaf o'r sail dystiolaeth, ac er nad nodi pob cyhoeddiad ar destun yw'r bwriad, dylai ganiatáu creu trosolwg. Cafodd astudiaethau sylfaenol eu hallgáu am y byddai cynnwys ffynonellau tystiolaeth sylfaenol ac eilaidd ar destun mor eang wedi gwneud yr adroddiad hwn yn anodd i'w reoli o fewn cyfnod amser yr ymchwil yma.

Ffynonellau data: Cafodd un ffynhonnell ar bymtheg sydd yn glynu wrth egwyddorion adolygu systematig cadarn[2], dwy gronfa ddata, Google scholar a briffiau Tystiolaeth Llyfrgell Asiantaeth Diogelwch Iechyd y DU eu chwilio am lenyddiaeth wedi ei chyhoeddi a llenyddiaeth lwyd gan ddefnyddio termau chwilio a strategaethau wedi eu dylunio'n benodol ar gyfer pob ffynhonnell ddata. Cafodd yr holl adolygiadau wedi eu cyhoeddi a heb eu cyhoeddi eu hasesu ar gyfer eu cynnwys ac nid oedd unrhyw gyfyngiadau o ran dyddiad cyhoeddi.

Dewis astudiaethau: Cafodd adolygiadau sydd yn cael eu creu gan ddefnyddio methodoleg systematig (yn cynnwys arfarnu beirniadol) h.y. adolygiadau systematig, adolygiadau cwmpasu, adolygiadau cyflym ac ati, eu hasesu ar gyfer eu cynnwys. Cafodd data meintiol o adolygiadau o astudiaethau lefel poblogaeth eu cynnwys.

Echdynnu data: Sgriniodd dau adolygydd yr adolygiadau yn annibynnol am berthnasedd ar lefel teitl, haniaethol a thestun llawn. Cafodd data o'r adolygiadau perthnasol wedyn eu hechdynnu i dabl echdynnu data. Archwiliodd ail adolygydd y data a echdynnwyd. Cafodd unrhyw anghytundeb yn ystod y cyfnod hwn ei ddatrys trwy drafod gyda thrydydd adolygydd. Gan fod yr adroddiad hwn yn ymwneud yn bennaf â nodi nodweddion grŵp, ni chafodd unrhyw un o'r adolygiadau gafodd eu cynnwys eu harfarnu'n feirniadol o ran eu hansawdd.

Cyfosod data: Lle y bo'n bosibl, cafodd data yn nodi'r mynediad gan nodweddion poblogaeth gwahanol, cyfeiriad yr anghydraddoldeb a'r math o wasanaeth iechyd, ei echdynnu. Mae'r rhain wedi eu hadrodd mewn tablau gyda naratif ategol.

---

[2] Yn dilyn egwyddorion adolygu systematig craidd: strategaeth chwilio gynhwysfawr ac wedi ei datgan, dewis ffynonellau yn seiliedig ar feini prawf gwrthrychol, asesu risg o ragfarn ffynonellau sylfaenol a/neu yn fethodoleg a ddatblygwyd gan gorff arbenigol e.e. NICE. Am restr lawn o'r ffynonellau a chwiliwyd, gweler yr adran Ffynonellau a chwiliwyd o'r adroddiad.

Gan fod yr adroddiad hwn yn ymwneud yn bennaf â nodi nodweddion poblogaeth, nid oes un o'r adolygiadau sydd wedi eu cynnwys wedi cael eu harfarnu'n feirniadol. Pe byddai angen tystiolaeth ar gyfer mentrau polisi ac ymarfer, byddai adolygiad tystiolaeth manylach yn briodol.

Meini Prawf Cynnwys/Allgáu		
	Cynnwys	**Allgáu**
Sampl	Oedolion a phlant sydd yn llai tebygol o gael mynediad at wasanaethau gofal iechyd ac unrhyw rwystrau penodol a brofwyd gan y grwpiau hynny.	
Ffenomen o Ddiddordeb	**Peidio â chael mynediad at wasanaethau gofal iechyd**: yn cynnwys • Peidio â bod wedi cofrestru â meddyg teulu • Peidio â chael mynediad at wasanaethau pryd a lle bynnag y bo'u hangen mewn gofal sylfaenol ac eilaidd. Gwahaniaethau o ran mynediad at wasanaethau, yn cynnwys: • Ymgymeriad gwasanaethau • Atgyfeirio at wasanaethau • Peidio â mynychu apwyntiadau	
Dyluniad	Data meintiol o adolygiadau o astudiaethau ar lefel poblogaeth.	Ansoddol
Gwerthuso (canlyniadau)	Nodweddion, grwpiau a rhwystrau	Rhwystrau mewnol a hwyluswyr (fel bod ofn, gwadu ac ati)
Math o ymchwil	Adolygiadau a gynhaliwyd gan ddefnyddio methodoleg systematig (yn cynnwys arfarnu beirniadol)	Astudiaethau sylfaenol
Gwlad	Adolygiadau yn cynnwys o leiaf un astudiaeth o'r DU/Iwerddon â chanlyniad perthnasol	Adolygiadau systematig ddim yn cynnwys astudiaethau'r DU/Iwerddon
Ystyriaethau Astudiaeth eraill		
Saesneg yn unig Ni osodwyd unrhyw derfynau dyddiad		

Diffiniadau:

Mae'r term "mynediad" yn cyfeirio at fynychu, peidio â mynychu, ymgymeriad a defnydd o wasanaethau gofal iechyd gan y boblogaeth.

Mae'r term "adolygiad" yn cyfeirio at unrhyw ddarn o dystiolaeth a gynhyrchwyd gan ddefnyddio methodoleg systematig (yn cynnwys arfarnu beirniadol) h.y., adolygiadau systematig, adolygiadau cwmpasu, adolygiadau cyflym ac ati

Mae'r term "croestoriadedd" yn cyfeirio at rhyng-gysylltedd dosbarthiadau cymdeithasol gwahanol (e.e. ethnigrwydd, hil, rhywedd, anabledd) ac yn cydnabod nad oes unrhyw gategori hunaniaeth gymdeithasol yn bodoli yn ynysig oddi wrth y lleill.

Canfyddiadau

Nodwyd pedwar deg pedwar o adolygiadau oedd yn mynd i'r afael yn rhannol â'r cwestiwn ymchwil. Ni chanfuwyd unrhyw adolygiadau systematig sydd yn mynd i'r afael â'r cwestiwn yn ei gyfanrwydd. Canolbwyntiodd yr adolygiadau a nodwyd ar boblogaeth benodol (e.e. lleiafrifoedd ethnig), nodweddion unigol (e.e. statws economaidd-gymdeithasol isel), gwasanaethau iechyd (e.e. gwiriadau iechyd y GIG, gwasanaethau sgrinio) neu rwystrau i fynediad at ofal iechyd mewn grŵp/lleoliad penodol. Roedd pob adolygiad yn cynnwys nifer fawr o astudiaethau sylfaenol. Gallai hyn esbonio pam na chafodd unrhyw adolygiadau trosfwaol yn edrych ar y testun yn ei gyfanrwydd eu nodi.

Cafodd saith nodwedd poblogaeth trosfwaol eu nodi:

- Oed
- Lefel addysg
- Ethnigrwydd neu statws mewnfudo
- Rhywedd
- Risg (sgiliau meddygol a ffordd o fyw)
- Gwledigrwydd neu amddifadedd cymdeithasol a
- Statws economaidd-gymdeithasol

Roedd y gwasanaethau iechyd a archwiliwyd yn dod o dan bum categori eang:

- Gwiriadau iechyd y GIG
- Gwasanaethau sgrinio
- Gwasanaethau brechu
- Gwasanaethau gofal sylfaenol
- Gwasanaethau gofal eilaidd/ arbenigol

Mae canfyddiadau'r adroddiad hwn yn awgrymu presenoldeb anghydraddoldebau o ran mynediad, ymgymeriad ac atygfeirio at wasanaethau iechyd o fewn pob

nodwedd poblogaeth a nodwyd. Fodd bynnag, mae cyfeiriad yr anghydraddoldeb hwn yn cael ei ddylanwadu gan nifer o ffactorau yn cynnwys y nodwedd poblogaeth benodol, ei hanghenion penodol, y math o wasanaeth iechyd y ceir mynediad ato, grŵp cymharu ac ati. Felly, gallai nodwedd poblogaeth fod yn llai tebygol o gael mynediad at un gwasanaeth iechyd tra'n fwy tebygol o gael mynediad at wasanaeth arall e.e., nodwyd bod pobl oedrannus (65 oed+) yn fwy tebygol o gael mynediad at wiriadau iechyd y GIG tra bod cyfraddau defnydd is wedi eu nodi yn y grŵp oedran hwn ar gyfer gofal arbenigol. Yn yr un modd, roedd mynediad at therapi lleferydd ac iaith yn amrywio ar draws chwe grŵp lleiafrif ethnig, ar ei uchaf ar gyfer y grŵp Dwyrain Canol/Arabaidd wedi ei ddilyn gan Ewropeaid gwyn, ac ar ei isaf ar gyfer grwpiau du.

Cyflwynir y dystiolaeth yn yr adroddiad hwn o dan ddwy adran. Mae adran un yn cynnwys adolygiadau yn cymharu mynediad â gwasanaethau gofal iechyd penodol rhwng nodweddion poblogaeth (n=17). Mae adran dau yn cynnwys adolygiadau yn archwilio nodwedd poblogaeth wedi ei rhagddiffinio gyda'r nod o gadarnhau neu wrthbrofi anghydraddoldeb yn y nodwedd poblogaeth a archwiliwyd, neu i archwilio a oes amrywiad pellach mewn anghydraddoldebau yn y boblogaeth a astudiwyd (n=27).

Mae'n rhaid nodi bod y diffiniad o 'fynediad' a'r dulliau a ddefnyddiwyd i'w gyfrifo, yn amrywio'n sylweddol ar draws yr adolygiadau sydd wedi eu cynnwys. Gan fod y rhanddeiliaid â diddordeb yn bennaf mewn nodi nodwedd poblogaeth lle mae ymgymeriad yn llai tebygol neu'n cyflwyno'n hwyr i'r gwasanaeth iechyd, gwnaed ymgais i echdynnu gwybodaeth oedd yn berthnasol i ymgymeriad, mynychu, peidio â mynychu a defnyddio gwasanaethau iechyd gan y grwpiau gwahanol o'r boblogaeth yn unig. Weithiau nodwyd mynediad fel cyfran y rheiny sydd wedi mynychu ond mewn adolygiadau eraill roedd wedi ei nodi'n syml fel maint y boblogaeth oedd wedi ei chynnwys a nifer y cysylltiadau gan gleifion.

Yn ogystal, cymharodd sawl adolygiad fynediad yn ôl nodwedd o'r grŵp poblogaeth penodol. Roeddent yn adrodd ar y nodweddion poblogaeth oedd yn fwy tebygol o gael mynediad at wasanaeth iechyd penodol. Er y gallai un nodwedd poblogaeth fod yn gysylltiedig â mwy o fynediad o'i gymharu ag un arall, nid yw hyn yn golygu yn awtomatig bod yr olaf yn llai tebygol o gael mynediad at y gwasanaeth iechyd hwnnw na'u hangen. Er enghraifft, adroddodd un adolygiad bod cleifion oedrannus yn fwy tebygol o gael mynediad at wiriadau iechyd cardiofasgwlaidd na chleifion iau. Nid yw hyn yn golygu'n awtomatig bod pobl iau yn cael llai o fynediad ato na'u hangen, mae gan bobl iau lai o risg o CVD felly efallai nad ydynt yn cael mynediad at wiriadau iechyd oherwydd yr amgyffrediad o risg is (a ffactorau eraill). Mae hefyd yn debygol y gallai'r rheiny sydd yn fwy tebygol o gael mynediad fod yn 'bryderus iach' neu'r 'rheiny sydd lleiaf tebygol o gael budd'. Fodd bynnag, roedd y rhain yn berthnasol ac o ddiddordeb i randdeiliaid, felly maent wedi cael eu cynnwys.

Adran 1: Nodweddion poblogaeth a allai fod yn llai tebygol o gael mynediad at wasanaethau iechyd penodol

Mae'r adran hon yn crynhoi data o ddau ar bymtheg o adolygiadau â'r nod o nodi patrymau mynediad i atgyfeirio at fath penodol o wasanaeth gofal iechyd yn ôl nodweddion poblogaeth amrywiol. Daeth y gwasanaethau gofal iechyd o dan bum categori eang. Y rhain oedd gwiriadau iechyd y GIG, gwasanaethau sgrinio, brechlynnau HPV, gwasanaethau gofal sylfaenol a gwasanaethau gofal arbenigol. Mae Tabl 1 yn rhestru'r adolygiadau sydd wedi eu cynnwys yn yr adran hon, eu dyluniad ymchwil a nifer yr astudiaethau sydd wedi eu cynnwys o'r DU.

Cyhoeddwyd yr adolygiadau hyn rhwng 2000 a 2022 ac yn cynnwys astudiaethau o wledydd Ewropeaidd yn bennaf, gyda phedair yn cynnwys astudiaethau o'r DU yn unig. Roedd tri adolygiad ond yn berthnasol i fenywod.

Roedd yr adolygiadau hyn yn aml yn cymharu mynediad at wasanaethau gofal iechyd rhwng sawl nodwedd poblogaeth. Mewn rhai achosion, roeddent ond yn adrodd ar nodweddion poblogaeth oedd yn fwy tebygol o gael mynediad at wasanaeth iechyd.

Tabl 1: Mynediad/ ymgymeriad gwasanaethau gofal iechyd (N= 17)
Gwiriadau iechyd y GIG (n= 3)
Gofal cardiofasgwlaidd yn y DU: Asthana et al. 2018 (meintiol, n=174) Gwiriad iechyd GIG yn y DU: Bunten et al. 2020 (meintiol, n=9) a Martin et al. 2018 (meintiol, n=26)
Gwasanaethau sgrinio (n= 4)
Profion HIV arferol yn yr ysbyty: Elgalib et al. 2018 (dulliau cymysg, 7/14 o astudiaethau yn y DU) Gwasanaethau sgrinio: Jepson et al. 2000 (meintiol, 3/65 o astudiaethau yn y DU) Sgrinio canser y colon a'r rhefr: Mosquera et al. 2020 (dulliau cymysg, 29/96 o astudiaethau yn y DU) Atal canser serfigol: Murfin et al. 2020 (meintiol, 1/10 o astudiaethau yn y DU)
Brechlynnau'r Feirws Papiloma Dynol [(HPV) n= 2]
HPV: Fisher et al. 2013 (meintiol, 1/27 o astudiaethau yn y DU) Atal canser serfigol: Murfin et al. 2020 (meintiol, 1/10 o astudiaethau yn y DU)
Gwasanaethau gofal sylfaenol (n= 3)
Gwasanaeth y tu allan i oriau gofal sylfaenol: Foster et al. 2000 (adolygiad meintiol o adolygiadau, 37/105 o astudiaethau yn y DU) Gwasanaethau iachaol mewn systemau iechyd cyffredinol: Hanratty et al. 2007 (meintiol, 8/26 o astudiaethau yn y DU)

Llwybr diagnostig o ganserau gynaecolegol: Williams et al. (2019) (dulliau cymysg, 21/37 o astudiaethau yn y DU)
Gwasanaethau gofal arbenigol (n= 6)
Gofal lliniarol arbenigol: Ahmed et al. 2004 (dulliau cymysg, 18/40 o astudiaethau yn y DU) Anghyfiawnder mewn gofal cardiofasgwlaidd yn y DU: Asthana et al. 2018 (meintiol, n=174) Apwyntiadau cleifion allanol diabetes: Brewster et al. 2020 (dulliau cymysg, 16/34 o astudiaethau yn y DU) Rheoli diabetes: Ricci-Cabello et al. 2010 (meintiol, 11/25 o astudiaethau yn y DU) Llawdriniaeth amnewid clun yn y DU: Ryan-Ndegwa et al. 2021 (meintiol, n=16) Gofal hosbis: Tobin et al. 2022 (dulliau cymysg, 90/130 o astudiaethau yn y DU)
Atgyfeirio at wasanaethau gofal arbenigol (n= 4)
Gofal lliniarol arbenigol: Ahmed et al. 2004 (dulliau cymysg, 18/40 o astudiaethau yn y DU) Cysylltiad â gofal HIV yn dilyn diagnosis: Croxford et al. 2018 (meintiol, 7/24 o astudiaethau yn y DU) Gofal hosbis: Tobin et al. 2022 (dulliau cymysg, 90/130 o astudiaethau yn y DU) Llwybr diagnostig o ganserau gynaecolegol: Williams et al. 2019 (dulliau cymysg, 21/37 o astudiaethau yn y DU)
Oedi wrth gael diagnosis (n= 1)
Llwybr diagnostig o ganserau gynaecolegol: Williams et al. 2019 (dulliau cymysg, 21/37 o astudiaethau yn y DU)

Nodweddion poblogaeth:

Nodwyd saith nodwedd poblogaeth trosfwaol yn yr adolygiadau sydd wedi eu cynnwys a chânt eu trafod yn yr adran hon. Mae'r gyfres o dablau gyda'u naratif ategol (isod) yn crynhoi a chafodd anghydraddoldeb o ran mynediad neu atgyfeirio at wasanaeth iechyd penodol ei nodi yn y nodwedd poblogaeth. Maent hefyd yn esbonio cyfeiriad yr anghydraddoldeb. Mae Atodiad B yn nodi'r holl nodweddion poblogaeth a nodwyd yn yr adran hon.

Oed:

Tabl 2: Anghydraddoldebau yn ôl oed (n=4)

Math o wasanaeth gofal iechyd		Oed hŷn	Oed iau
Mynediad at	**Gwiriadau iechyd y GIG**	↑ (Bunten et al. 2020) ↑ (Martin et al. 2018)	↓ (Asthana et al. 2018)
	Gwasanaethau sgrinio	↑ (Jepson et al. 2000)	↑ (Elgalib et al. 2018)
	Gofal sylfaenol	↑ (Foster et al. 2019)	
	Gofal arbenigol	↓ (Asthana et al. 2018) ↓ (Brewster et al. 2020)	↓ (Brewster et al. 2020)
Atgyfeirio at	**Gofal arbenigol**	↓ (Ahmed et al. 2004) ↓ (Williams et al. 2019)	↓ (Croxford et al. 2018)

Nododd deg adolygiad systematig anghydraddoldeb o ran mynediad at wasanaethau gofal iechyd sydd yn gysylltiedig ag oed. Roedd cyfeiriad yr anghydraddoldeb yn amrywio gydag oed y cyfranogwyr yn ogystal â'r math o wasanaeth gofal iechyd. Roedd yr adolygiadau systematig yn awgrymu y gallai pobl hŷn (65 oed+) fod yn fwy tebygol o gael mynediad at wasanaethau iechyd penodol fel gwiriadau iechyd y GIG (Bunten et al. 2010 a Martin et al. 2018), gwasanaethau gofal sylfaenol y tu allan i oriau (OOHSs) (Foster et al. 2019) a sgrinio prawf gwaed cudd yn yr ysgarthion (Jepson et al. 2000). Nodwyd cyfraddau defnydd is yn y grŵp oedran hwn ar gyfer gofal arbenigol fel gofal cardiofasgwlaidd (Asthana et al. 2018) ac apwyntiadau cleifion allanol diabetes (Brewster et al. 2020). Nododd dau adolygiad systematig pellach gysylltiad hefyd rhwng oed cynyddol ac oedi cynyddol yn atgyfeirio at wasanaethau gofal arbenigol fel gofal lliniarol (Ahmed et al. 2004) a llwybr diagnostig canserau gynaecolegol (Williams et al. 2019).

Mewn gwrthgyferbyniad, nodwyd ieuenctid fel ffactor yn lleihau cyfraddau cyflwyno, ymgymeriad a pheidio â mynychu gwiriadau iechyd y GIG (Asthana et al. 2018) ac apwyntiadau cleifion allanol diabetes (Brewster et al. 2020). Er bod un adolygiad

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

systematig wedi nodi ieuenctid fel ffactor sydd yn gysylltiedig ag ymgymeriad uwch o brofion HIV (Elgalib et al. 2018), nododd adolygiad systematig arall ei fod yn gysylltiedig ag oedi mewn cysylltiad â gofal HIV (Croxford et al. 2018). Roedd un adolygiad systematig yn aneglur a oedd menywod hŷn neu iau yn fwy tebygol o fynychu profion serfigol papanicolaou (Jepson et al. 2000).

Lefel addysg:

Tabl 3: Anghydraddoldebau yn ôl lefel addysg (n=4)			
Math o wasanaeth gofal iechyd		Lefelau addysg is	Lefelau addysg uwch
Mynediad at	**Gwasanaethau sgrinio**		↑ (Jepson et al. 2000) ↑ (Mosquera et al. 2020) ↑ (Murfin et al. 2020)
	Brechlyn HPV	↓ (Murfin et al. 2020)	↑ (Murfin et al. 2020)
Atgyfeiriad at	**Gofal arbenigol**	↓ (Croxford et al. 2018)	↑ (Williams et al. 2019)

Nododd tri adolygiad systematig yn ymwneud â rhaglenni sgrinio ar gyfer canserau ceg y groth, y colon a'r rhefr a'r prostad gysylltiad cadarnhaol rhwng lefel addysg ac ymgymeriad sgrinio (Murfin et al. 2020; Mosquera et al. 2020 a Jepson et al. 2000 yn y drefn honno). Yn yr un modd, canfu adolygiadau systematig fod lefelau addysg is yn gysylltiedig ag **oedi o ran cael diagnosis ac oedi yn cysylltu â gofal arbenigol ar ôl cael diagnosis o ganser yr ofari** (Williams et al. 2019) yn ogystal ag oedi yn cysylltu neu ddim yn cysylltu â gofal HIV (Croxford et al. 2018).

Nododd un adolygiad systematig oedd yn mesur ymgymeriad brechlyn HPV fod mamau ag addysg is yn llai tebygol o gychwyn cael y brechlyn ar gyfer eu merched (Murfin et al. 2020). Nododd hefyd berthynas gadarnhaol arwyddocaol rhwng lefelau addysg uchel ac ymgymeriad y brechlyn o'i gymharu â'r lefelau addysg isaf ond nid oedd unrhyw wahaniaethau arwyddocaol rhwng lefelau addysg tebyg, fel ysgol uwchradd a choleg neu gynradd ac uwchradd isaf.

Ethnigrwydd a statws mewnfudo:

Tabl 4: Anghydraddoldebau yn ôl Ethnigrwydd a statws mewnfudo (n=9)			
Math o wasanaeth gofal iechyd		**Grwpiau lleiafrifoedd ethnig**	**Statws mewnfudo**
Mynediad at	**Gwiriadau iechyd y GIG**	↕ (Asthana et al. 2018) ↕ (Bunten et al. 2020)	

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

		↕ (Martin et al. 2018)	
	Gwasanaethau sgrinio	↑ (Jepson et al. 2000)	
	Gofal sylfaenol	↕ (Foster et al. 2019)	↕ (Foster et al. 2019)
	Gofal arbenigol	↓ (Ahmed et al. 2004) ↕ (Asthana et al. 2018) ↕ (Ricci-Cabello et al. 2010) ↓ (Tobin et al. 2022)	
Atgyfeiriadau	**Gofal arbenigol**	↓ (Ahmed et al. 2004) ↕ (Williams et al. 2019)	

Canolbwyntiodd naw adolygiad systematig ar amrywiadau ethnig o ran mynediad at wasanaethau gofal iechyd gwahanol. Gwerthusodd un adolygiad systematig yr annhegwch mewn gofal cardiofasgwlaidd mewn gwasanaethau GIG yn Lloegr. Nododd effaith gyffredinol ethnigrwydd ar gyfer mynediad at wiriadau iechyd cardiofasgwlaidd a gofal cardiofasgwlaidd cymysg. Nododd lefelau uchel o gyflwyno ar gyfer gwiriadau iechyd cardiofasgwlaidd a mynediad at ofal arbenigol cardiofasgwlaidd ymysg cleifion De Asia. Canfu fod mynediad at ofal arbenigol ar gyfer cleifion du yn gymysg gyda rhai astudiaethau oedd wedi eu cynnwys yn awgrymu cyfraddau is na'r disgwyl o ddefnydd arbenigol, tra bod eraill yn uwch (Asthana et al. 2018).

Asesodd dau adolygiad systematig ethnigrwydd fel ffactor sydd yn dylanwadu ar ymgymeriad gwiriadau iechyd y GIG (Martin et al. 2018; Bunten et al. 2020). Cyflwynodd canfyddiadau o'r ddau ddarlun cymysg ar draws yr astudiaethau: canfuodd rhai fod presenoldeb yn sylweddol uwch mewn rhai grwpiau ethnig (De Asiaidd a grwpiau ethnigrwydd cymysg) a chanfu eraill nad oedd ymgymeriad yn gwahaniaethu yn ôl ethnigrwydd claf.

Yn seiliedig ar nifer fach o astudiaethau sydd wedi eu cynnwys yn archwilio ethnigrwydd neu statws mudol claf, adroddodd adolygiad systematig dystiolaeth gymysg o gysylltiad â'r defnydd o OOHSs gofal sylfaenol. Roedd yr adolygiad systematig yn cynnwys astudiaeth y DU yn defnyddio data brysbennu a chyngor dros y ffôn ar gyfer Lloegr. Canfu, yn dilyn cyswllt ag NHS Direct, mai plant Prydeing Gwyn neu blant Bangladeshaidd oedd fwyaf tebygol o gael eu hatgyfeirio at wasanaethau gofal brys yn cynnwys OOHS ac mai plant o ethnigrwydd Indiaidd neu 'wyn arall' oedd lleiaf tebygol o gael eu hatgyfeirio (Foster et al. 2019).

Cydnabu un adolygiad systematig gyfraddau defnydd is o ofal lliniarol mewn grwpiau lleiafrifoedd ethnig o'u cymharu â chleifion gwyn, gyda chyfraddau atgyfeirio is ar gyfer grwpiau du a lleiafrifoedd ethnig eraill (Ahmed et al. 2004). Yn yr un modd, mae adolygiad systematig arall yn awgrymu llai o fynediad at ofal hosbis yn y DU o fewn grwpiau ethnig penodol: Pacistanaidd/Indiaidd/Bangladeshaidd, Caribïaidd, Tsieineaidd ac Affricanaidd (Tobin et al. 2022). Nododd adolygiad systematig arall dystiolaeth gymysg ar gyfer anghydraddoldebau ethnig o ran mynediad at wasanaethau rheoli diabetes, gydag astudiaethau gwahanol gafodd eu cynnwys yn

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

arsylwi mwy o ddefnydd o wasanaethau gofal iechyd penodol yn ymwneud â rheoli diabetes mellitu mewn cleifion o grwpiau ethnig gwahanol (Ricci-Cabello et al. 2010).

Adroddodd un adolygiad systematig effaith gyffredinol ethnigrwydd ar gyfer atgyfeirio at ofal canser gynaecolegol arbenigol i fod yn gymysg, gyda sawl astudiaeth gafodd eu cynnwys yn nodi dim cyswllt rhwng ethnigrwydd ac oedi wrth atgyfeirio, tra bod eraill wedi adrodd bod menywod du neu o leiafrifoedd ethnig yn fwy tebygol o fod angen tri ymweliad neu fwy at eu meddyg teulu cyn cael eu hatgyfeirio (Williams et al. 2019).

Rhywedd:

Tabl 5: Anghydraddoldebau yn ôl rhywedd (n=8)

Math o wasanaeth gofal iechyd		**Menywod**	**Dynion**
Mynediad at	**Gwiriadau iechyd y GIG**	↕ (Asthana et al. 2018) ↑ (Bunten et al. 2020) ↑ (Martin et al. 2018)	↕ (Asthana et al. 2018)
	Gwasanaethau sgrinio	↕ (Mosquera et al. 2020)	↑ (Elgalib et al. 2018) ↕ (Mosquera et al. 2020)
	Gofal sylfaenol	↑ (Foster et al. 2019)	
	Gofal arbenigol	↓ (Asthana et al. 2018) ↔ (Ricci-Cabello et al. 2010)	↕ (Brewster et al. 2020) ↔ (Ricci-Cabello et al. 2010)

Canolbwyntiodd wyth adolygiad systematig ar amrywiadau rhywedd mewn ymgymeriad gwasanaethau gofal iechyd. Nododd un adolygiad systematig amrywiad aneglur o ran mynediad at wiriadau iechyd gofal cardiofasgwlaidd GIG Lloegr rhwng dynion a menywod gyda rhai yn cynnwys astudiaethau oedd yn canfod bod cyflwyno yn waeth ar gyfer menywod (Asthana et al. 2018). Nododd yr un adolygiad systematig hefyd amrywiadau rhywedd cryf a chyson mewn rheolaeth arbenigol gyda defnydd is o adsefydlu cardiofasgwlaidd gan fenywod.

Nododd dau adolygiad systematig gysylltiad rhwng ymgymeriad gwiriadau iechyd y GIG a rhywedd. Nododd y ddau fod benywod yn fwy tebygol o dderbyn gwahoddiadau gwiriad iechyd (Martin et al. 2018; Bunten et al. 2020). Yn ogystal, canfu'r adolygiad systematig blaenorol hefyd effaith ryngweithio arwyddocaol rhwng oed a rhyw, gyda menywod yn y grŵp oedran ifancaf yn fwy tebygol o fynychu gwiriadau iechyd y GIG (Bunten et al. 2020).

Canfu adolygiad systematig yn archwilio demograffeg defnyddwyr fod menywod yn tueddu i ddefnyddio OOHSs yn fwy o'u cymharu â dynion (Foster et al. 2019). Archwiliodd dau adolygiad systematig anghydraddoldebau o ran mynediad at

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

wasanaethau rheoli diabetes. Adroddodd un fod mynychu apwyntiadau cleifion allanol diabetes yn gymysg gyda rhai o'r astudiaethau oedd wedi eu cynnwys yn canfod bod dynion yn llai tebygol o fynychu (Brewster et al. 2020), ni nododd yr ail unrhyw anghydraddoldebau rhywedd o ran glynu wrth wasanaethau sgrinio retinopathi diabetig (Ricci-Cabello et al. 2010).

Nododd dau adolygiad systematig ar ymgymeriad gwasanaethau sgrinio ganfyddiadau cymysg ar gyfer dynion a menywod. Gydag un adolygiad systematig yn nodi rhywfaint o dystiolaeth o gynnydd yn ymgymeriad profion HIV mewn dynion (Elgalib et al. 2018), adroddodd yr ail adolygiad systematig fod ymgymeriad rhaglenni sgrinio'r colon a'r rhefr yn gymysg ar gyfer y ddau ryw (Mosquera et al. 2020).

Risgiau:

Tabl 6: Anghydraddoldebau yn ôl risgiau (n=7)			
Math o wasanaeth gofal iechyd		**Risgiau**	**Cyfeiriad yr anghydraddoldeb (cyfeiriad)**
Mynediad at	**Gwiriadau Iechyd y GIG**	Cyflyrau iechyd sydd eisoes yn bodoli	↑ (Martin et al. 2018)
		Hanes teuluol	↑ (Bunten et al. 2020)
		Smygu	↓ (Bunten et al. 2020)
		Dim smygu	↑ (Martin et al. 2018)
	Gwasanaethau sgrinio	Difrifoldeb is symptomau yn ystod diagnosis	↑ (Jepson et al. 2000)
	Gofal sylfaenol	Cyflyrau iechyd sydd eisoes yn bodoli	↑ (Foster et al. 2019)
	Gofal arbenigol	Hyd byrrach y diagnosis	↕ (Brewster et al. 2020)
		Smygu	↓ (Brewster et al. 2020)
		Cynnydd yng nghymeriant alcohol	↓ (Brewster et al. 2020)
Atgyfeiriad at	**Gofal arbenigol**	Difrifoldeb isel symptomau yn ystod diagnosis	↓ (Croxford et al. 2018)
		Cynnydd yng nghymeriant alcohol	↓ (Williams et al. 2019)
		Defnydd o gyffuriau chwistrellu	↓ (Croxford et al. 2018)

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Ymchwiliodd saith adolygiad systematig ffactorau risg penodol a'r cysylltiad rhwng lefelau risg ac ymgymeriad gwasanaethau gofal iechyd penodol. Roedd cysyniadoli risg yn amrywio ar draws yr adolygiadau systematig, gyda rhai yn ei ddosbarthu fel risg meddygol (e.e., hanes teuluol o anhwylder cardiofasgwlaidd, hanes meddygol) ac eraill yn cynnwys ffactorau ffordd o fyw (e.e., statws smygu, cymeriant alcohol).

Nododd yr adolygiadau systematig ostyngiad yn ymgymeriad gwiriadau iechyd y GIG ymysg smygwyr (Bunten et al. 2020) ac i'r gwrthwyneb ar gyfer y rheiny nad ydynt yn smygu (Martin et al. 2018). Nododd y ddau adolygiad systematig hefyd gynnydd yn ymgymeriad gwiriadau iechyd y GIG ymysg y rheiny yr ystyrir eu bod â risg uwch o anhwylderau cardiofasgwlaidd (Bunten et al. 2020 a Martin et al. 2018). Yn yr un modd, canfu adolygiad systematig arall fod cael clefyd cronig yn gysylltiedig â defnydd cynyddol o OOHSs (Foster et al. 2019).

O'r adolygiadau systematig, yn archwilio ymgymeriad gwasanaethau gofal iechyd arbenigol a gwasanaethau sgrinio, canfu un adolygiad systematig fod smygu a chynnydd yng nghymeriant alcohol yn gysylltiedig â pheidio â mynychu apwyntiadau cleifion allanol diabetes mewn adolygiad systematig arall (Brewster et al. 2020). Adroddodd un arall bod cymeriant alcohol uchel yn gysylltiedig â mwy o oedi mewn systemau yn llwybr diagnostig gofal sylfaenol canserau gynaecolegol (Williams et al. 2019). Yn yr un modd, adroddodd adolygiad systematig fod y rheiny oedd â defnydd o gyffuriau chwistrellu neu'r rheiny oedd yn teimlo'n iach yn ystod diagnosis yn profi oedi o ran cyswllt â gofal HIV (Croxford et al. 2018). Ar y llaw arall, canfu adolygiad systematig fod y gallu i wneud gweithgareddau bywyd bob dydd a chyfranogiad blaenorol mewn gwasanaethau sgrinio fel mamograffeg a phrawf gwaed cudd yn yr ysgarthion yn gysylltiedig â chynnydd yn y tebygolrwydd o fynychu'r gwasanaethau sgrinio (Jepson et al. 2000).

Gwledigrwydd ac amddifadedd cymdeithasol:

Tabl 7: Anghydraddoldebau yn ôl gwledigrwydd ac amddifadedd cymdeithasol

Math o wasanaeth gofal iechyd		**Risgiau**	**Cyfeiriad yr anghydraddoldeb (cyfeiriad)**
Mynediad at	**Gwiriadau iechyd y GIG**	Amddifadedd uwch	↕ (Bunten et al. 2020)
		Amddifadedd is	↑ (Martin et al. 2018)
	Gwasanaethau sgrinio	Amddifadedd is	↑ (Mosquera et al. 2020)
	Brechlyn HPV	Amddifadedd uwch	↓ (Fisher et al. 2013)
	Gofal sylfaenol	Preswylwyr gwledig	↓ (Williams et al. 2019)
		Preswylwyr trefol	↑ (Foster et al. 2019)

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

		Agosach at y gwasanaeth	↑ (Foster et al. 2019)
	Gofal arbenigol	Preswylwyr gwledig	↓ (Ryan-Ndegwa et al. 2021)
		Preswylwyr trefol	↑ (Tobin et al. 2022)
		Agosach at y gwasanaeth	↑ (Tobin et al. 2022)
		Amddifadedd uwch	↕ (Brewster et al. 2020) ↕ (Ryan-Ndegwa et al. 2021)

Gwerthusodd dau adolygiad systematig effaith amddifadedd cymdeithasol ar ddefnyddio gwiriadau iechyd y GIG. Er bod un adolygiad systematig yn dangos bod y tebygolrwydd o dderbyn gwahoddiad am wiriad iechyd y GIG yn cynyddu'n sylweddol gydag oed ac amddifadedd is (Martin et al. 2018), roedd effaith amddifadedd yn amrywio ar draws yr astudiaethau gafodd eu cynnwys mewn adolygiad systematig arall (Bunten et al. 2020). Nododd y ddau fod y berthynas yn dibynnu a oedd dadansoddiadau'n cael eu haddasu ar gyfer ffactorau eraill neu beidio.

O ran mynediad at wasanaethau gofal sylfaenol, arddangosodd un adolygiad systematig fod gwledigrwydd a phellter o wasanaethau gofal iechyd yn cynnyddu **oedi o ran gofal sylfaenol yn llwybr diagnostig canserau gynaecolegol** (Williams et al. 2019). Roedd cyfraddau uwch o ddefnydd o OOHSs yn gysylltiedig â phellter o OOHS ac ardaloedd trefol (Foster et al. 2019). Mewn adolygiad systematig arall, canfuwyd bod amddifadedd ardal hefyd yn gysylltiedig â mynychu sgrinio'r colon a'r rhefr, yn uwch ymysg yr ardaloedd lleiaf difreintiedig oedd yn defnyddio prawf gwaed cudd yn yr ysgarthion, sigmoidosgopi, ac mewn colonosgopi ar ôl prawf cadarnhaol (Mosquera et al. 2020).

Er bod tystiolaeth o adolygiad systematig yn awgrymu bod mynediad at ofal hosbis yn uwch ymysg y rheiny sydd yn byw mewn ardaloedd trefol ac yn agosach at hosbis (Tobin et al. 2022), mae tystiolaeth o adolygiad systematig arall yn asesu mynediad at lawdriniaeth gosod clun newydd yn y DU yn awgrymu bod lefelau amddifadedd uwch yn Lloegr yn gysylltiedig â darpariaeth lawfeddygol is (Ryan-Ndegwa et al. 2021). Canfu'r adolygiad systematig gan Brewster et al. (2020) fod cysylltiad ysgafn rhwng amddifadedd cymdeithasol a pheidio â mynychu apwyntiadau cleifion allanol yn seiliedig ar dystiolaeth o un astudiaeth yn y DU.

Nododd tystiolaeth o un adolygiad systematig fod menywod ifanc sydd yn byw yn yr ardaloedd mwyaf difreintiedig yn llai tebygol o ddechrau cael brechlyn HPV na'r rheiny sydd yn byw yn yr ardaloedd lleiaf difreintiedig (Fisher et al. 2013).

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Statws economaidd-gymdeithasol:

Tabl 8: Anghydraddoldebau yn ôl statws economaidd-gymdeithasol			
Math o wasanaeth gofal iechyd		**Statws economaidd-gymdeithasol isel**	**Statws economaidd-gymdeithasol uwch**
Mynediad at	**Gwiriadau iechyd y GIG**	↕ (Asthana et al. 2018)	↕ (Asthana et al. 2018)
	Gwasanaethau sgrinio	↕ (Murfin et al. 2020)	↑ (Mosquera et al. 2020)
	Brechlyn HPV	↓ (Murfin et al. 2020)	
	Gofal sylfaenol	↑ (Foster et al. 2019) ↔ (Hanratty et al. 2007)	↕ (Hanratty et al. 2007)
	Gofal arbenigol	↕ (Asthana et al. 2018) ↓ (Brewster et al. 2020) ↕ (Ricci-Cabello et al. 2010) ↓ (Tobin et al. 2022)	↕ (Asthana et al. 2018) ↕ (Ricci-Cabello et al. 2010)
Atgyfeirio at	**Gofal arbenigol**		↑ (Williams et al. 2019)

Canolbwyntiodd naw adolygiad systematig ar amrywiadau economaidd-gymdeithasol yn ymgymeriad gwasanaethau gofal iechyd gwahanol. Er na wnaeth un adolygiad systematig ganfod unrhyw dystiolaeth o amrywiad yn y defnydd o wasanaethau gofal sylfaenol yn ôl statws economaidd-gymdeithasol (Hanratty et al. 2007), adroddodd adolygiadau systematig eraill berthynas wrthgyfartal rhwng statws economaidd-gymdeithasol a'r defnydd o sawl gwasanaeth gofal iechyd. Roedd y rhain yn cynnwys OOHSs (Foster et al. 2019), gofal ysbyty arbenigol (Hanratty et al. 2007), brechlynnau HPV ymysg merched (Murfin et al. 2020), gofal hosbis (Tobin et al. 2022) ac atgyfeirio menywod i ofal canser gynaecolegol arbenigol.

Adroddodd un adolygiad systematig raddiant arwyddocaol yn ffafrio'r rheiny mewn safle o fantais mawr; fodd bynnag, nododd gyfradd fynychu uwch ar gyfer gwasanaethau sgrinio'r colon a'r rhefr ar gyfer dynion na menywod (Mosquera et al. 2020). Nododd sawl adolygiad systematig fod cyfeiriad annhegwch economaidd-gymdeithasol o ran mynediad at wasanaethau gofal iechyd amrywiol yn aneglur. Roedd y rhain yn cynnwys gwiriadau iechyd y GIG (Asthana et al. 2018), gwasanaethau rheoli diabetes (Ricci-Cabello et al. 2010; Brewster et al. 2020), gwasanaethau gofal cardiofasgwlaidd arbenigol (Asthana et al. 2018) a gwasanaethau sgrinio serfigol (Murfin et al. 2020).

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Adran 2: Adolygiadau yn cadarnhau presenoldeb annhegwch o fewn nodwedd poblogaeth benodol

Nod y y saith ar hugain o adolygaidau sydd wedi eu cynnwys yn yr adran hon yw cadarnhau neu wrthbrofi bod anghydraddoldeb yn bodoli ar gyfer y nodwedd poblogaeth a astudiwyd (er enghraifft, gwahaniaethau rhwng grwpiau lleiafrifoedd ethnig gwahanol). Mewn rhai enghreifftiau, roedd hyn yn cynnwys archwilio croestoriadedd sawl nodwedd poblogaeth a'u rôl yn pwysleisio anghydraddoldebau ar gyfer rhai aelodau o'r boblogaeth. Archwiliodd rhai o'r adolygiadau a nodwyd y rhwystrau a allai arwain at anghydraddoldeb o ran mynediad.

Roedd dau ar bymtheg o'r adolygiadau gafodd eu cynnwys yn ddulliau cymysg o ran dyluniad ac roedd 10 yn feintiol. Cyhoeddwyd yr adolygiadau rhwng 2005 a 2022. Roedd deg yn cynnwys astudiaethau o wledydd y DU yn unig a chyhoeddodd pum adolygiad rwystrau o ran mynediad yn unig.

Archwiliodd yr adolygiadau a nodwyd fynediad at amrywiaeth o wasanaethau gofal iechyd. Canolbwyntiodd pump yn benodol ar wasanaethau gofal sylfaenol, saith ar wasanaethau gofal arbenigol a chwech ar sgrinio neu wasanaethau ataliol. Archwiliodd pedwar adolygiad fwy nag un o'r meysydd hyn; archwiliodd dau ofal arbenigol a gofal sylfaenol (Phung et al. 2010; Luekmann et al. 2021), edrychodd un ar ofal sylfaenol a gwasanaethau sgrinio/ataliol (Meads et al. 2019) ac edrychodd un ar bob un o'r tri (Wilson et al. 2012). O'r pum adolygiad yn archwilio rhwystrau yn unig, canolbwyntiodd tri ar rwystrau i fynediad mewn gofal arbenigol (Chamberlain et al. 2016; Mayland et al. 2021; Best et al. 2022), un ar ofal sylfaenol (McFadden et al. 2018) ac roedd un yn amhenodol o ran math o wasanaeth iechyd (Robards et al. 2018).

Nodweddion poblogaeth:

Mae'r gyfres o dablau gyda'u naratif ategol, isod, yn crynhoi a chafodd anghydraddoldeb o ran mynediad neu atgyfeirio at wasanaeth gofal iechyd penodol ei nodi. Mewn rhai achosion, mae elfen o groestoriadedd wedi cael ei archwilio neu ei nodi gan yr awduron adolygu. Mae deall croestoriadedd o ran mynediad at wasanaethau gofal iechyd yn bwysig i ddiogelu yn erbyn anghydraddoldebau sy'n ehangu. Cafodd data croestoriadol ei gipio o nifer o adolygiadau oedd wedi eu cynnwys, ond roedd y rhan fwyaf yn canolbwyntio ar un grŵp poblogaeth yn unig.

Defnyddiwyd ffocws yr adolygiad i grwpio nodweddion poblogaeth yn y tablau isod ac mae elfennau o groestoriadedd wedi eu hamlygu yn y tablau i ddangos gwahaniaethau rhwng nodweddion poblogaeth sydd yn rhannu un neu fwy o ddosbarthiadau cymdeithasol. Mae anghydraddoldebau wedi cael eu cynnwys lle maent wedi cael eu nodi gan awduron yr adolygiadau ac yn dod o un astudiaeth yn y DU o leiaf. Mae casgliad cyffredinol yr awduron wedi cael ei adrodd lle y bo'n bosibl.

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Grwpiau lleiafrifoedd ethnig:

Tabl 9: Anghydraddoldebau mewn grwpiau lleiafrifoedd ethnig (n= 9)
Adolygiadau meintiol = 3; Adolygiadau dull cymysg = 6; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 5
Allwedd: CAMHS= Gwasanaeth iechyd meddwl plant a'r glasoed; CYP= Plant a phobl ifanc; GP= Ymarferydd cyffredinol; ID= Anabledd deallusol

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Brechlyn COVID-19**	Grwpiau lleiafrifoedd ethnig	↓ (Abba-Aji et al. 2022) ↓ (Kamal et al. 2021)
	Sgrinio canser y fron a cheg y groth	Menywod De Asia	↓ (Anderson de Cuevas et al. 2018)
	Sgrinio canser y fron a cheg y groth	Menywod De Asia: Oed iau	↓ (Anderson de Cuevas et al. 2018)
	Sgrinio canser y fron a cheg y groth	Menywod De Asia: lefelau addysg isel	↓ (Anderson de Cuevas et al. 2018)
	Gwasanaethau atal diabetes	Grwpiau lleiafrifoedd ethnig â diabetes	↕ (Wilson et al. 2012)
	Gwiriadau iechyd gofal sylfaenol	Rhieni Du Affricanaidd â diabetes	↑ (Wilson et al. 2012)
	Gwiriadau iechyd gofal sylfaenol	Cleifion Caribïaidd â diabetes	↑ (Wilson et al. 2012)
	Mynediad / cyswllt â meddyg teulu	Oedolion De Asia â seicosis	↑ (Halvorsrud et al. 2018)
	Mynediad / cyswllt â meddyg teulu	Oedolion du â seicosis	↓ (Halvorsrud et al. 2018)
	Ymgynghoriad meddyg teulu	Pobl De Asia ag asthma	↑ (Netuvelli et al. 2005)
	Ymgynghoriad meddyg teulu	Pobl Affro-Caribïaidd ag asthma	↑ (Netuvelli et al. 2005)
	Gwasanaethau seiciatrig anabledd deallusol	Pobl De Asia ag ID	↓ (Robertson et al. 2019)

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

	Gwasanaethau iechyd meddwl	Pobl De Asia ag ID	↕ (Durà-Vilà et al. 2012)
	CAMHS a gwasanaethau arbenigol	CYP De Asia ag ID	↓ (Durà-Vilà et al. 2012; Robertson et al. 2019)
	Uned asesu a thrin	Grwpiau lleiafrifoedd ethnig ag ID	↓ (Durà-Vilà et al. 2012)
	Gwasanaethau iechyd meddwl	Menywod Pacistanaidd	↓ (Kapadia et al. 2017)
	Therapi lleferydd ac iaith	Plant ag ID: grwpiau du (o'u cymharu â grwpiau'r Dwyrain Canol/Arabaidd, gwyn a grwpiau ethnig eraill)	↓ (Robertson et al. 2019)
Atgyfeirio	**Gwasanaethau arbenigol**	Grwpiau lleiafrifoedd ethnig ag ID ac anhwylder seiciatrig	↑ (Durà-Vilà et al. 2012)

Nodwyd naw adolygiad systematig oedd yn archwilio amrywiadau ethnig a mynediad lleiafrifoedd ethnig at wasanaethau gofal iechyd. Archwiliodd dau adolygiad anghydraddoldebau mewn mynediad at wasanaethau brechu ar gyfer grwpiau lleiafrifoedd ethnig (Kamal et al. 2021; Abba-Aji et al. 2022). Nododd y ddau adolygiad fynediad is at frechlyn COVID-19 ar gyfer grwpiau lleiafrifoedd ethnig. Dangoswyd mai grwpiau du oedd â'r derbyniad isaf i'r brechlyn o'u cymharu â lleiafrifoedd ethnig eraill, ac adroddwyd ymgymeriad uwch ar gyfer grwpiau Indiaidd, Bangladeshaidd, a Tsieineaidd, ond roedd hyn yn dal yn is na grwpiau gwyn (Kamal et al. 2022).

Canfu un adolygiad fynediad is at gyfraddau sgrinio canser y fron a chanser ceg y groth ymysg menywod De Asia (Anderson de Cuevas et al. 2018). Roedd y gwahaniaeth hwn yn amlwg ymysg menywod De Asia oedd yn iau a'r rheiny â lefelau addysg is. Roedd gwasanaethau ataliol eraill yn cynnwys gwasanaethau atal diabetes, lle nodwyd tystiolaeth gymysg ar gyfer anghydraddoldebau o ran mynediad ar gyfer lleiafrifoedd ethnig (Wilson et al. 2012).

Archwiliodd tri adolygiad anghydraddoldebau o ran mynediad at wasanaethau gofal sylfaenol ar gyfer lleiafrifoedd ethnig (Netuveli et al. 2005; Wilson et al. 2012; Halvosrud et al. 2018). Mewn adolygiad yn archwilio llwybrau i ofal seicosis, roedd oedolion De Asia â seicosis yn fwy tebygol o gael mynediad at wasanaethau meddyg teulu o'u cymharu â phobl wyn, lle'r oedd oedolion du â seicosis yn llai tebygol (Halvosrud et al. 2018). Canfu adolygiad arall fod cyfraddau ymgynghoriadau meddygon teulu ar gyfer asthma yn uwch ymysg pobl De Asia ac Affro-Caribïaidd o'u cymharu â grwpiau gwyn (Netuveli et al. 2005). Nododd Wilson et al. (2012) fod

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

gwiriadau iechyd mewn lleoliadau gofal sylfaenol yn cael eu defnyddio mwy gan gleifion Caribïaidd a du Affricanaidd â diabetes o'u cymharu â chleifion gwyn.

Adroddwyd anghydraddoldebau o ran mynediad at wasanaethau gofal eilaidd neu arbenigol ar gyfer lleiafrifoedd ethnig mewn tri adolygiad systematig (Durà-Vilà et al. 2012; Kapadia et al. 2017; Robertson et al. 2019). Canfu un adolygiad fod menywod Pacistanaidd yn llai tebygol o ddefnyddio gwasanaethau iechyd meddwl arbenigol o'u cymharu â menywod Prydeinig gwyn. Edrychodd dau adolygiad ar amrywiadau ethnig o ran mynediad yn unig ymysg unigolion ag anableddau deallusol. Adroddwyd bod pobl De Asia ag anableddau deallusol yn llai tebygol o gael mynediad at wasanaethau seiciatrig arbenigol (Robertson et al. 2019) ond adroddwyd tystiolaeth anghyson ar gyfer defnydd pobl De Asia o wasanaethau iechyd meddwl (Durà-Vilà et al. 2012). Roedd plant a phobl ifanc De Asia yn llai tebygol o gael mynediad at CAMHS (Durà-Vilà et al. 2012; Robertson et al. 2019). Roedd grwpiau lleiafrifoedd ethnig ag anableddau deallusol ac anhwylderau seiciatrig, o'u cymharu â grwpiau gwyn, yn fwy tebygol o gael eu hatgyfeirio at wasanaethau iechyd meddwl mewn un astudiaeth (roedd y cynnydd hwn yn fwyaf nodedig ymysg pobl o darddiad Affricanaidd Caribïaidd), ond cafodd llai eu derbyn o gymunedau lleiafrifoedd ethnig i uned asesu a thriniaeth ar gyfer oedolion ag anableddau deallusol a phroblemau iechyd meddwl a/neu ymddygiad heriol mewn astudiaeth arall (Durà-Vilà et al. 2012). Ar gyfer plant ag anableddau deallusol, dangoswyd bod strwythur teuluol yn pennu'r defnydd o CAMHS gyda phlant o deuluoedd dau riant yn llai tebygol o gael mynediad at wasanaethau; adroddodd yr adolygiad fod y strwythur hwn yn fwyaf mynych o fewn teuluoedd De Asia (Durà-Vilà et al. 2012). Roedd y cyfraddau mynediad uchaf at therapi lleferydd ac iaith ymysg plant ag anableddau deallusol yn amlwg mewn grwpiau o'r Dwyrain Canol/Arabaidd, wedi ei ddilyn gan Ewropeaid gwyn, a grŵp ethnig cymysg/ grwpiau ethnig eraill, ac ar ei isaf ar gyfer grwpiau du (Robertson et al. 2019).

Tabl 10: Oedi yn cyflwyno i wasanaeth gofal iechyd mewn grwpiau lleiafrifoedd ethnig (n=2)

Adolygiadau meintiol = 1; Adolygiadau dulliau cymysg = 1; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 0

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeirnod)
Oedi yn cyflwyno	**Gwasanaethau iechyd meddwl**	Oedolion hŷn De Asia	↑ (Giebel et al. 2015)
	Oedi rhwng ymweliadau'n ymwneud â Chanser â gofal sylfaenol	Grwpiau lleiafrifoedd ethnig	↕ (Martins et al. 2013)

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Allwedd ar gyfer tabl 10:
↑ Mwy tebygol o oedi wrth gyflwyno i wasanaeth
↓ Llai tebygol o oedi wrth gyflwyno i wasanaeth
↕ adolygiad wedi nodi tystiolaeth gymysg
↔ Adolygiad wedi nodi dim gwahaniaeth o ran oedi wrth gyflwyno

Nodwyd dau adolygiad oedd yn archwilio oedi o ran mynd at wasanaethau gofal iechyd mewn grwpiau lleiafrifoedd ethnig o'n chwiliad (Martins et al. 2013; Giebel et al. 2015). Nododd tystiolaeth feintiol o un adolygiad fod oedolion hŷn De Asia wedi dangos mwy o debygolrwydd o oedi wrth fynd at wasanaethau iechyd meddwl (Giebel et al. 2015). Nodwyd tystiolaeth gymysg ar gyfer gwahaniaethau ethnig o ran oedi cyn cyflwyno i'r meddyg teulu yn dilyn symptomau cyntaf o ganser (Martins et al. 2013). Nodwyd tystiolaeth gymysg hefyd ar gyfer oedi o ran cyfnodau rhwng cyflwyno i'r meddyg teulu ac ymweliadau gofal arbenigol (Martins et al. 2013).

Mudwyr, Teithwyr, Ffoaduriaid a Cheiswyr Lloches:

Tabl 11: Anghydraddoldebau ymysg Mudwyr, Ffoaduriaid a Cheiswyr Lloches (n= 5)

Adolygiadau meintiol = 1; Adolygiadau dulliau cymysg = 4; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 2

Allwedd: Meddyg Teulu = Ymarferydd cyffredinol

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Brechlyn COVID-19**	Plant ceiswyr lloches	↓ (Crawshaw et al. 2022)
	Brechlyn COVID-19	Mudwyr	↑ (Abba-Aji et al. 2022)
	Ymgynghoriad asthma gan feddyg teulu	Pobl wedi eu geni y tu allan i'r DU	↓ (Netuveli et al. 2005)
	Ymgynghoriad meddyg teulu	Menywod ymfudol Pwylaidd	↑ (Phung et al. 2020)
	Gofal amenedigol (arferol ac arbenigol)	Menywod ymfudol	↓ (Hazlehurst et al. 2018)

Roedd chwech adolygiad yn canolbwyntio ar anghydraddoldebau ymysg mudwyr, ffoaduriaid neu geiswyr lloches. Roedd dau adolygiad yng nghyd-destun brechlynnau COVID-19 (Abba-Aji et al. 2022; Crawshaw et al. 2022) ond yn

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

canolbwyntio ar grwpiau poblogaeth ychydig yn wahanol. Canfu Abba-Aji et al. (2022) fod grwpiau ymfudol yn fwy tebygol o dderbyn brechlyn o'u cymharu â'r boblogaeth yn gyffredinol. Nododd Crawshaw et al. (2022) fod gan blant ceiswyr lloches ymgymeriad brechlynnau is o'u cymharu â'r boblogaeth yn gyffredinol mewn un astudiaeth yng Nghymru. Mewn cymhariaeth, nodwyd hefyd bod plant wedi eu geni o famau Pacistanaidd wedi eu geni mewn gwlad arall yn fwy tebygol o fod wedi eu himiwneiddio'n llawn na phlant Pacistanaidd â mamau wedi eu geni yn y DU.

Canolbwyntiodd dau adolygiad ar fudwyr yn cael mynediad at wasanaethau meddygon teulu (Netuveli et al. 2005; Phung et al. 2020). Canfu un adolygiad fod menywod ymfudol Pwylaidd yn fwy tebygol o ymweld â'u meddyg teulu o'u cymharu â dynion Pwylaidd (Phung et al. 2020); roedd hyn yn arbennig o wir am y rheiny sydd yn 25-44 oed. Nododd yr un adolygiad hefyd astudiaeth lle canfuwyd bod mudwyr Pwylaidd yn fwy tebygol o ddefnyddio gwasanaethau Unedau Brys yn amhriodol o'u cymharu â'r boblogaeth gynhenid, gyda llawer heb fod wedi cofrestru gyda meddyg teulu. Archwiliodd yr ail adolygiad amrywiadau ethnig yn y defnydd o'r gwasanaeth iechyd ar gyfer unigolion ag asthma (Netuveli et al. 2005). Nododd yr awduron un astudiaeth yn y DU wnaeth ganfod bod gan gleifion wedi eu geni y tu allan i'r DU risg sylweddol is o gael ymgynghoriad ar gyfer asthma, sy'n awgrymu y gallai statws mewnfudo fod yn benderfynydd o ran defnydd o'r gwasanaeth iechyd i rai.

Roedd yr adolygiad olaf yn canolbwyntio ar ofal amenedigol a chanfu fod mynediad at gymorth amenedigol arferol, arbenigol ac iechyd meddwl yn waeth ymysg menywod ymfudol (Heslehurst et al. 2020).

Anghydraddoldebau economaidd-gymdeithasol:

Tabl 12: Anghydraddoldebau economaidd-gymdeithasol (n= 5)
Adolygiadau meintiol = 5; Adolygiadau dulliau cymysg = 0; Nifer yr adolygiadau yn cynnwys astudiaethau yn y DU yn unig = 1
Allwedd: CHD= Clefyd coronaidd y galon

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Sgrinio canser y fron**	Menywod mewn ardaloedd o amddifadedd economaidd-gymdeithasol uwch	↓ (Smith et al. 2019)
	Defnydd o ofal sylfaenol	Statws economaidd-gymdeithasol uchel v isel	↔ (Lueckmann et al. 2021)
	Gwasanaethau iechyd y llygaid	Pobl o statws economaidd-gymdeithasol is	↕ (Knight & Lindfield, 2015)

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

	Gweithdrefnau coronaidd ymledol	Grwpiau statws economaidd-gymdeithasol isel	↓ (Schroder et al. 2016)
	Llawdriniaeth neu gemotherapi ar gyfer canser yr ysgyfaint	Safle economaidd-gymdeithasol isel	↓ (Forrest et al. 2013)
	Radiotherapi ar gyfer canser yr ysgyfaint	Safle economaidd-gymdeithasol isel	↔ (Forrest et al. 2013)
	Triniaeth gyffuriau CHD ac adsefydlu cardiaidd	Statws economaidd-gymdeithasol	↕ (Schroder et al. 2016)
	Ymweliadau arbenigol	Grwpiau statws economaidd-gymdeithasol uchel	↑ (Lueckmann et al. 2021)

Mae pum adolygiad yn archwilio anghydraddoldebau economaidd-gymdeithasol o ran mynediad at wasanaethau iechyd amrywiol.

Roedd un adolygiad yn canolbwyntio ar sgrinio canser y fron gan nodi bod menywod sydd yn byw mewn cymdogaethau mwy difreintiedig yn economaidd-gymdeithasol yn llai tebygol o fynychu sgrinio canser y fron, gyda holl astudiaethau'r DU a nodwyd yn cefnogi'r casgliad hwn (Smith et al. 2019).

Edrychodd un adolygiad ar fynediad at wasanaethau iechyd y llygaid a chanfod tystiolaeth gymysg am anghydraddoldeb ar gyfer pobl o statws economaidd-gymdeithasol is (Knight a Lindfield 2015).

Canolbwyntiodd y tri oedd yn weddill ar wasanaethau arbenigol, gydag un hefyd yn cynnwys y defnydd o ofal sylfaenol (Lueckmann et al. 2021). Ni wnaeth yr adolygiad gan Leuckmann et al. (2021) ganfod unrhyw dystiolaeth o statws economaidd-gymdeithasol yn dylanwadu ar fynediad at ofal sylfaenol, ond fe wnaeth awgrymu bod pobl ddifreintiedig yn ymweld â'u meddyg gofal sylfaenol yn fwy aml. Ar gyfer gofal arbenigol, canfu'r un adolygiad dystiolaeth gymysg; gyda'r grwpiau statws economaidd-gymdeithasol uchaf yn nodi bod tebygolrwydd uwch o ymweliadau arbenigol, ond heb unrhyw gysylltiadau rhwng statws economaidd-gymdeithasol ac amlder amodol (nifer yr ymweliadau yn amodol ar fod wedi ymweld â meddyg unwaith o leiaf) ymweliadau arbenigol. Roedd y ddau adolygiad arall yn canolbwyntio ar fynediad at wasanaethau coronaidd (Schroder et al. 2016) neu wasanaethau triniaeth canser yr ysgyfaint (Forrest et al. 2013). Canfuwyd bod gan bobl o statws economaidd-gymdeithasol is gyfraddau is o driniaethau coronaidd ymledol o'u cymharu â'r rheiny o statws economaidd-gymdeithasol uwch, ond roedd y dystiolaeth yn fwy anghyson ar gyfer anghydraddoldebau economaidd-gymdeithasol o ran mynediad at driniaeth gyffuriau neu adsefydlu cardiaidd (Schroder et al. 2016).

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Ar gyfer triniaeth canser yr ysgyfaint, roedd statws economaidd-gymdeithasol is yn cael effaith negyddol arwyddocaol ar y tebygolrwydd o dderbyn llawdriniaeth neu gemotherapi, ond nid oedd unrhyw gysylltiad rhwng statws economaidd-gymdeithasol a derbyn radiotherapi (Forrest et al. 2013).

Grwpiau eraill:

Tabl 13: Anghydraddoldebau mewn grwpiau lleiafrifoedd rhywiol (n= 1)
Adolygiadau dulliau cymysg = 1; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 1
Allwedd: Meddyg teulu = Ymarferydd cyffredinol

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodweddion grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Ymweliadau â meddyg teulu**	Menywod lesbiaidd / deurywiol	↓ (Meads et al. 2019)
	Sgrinio serfigol	Menywod lesbiaidd / deurywiol	↓ (Meads et al. 2019)
	Ymweliadau â meddyg teulu	Y glasoed benywaidd o leiafrifoedd rhywiol	↑ (Meads et al. 2019)

Canolbwyntiodd un adolygiad systematig ar anghydraddoldebau mewn grwpiau lleiafrifoedd rhywiol (Meads et al. 2019). Roedd yr adolygiad yn edrych ar wasanaethau meddygon teulu a sgrinio. Nododd fod menywod lesbiaidd a deurywiol yn llai tebygol o ymweld â meddyg teulu o'u cymharu â menywod heterorywiol. Nodwyd ymgymeriad is o ran sgrinio serfigol ymysg menywod lesbiaidd a deurywiol hefyd, ond ni nodwyd gwybodaeth gymharol ar gyfer menywod heterorywiol ar gyfer y canlyniad hwn. Canfu'r un adolygiad hefyd fod y glasoed benywaidd o leiafrifoedd rhywiol yn fwy tebygol o ymweld â'u meddyg teulu na merched heterorywiol (Meads et al. 2019).

Oedolion digartref:

Tabl 14: Anghydraddoldebau ymysg oedolion digartref (n= 1)
Adolygiadau dulliau cymysg = 1; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 0
Allwedd: Meddyg teulu = Ymarferydd cyffredinol

Canlyniad	Math o wasanaeth gofal iechyd	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Gwasanaeth deintyddol**	Oedolion digartref:	

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

		defnydd o gyffuriau, ethnigrwydd a derbyn budd-daliadau'r llywodraeth	↓ (Goode et al. 2012)

Canolbwyntiodd un adolygiad systematig ar fynediad oedolion digartref at wasanaethau deintyddol (Goode et al. 2012). Mae awduron yr adolygiad yn amlygu rhai elfennau croestoriadedd. Canfu'r awduron fod cyfradd oedolion digartref o fethu â dychwelyd am ail apwyntiad deintyddol yn aml yn gysylltiedig â'r defnydd o gyffuriau, ethnigrwydd a derbyn budd-daliadau'r llywodraeth. Mae astudiaethau nad ydynt yn y DU hefyd yn adrodd rai canfyddiadau pellach ar fynediad, gydag un astudiaeth o UDA yn awgrymu mai "Dim ond 27% geisiodd ofal iechyd y geg pan oeddent wedi canfod angen" ac mae astudiaeth bellach o Ganada yn awgrymu bod pobl ddigartref 2.27 gwaith yn fwy tebygol o ddefnyddio'r adran frys am broblemau deintyddol nad ydynt yn drawmatig o'u cymharu â phoblogaeth incwm isel gyfatebol.

Oed:

Tabl 15: Anghydraddoldebau oherwydd Oed
Adolygiadau dulliau cymysg = 1; Nifer yr adolygiadau yn cynnwys astudiaethau o'r DU yn unig = 0

Canlyniad	**Math o wasanaeth gofal iechyd**	O fewn nodwedd grŵp	Cyfeiriad yr anghydraddoldeb (Cyfeiriad)
Mynediad	**Brechlyn y ffliw**	Oedolion hŷn (≥ 65 oed): Statws priodasol, Statws addysg, Gwledigrwydd, Rhywedd, Statws economaidd-gymdeithasol is	↕ (Nagata et al. 2013)
	Brechlyn y ffliw	Oedolion hŷn (≥ 65 oed): Clefydau cronig, Oed (75+ v 65-74 oed)	↑ (Nagata et al. 2013)

Roedd un adolygiad yn canolbwyntio ar fynediad ac ymgymeriad brechlynnau'r ffliw tymorol ymysg grwpiau oedran hŷn (>65+). Canfu'r adolygiad fod llawer o elfennau croestoriadedd yn bresennol, gyda'r rheiny sydd yn 75+ oed (o'u cymharu â phobl 65–74 oed), a'r rheiny â chlefydau cronig yn fwy tebygol o dderbyn brechlyn y ffliw tymhorol. Awgrymodd canfyddiadau o'r DU fod y tebygolrwydd o frechu ymysg oedolion hŷn yn cynyddu wrth i nifer y clefydau cronig gynyddu (Nagata et al. 2013). Roedd y canfyddiadau ar gyfer elfennau eraill fel statws priodasol, statws addysg, gwledigrwydd, rhywedd, neu statws economaidd-gymdeithasol yn cael effaith ar ymgymeriad brechlynnau ymysg oedolion hŷn yn fwy cymysg (Nagata et al. 2013).

Allwedd ar gyfer tabl 2-15, ac eithrio tabl 10:
↑ Nododd yr adolygiad bod y grŵp yn fwy tebygol o gael mynediad at y gwasanaeth iechyd
↓ Nododd yr adolygiad bod y grŵp yn llai tebygol o gael mynediad at y gwasanaeth iechyd
↕ Nododd yr adolygiad dystiolaeth gymysg h.y., mae cyfeiriad yr anghydraddoldeb yn aneglur
↔ Ni chafodd unrhyw dystiolaeth o anghydraddoldeb ei nodi

Rhwystrau a nodir a allai gyfrannu at anghydraddoldeb o ran mynediad at ofal iechyd

Nododd dau ar bymtheg o adolygiadau rwystrau o ran mynediad (n=16) ac atgyfeirio gwasanaethau gofal iechyd (n=2). O'r rhain, roedd un yn adolygiad systematig o adolygiadau. Er bod y rhan fwyaf o'r adolygiadau yn cynnwys astudiaethau ansoddol a meintiol (n=17), roedd un adolygiad yn cynnwys astudiaethau meintiol yn unig. Lle y bo'n bosibl, gwnaed ymgais i echdynnu canlyniadau ar gyfer astudiaethau meintiol yn unig.

O'r adolygiadau oedd yn mynd i'r afael â mynediad, roedd pedwar yn canolbwyntio ar rwystrau i wasanaethau gofal iechyd yn gyffredinol, gyda 12 yn canolbwyntio ar wasanaethau gofal iechyd penodol yn cynnwys brechu (n=4), gwasanaethau iechyd meddwl (n=3), hunan-reoli diabetes (n=1), gwasanaethau deintyddol (n=1), cemotherapi (n=1) a gwasanaethau geneteg a genomeg clinigol (n=1). Archwiliodd y rhan fwyaf o ffactorau sydd yn rhwystro grŵp neu grwpiau penodol rhag cael mynediad at wasanaeth gofal iechyd. Roedd y rhain yn cynnwys lleiafrifoedd ethnig (n=4), mudwyr (n=4), ceiswyr lloches a ffoaduriaid (n=1), Sipsiwn, Roma a theithwyr (n=1), menywod o leiafrifoedd rhywiol (n=1), oedolion digartref (n=1), oedolion hŷn ar y cyrion (n=1) ac oedolion hŷn De Asia (n=1). Aeth dau adolygiad i'r afael ag anghydraddoldebau daearyddol.

Gyda'i gilydd, datgelodd yr adolygiadau nifer o rwystrau. Mae tablau 16-23 isod yn crynhoi'r rhain yn ôl poblogaeth a nodir trwy gydol yr adroddiad hwn.

Tabl 16: Rhwystrau a brofwyd gan grwpiau lleiafrifoedd ethnig (n=4)

Covid-19 vaccination: Abba-Aji et al. 2022 (dulliau cymysg, 10/33 o astudiaethau yn y DU) Covid-19 vaccination in UK: Kamal et al. 2021 (dulliau cymysg, n= 21) Bereavement care in UK: Mayland et al. 2021 (dulliau cymysg, n=7) Diabetes self-management: Wilson et al. 2012 (dulliau cymysg, 32/47 o astudiaethau yn y DU)		
Rhwystrau		**Cyfeiriadau**
Rhwystrau yn ymwneud â hygyrchedd	Rhwystrau iaith a chyfathrebu (yn cynnwys gwasanaethau dehongli)	Abba-Aji et al. (2022) Kamal et al. (2021) Mayland et al. (2021) Wilson et al. (2012)
	Llythrennedd iechyd isel (yn cynnwys bod yn anghyfarwydd â darpariaeth gofal iechyd a chamwybodaeth)	Abba-Aji et al. (2022) Kamal et al. (2021) Mayland et al. (2021)

	Allgáu digidol	Kamal et al. (2021)
	Anhygyrchedd daearyddol	Abba-Aji et al. (2022) Kamal et al. (2021)
	Prinder gwasanaethau sy'n briodol yn ddiwylliannol	Mayland et al. (2021) Wilson et al. (2012)
Rhwystrau sy'n benodol i ddarparwr gofal iechyd	Dyrannu adnoddau	Mayland et al. (2021)
Fforddiadwyedd (ariannol a ddim yn ariannol)	Costau anuniongyrchol	Abba-Aji et al. (2022)
	Costau cyfle (amser i ffwrdd o'r gwaith, costau gofal plant, costau teithio	Abba-Aji et al. (2022) Kamal et al. (2021)

Tabl 17: Rhwystrau a brofir gan boblogaethau Mudwyr (n=4)

Covid-19 vaccination: Abba-Aji et al. 2022 (dulliau cymysg, 10/33 o astudiaethau yn y DU) a Crawshaw et al. 2022 (dulliau cymysg, n=67, nifer yr holl astudiaethau yn y DU nas adroddwyd arnynt)

Healthcare services in UK: Phung et al. 2020 (dulliau cymysg, n=13)

Perinatal primary and specialist mental health services: Heslehurst et al. 2018$+ (adolygiad o adolygiadau dulliau cymysg, 14/29 o adolygiadau yn y DU)

Allwedd: $ = menywod yn unig, + = mudwyr, ceiswyr lloches a ffoaduriaid

Rhwystrau		**Cyfeiriadau**
Rhwystrau yn ymwneud â hygyrchedd	Rhwystrau iaith a chyfathrebu (yn cynnwys gwasanaethau dehongli)	Abba-Aji et al. (2022) Crawshaw et al. (2022) Phung et al. (2020) Heslehurst et al. (2018)$+
	Llythrennedd iechyd isel (yn cynnwys bod yn anghyfarwydd â darpariaeth gofal iechyd lleol a chamwybodaeth)	Abba-Aji et al. (2022) Crawshaw et al. (2022) Heslehurst et al. (2018)$+
	Rhwystrau ymarferol (yn cynnwys tai anniogel, newid cyfeiriad yn aml neu ddim cyfeiriad sefydlog yn achosi anawsterau yn cofrestru gyda gwasanaeth gofal iechyd)	Crawshaw et al. (2022)
	Rhwystrau cyfreithiol (ansicrwydd ynghylch hawl cyfreithiol)	Crawshaw et al. (2022) Phung et al. (2020)
	Allgáu digidol	Crawshaw et al. (2022)
	Teimlad o wahaniaethu; dieithrio a dadrymuso	Crawshaw et al. (2022)

	Anhygyrchedd daearyddol	Abba-Aji et al. (2022) Crawshaw et al. (2022) Heslehurst et al. (2018)[$]
	Prinder gwasanaethau priodol yn ddiwylliannol	Heslehurst et al. (2018)[$]
Rhwystrau sy'n benodol i ddarparwr gofal iechyd	Diffyg dealltwriaeth ddiwylliannol	Crawshaw et al. (2022)
	Amrywioldeb lleol o ran ymagwedd ac ymarfer	Crawshaw et al. (2022)
	Gallu gweithlu a'r gwasanaeth (yn cynnwys argaeledd staff, rhestrau aros hir am wasanaethau)	Heslehurst et al. (2018)[$]
	Dyrannu adnoddau	Crawshaw et al. (2022)
Fforddiadwyedd (ariannol a ddim yn ariannol)	Costau uniongyrchol	Abba-Aji et al. (2022) Heslehurst et al. (2018)[$+]
	Blaenoriaethau sy'n cystadlu (gofal plant, ymrwymiadau teuluol)	Heslehurst et al. (2018)[$]
	Costau cyfle (amser i ffwrdd o'r gwaith, costau gofal plant, costau teithio)	Heslehurst et al. (2018)[$]

Tabl 18: Rhwystrau a brofwyd gan Sipsiwn, Roma a theithwyr (n=1)

Healthcare services: McFadden et al. 2018 (dulliau cymysg, 49/99 o astudiaethau yn y DU)		
Rhwystrau		**Cyfeiriadau**
Rhwystrau'n ymwneud â hygyrchedd	Rhwystrau iaith a chyfathrebu (yn cynnwys gwasanaethau dehongli)	McFadden et al. (2018)
	Llythrennedd iechyd isel (yn cynnwys bod yn anghyfarwydd â darpariaeth gofal iechyd lleol a chamwybodaeth)	McFadden et al. (2018)
	Rhwystrau ymarferol (yn cynnwys tai anniogel, newid cyfeiriad yn aml neu dim cyfeiriad sefydlog ar gyfer cofrestru gyda gwasanaeth gofal iechyd)	McFadden et al. (2018)
	Rhwystrau cyfreithiol (ansicrwydd ynghylch statws a hawl cyfreithiol)	McFadden et al. (2018)
	Teimlad o wahaniaethu; dieithrio a dadrymuso	McFadden et al. (2018)

	Anhygyrchedd daearyddol	McFadden et al. (2018)
	Prinder gwasanaethau priodol yn ddiwylliannol	McFadden et al. (2018)
Rhwystrau sy'n benodol i ddarparwr iechyd	Diffyg dealltwriaeth ddiwylliannol	McFadden et al. (2018)
Fforddiadwyedd (ariannol a ddim yn ariannol)	Costau cyfle (costau teithio)	McFadden et al. (2018)

Tabl 19: Rhwystrau a brofwyd gan oedolion hŷn (n=3)

Mental health services: Giebel et al. 2015£ (dulliau cymysg, 15/18 o astudiaethau yn y DU)

Influenza vaccination: Nagata et al. 2013 (dulliau cymysg, n=58, nifer o astudiaethau yn y DU nas adroddwyd arnynt)

Specialist palliative care: Ahmed et al. 2004% (dulliau cymysg, 18/40 o astudiaethau yn y DU)

Allwedd: £= Oedolion hŷn De Asia, %= atgyfeirio

Rhwystrau		**Cyfeiriadau**
Rhwystrau'n ymwneud â hygyrchedd	Rhwystrau iaith a chyfathrebu (yn cynnwys gwasanaethau dehongli)	Giebel et al. (2015)£ Nagata et al. (2013)
	Anhygyrchedd daearyddol (pellter at wasanaeth gofal iechyd, cyfleustra'r lleoliad, argaeledd trafnidiaeth)	Nagata et al. (2013)
	Costau cyfle (costau teithio)	Nagata et al. (2013)
	Llythrennedd iechyd isel (yn cynnwys bod yn anghyfarwydd â darpariaeth gofal iechyd lleol a chamwybodaeth)	Giebel et al. (2015)£ Ahmed et al. (2004)%
	Prinder gwasanaethau priodol yn ddiwylliannol	Giebel et al. (2015)£
Materion teuluol	Gwrthdaro teuluol am y camau gorau ar gyfer y claf	Ahmed et al. (2004)%
	Credoau diwylliannol neu grefyddol y teulu	Ahmed et al. (2004)%
	Methiant y teulu i dderbyn prognosis y claf	Ahmed et al. (2004)%

Tabl 20: Rhwystrau a brofwyd gan bobl ifanc ar y cyrion (n=1)

Healthcare services: Robards et al. 2018 (dulliau cymysg, 7/68 o astudiaethau yn y DU)

Rhwystrau	**Cyfeiriadau**

Rhwystrau'n ymwneud â hygyrchedd	Rhwystrau iaith a chyfathrebu (iaith gynhwysol)	Robards et al. (2018)
Rhwystrau sy'n benodol i ddarparwr gofal iechyd	Diffyg dealltwriaeth a gwybodaeth yn ymwneud â phobl ifanc amrywiol o ran rhywedd a rhywioldeb	Robards et al. (2018)
Fforddiadwyedd (ariannol a ddim yn ariannol)	Costau cyfle (costau teithio)	Robards et al. (2018)

Tabl 21: Rhwystrau a brofwyd gan fenywod o leiafrifoedd rhywiol (n=1)

Healthcare services in UK: Meads et al. 2019 (dulliau cymysg, n= 26)		
	Rhwystrau	**Cyfeiriadau**
Rhwystrau'n ymwneud â hygyrchedd	Llythrennedd iechyd isel (camwybodaeth)	Meads et al. (2019)
	Teimlad o wahaniaethu; dieithrio a dadrymuso	Meads et al. (2019)
Rhwystrau sy'n benodol i ddarparwr gofal iechyd	Gwrthod gwasanaeth	Meads et al. (2019)

Tabl 22: Rhwystrau a brofwyd gan oedolion digartref (n=1)

Dental care services: Goode et al. 2018 (dulliau cymysg, 8/22 o astudiaethau yn y DU)		
	Rhwystrau	**Cyfeiriadau**
Rhwystrau'n ymwneud â hygyrchedd	Anawsterau yn cofrestru am gymorth gan y llywodraeth	Goode et al. (2018)
Fforddiadwyedd	Cost uniongyrchol	Goode et al. (2018)

Tabl 23: Rhwystrau daearyddol (n=3)

Clinical genomic and genetic services: Best et al. 2022 (dulliau cymysg, 4/20 o astudiaethau yn y DU) Hosbice care: Tobin et al. 2022% (dulliau cymysg, 90/130 o astudiaethau yn y DU) Chemotherapy in UK: Chamberlain et al. 2016 (Meintiol, n=26) **Allwedd:** %= atgyfeirio		
	Rhwystrau	**Cyfeiriadau**
Rhwystrau'n ymwneud â hygyrchedd	Anhygyrchedd daearyddol	Best et al. (2022)
Rhwystrau sy'n benodol i ddarparwr gofal iechyd	Prinder argaeledd gwasanaeth	Best et al. (2022) Tobin et al. (2022)%
	Dosbarthiad gweithlu (mewn ardaloedd trefol)	Best et al. (2022) Chamberlain et al. (2016)

	Amrywioldeb lleol o ran ymagwedd ac ymarfer (arferion presgripsiynu a thrin)	Chamberlain et al. (2016)
Fforddiadwyedd (ariannol a ddim yn ariannol)	Blaenoriaethau sy'n cystadlu (gofal plant, ymrwymiadau teuluol)	Best et al. (2022)

Cryfderau, Cyfyngiadau ac ystyriaethau ar gyfer yr adroddiad hwn

Dyluniwyd yr adolygiad cwmpasu hwn i roi trosolwg o'r dystiolaeth sydd ar gael ar anghydraddoldeb yn cael mynediad at wasanaethau gofal iechyd. Oherwydd y cwestiwn eang, a'r raddfa amser fer ar gyfer cwblhau'r gwaith, nid oedd modd cynnal adolygiad systematig llawn, ac o ganlyniad, nid yw'r adolygiadau sydd wedi eu cynnwys yn yr adroddiad hwn wedi cael eu harfarnu'n feirniadol.

Er i chwiliad cynhwysfawr gael ei wneud yn Medline a Google scholar, yn ogystal â chwiliadau mewn ffynonellau eilaidd cadarn (llyfrgell Cochrane a NICE), nid oedd y chwiliad yn gyflawn, a gallai chwilio cronfeydd data ychwanegol fod wedi nodi adolygiadau systematig pellach ar y cwestiwn ymchwil hwn.

Er mwyn cipio cymaint o lenyddiaeth berthnasol â phosibl o'r chwiliadau, ni chafodd dyddiad terfynol ei gymhwyso i'r meini prawf ar gyfer cynnwys. Felly, gallai rhai o'r adolygiadau sydd wedi eu cynnwys gynnwys ymchwil sylfaenol sydd wedi dyddio. Cafodd adolygiadau systematig gydag o leiaf un astudiaeth yn y DU gyda chanlyniadau perthnasol ei gynnwys. O ganlyniad, mae sawl un o'r adolygiadau yn cynnwys llenyddiaeth ryngwladol ac felly efallai nad oes modd cyffredinoli rhai o'r canfyddiadau i gyd-destun Cymru/y DU. Mae'r adolygiadau sydd wedi eu cynnwys hefyd yn benodol yn aml i wasanaeth iechyd penodol, ac felly efallai nad oes modd eu cyffredinoli ar draws gwasanaethau.

Cafodd amrywiaeth o wasanaethau gofal iechyd yn rhychwantu gofal sylfaenol, eilaidd, ac arbenigol eu cynnwys, ac er i hyn gynyddu nifer yr adolygiadau cymwys, arweiniodd at nodi sawl canlyniad gafodd eu hymchwilio gan nifer fach o astudiaethau yn unig.

Cafodd data ansoddol ei allgáu er mwyn 1) sicrhau bod modd rheoli'r adolygiad o fewn y cyfnod amser a roddwyd, a 2) cynnal ffocws ar rwystrau strwythurol o ran cael mynediad at ofal iechyd. Roedd hyn yn cyfyngu'r adolygiad oherwydd bod y rhan fwyaf o'r ymchwil a nodwyd ar rwystrau i fynediad yn ansoddol. Yn ogystal, ar gyfer rhai adolygiadau systematig dulliau cymysg, nid oedd bob amser yn glir pa ganlyniadau oedd o ymchwil meintiol neu ansoddol, felly mae'n bosibl bod rhywfaint o ddata ansoddol wedi dylanwadu ar yr hyn gafodd ei adrodd.

Er gwaetha'r cyfyngiadau hyn, cryfder yr adolygiad cwmpasu hwn oedd bod y strategaeth chwilio, y teitl, sgrinio crynodeb a thestun llawn, ac echdynnu data i gyd wedi cael eu gwirio'n gyson, felly defnyddiwyd methodoleg gadarn yn ystod pob cam o'r adolygiad.

Opsiynau ar gyfer gwaith pellach

Cafodd saith nodwedd poblogaeth trosfwaol eu nodi yn yr adolygiad cwmpasu hwn. Fodd bynnag, oherwydd natur eang y cwestiwn a'r ffactorau lluosog sydd yn dylanwadu ar gyfeiriad yr anghydraddoldeb, mae'n bwysig ystyried y canfyddiadau o'r adroddiad hwn wrth ddylunio ymchwil bellach. Argymhellir edrych ar ddata Cymru ar nodweddion poblogaeth a nodwyd yn yr adroddiad hwn, i nodi'r anghydraddoldebau a brofwyd gan y grwpiau hyn.

Mae'r awgrymiadau ar gyfer gwaith pellach gan y Gwasanaeth Tystiolaeth yn cynnwys:

1. Archwilio dulliau a ddefnyddiwyd i nodi anghydraddoldebau o ran mynediad at wasanaethau iechyd mewn gwledydd eraill a'r ffordd y gellid eu cymhwyso i ddata yng Nghymru

Neu

2. Cynhyrchu crynodeb tystiolaeth testun yn canolbwyntio ar:

(ii) Nodi anghydraddoldebau o ran mynediad at wasanaethau iechyd mewn grŵp poblogaeth benodol (e.e., lleiafrifoedd ethnig) neu nodwedd (e.e., statws economaidd-gymdeithasol), gwasanaeth gofal iechyd penodol (e.e., gwasanaethau sgrinio), neu gyfuniad o sawl ffactor. Gallai hyn hefyd gynnwys archwilio rhwystrau sy'n benodol i'r grŵp, y nodwedd neu'r gwasanaeth. Er ei fod yn debyg i'r hyn a wnaed ar gyfer yr adolygiad cwmpasu presennol, gallai hyn fod yn ddefnyddiol i archwilio'n fanylach unrhyw fylchau a nodwyd gan yr adolygiad cwmpasu hwn, trwy archwilio llenyddiaeth sylfaenol mewn maes ffocws.

Neu

(iii) Ymyriadau i wella mynediad at wasanaeth iechyd penodol o fewn grŵp penodol.

Mae crynodeb tystiolaeth testun yn cael ei gynhyrchu yn dilyn methodoleg gynhwysfawr ac mae'n mynd i'r afael â chwestiwn ymchwil â ffocws. Mae'r fethodoleg yn cynnwys chwiliad systematig ar gyfer llenyddiaeth sylfaenol mewn amrywiaeth ehangach o gronfeydd data, arfarniad ansawdd yn ogystal â graddio a chyfosod y dystiolaeth a nodwyd. Ei gyfnod cyflawni yw 10-12 wythnos/testun.

Cyfeiriadau :

Abba-Aji M, Stuckler D, Galea S, et al. (2022). Ethnic/racial minorities' and migrants' access to COVID-19 vaccines: A systematic review of barriers and facilitators. *Journal of migration and health.* 5: pp.100086.

Ahmed N, Bestall JC, Ahmedzai SH, et al. (2004). Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliative medicine.* 18(6): pp.525-42.

Anderson De Cuevas RM, Saini P, Roberts D, et al. (2018). A systematic review of barriers and enablers to South Asian women's attendance for asymptomatic screening of breast and cervical cancers in emigrant countries. *BMJ open.* 8(7): pp.e020892.

Asthana S, Moon G, Gibson A, et al. (2018). Inequity in cardiovascular care in the English National Health Service (NHS): a scoping review of the literature. *Health & social care in the community.* 26(3): pp.259-272.

Best S, Vidic N, An K, et al. (2022). A systematic review of geographical inequities for accessing clinical genomic and genetic services for non-cancer related rare disease. *European Journal of Human Genetics.* 30(6): pp.645-652.

Brewster S, Bartholomew J, Holt RIG, et al. (2020). Non-attendance at diabetes outpatient appointments: a systematic review. *Diabetic medicine: a journal of the British Diabetic Association.* 37(9): pp.1427-1442.

Bunten A, Porter L, Gold N, et al. (2020). A systematic review of factors influencing NHS health check uptake: invitation methods, patient characteristics, and the impact of interventions. *BMC public health.* 20(1): pp.93.

Chamberlain C, Owen-Smith A, Donovan J, et al. (2016). A systematic review of geographical variation in access to chemotherapy. *BMC cancer.* 16(1): pp.1-15.

Crawshaw AF, Farah Y, Deal A, et al. (2022). Defining the determinants of vaccine uptake and undervaccination in migrant populations in Europe to improve routine and COVID-19 vaccine uptake: a systematic review. *The Lancet. Infectious diseases.* 22(9): e254-e266.

Croxford S, Yin Z, Burns F, et al. (2018). Linkage to HIV care following diagnosis in the WHO European Region: A systematic review and meta-analysis, 2006-2017. *PloS one.* 13(2): pp.e0192403.

Durà-Vilà G and Hodes M. (2012). Ethnic factors in mental health service utilisation among people with intellectual disability in high-income countries: systematic review. *Journal of intellectual disability research : JIDR.* 56(9): pp.827-42.

Elgalib A, Fidler S and Sabapathy K. (2018). Hospital-based routine HIV testing in high-income countries: a systematic literature review. *HIV medicine.* 19(3): pp.195-205.

Fisher H, Trotter CL, Audrey S, et al. (2013). Inequalities in the uptake of human papillomavirus vaccination: a systematic review and meta-analysis. *International journal of epidemiology.* 42(3): pp.896-908.

Forrest LF, Adams J, Wareham H, et al. (2013). Socioeconomic inequalities in lung cancer treatment: systematic review and meta-analysis. *PLoS medicine*. 10(2): pp.e1001376.

Foster H, Moffat KR, Burns N, et al. (2020). What do we know about demand, use and outcomes in primary care out-of-hours services? A systematic scoping review of international literature. *BMJ open.* 10(1): pp.e033481.

Giebel CM, Zubair M, Jolley D, et al. (2015). South Asian older adults with memory impairment: improving assessment and access to dementia care. *International journal of geriatric psychiatry.* 30(4): pp.345-56.

Goode J, Hoang H and Crocombe L. (2018). Homeless adults' access to dental services and strategies to improve their oral health: a systematic literature review. *Australian journal of primary health.* 24(4) 287-298

Halvorsrud K, Nazroo J, Otis M, et al. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC medicine*. 16(1): pp.1-17.

Hanratty B, Zhang T and Whitehead M. (2007). How close have universal health systems come to achieving equity in use of curative services? A systematic review. *International Journal of Health Services.* 37(1): pp.89-109.

Heslehurst N, Brown H, Pemu A, et al. (2018). Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC medicine.* 16(1): pp.89.

Jepson R, Clegg A, Forbes C, et al. (2000). The determinants of screening uptake and interventions for increasing uptake: a systematic review. *Health technology assessment (Winchester, England).* 4(14): pp.i-vii, 1-133.

Kamal A, Hodson A and Pearce JM. (2021). A Rapid Systematic Review of Factors Influencing COVID-19 Vaccination Uptake in Minority Ethnic Groups in the UK. *Vaccines*. 9(10).

Kapadia D, Brooks HL, Nazroo J, et al. (2017). Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research. *Health & social care in the community.* 25(4): pp.1304-1317.

Knight A and Lindfield R. (2015). The relationship between socio-economic status and access to eye health services in the UK: a systematic review*. Public health.* 129(2): pp.94-102.

Lueckmann SL, Hoebel J, Roick J, et al. (2021). Socioeconomic inequalities in primary-care and specialist physician visits: a systematic review. *International journal for equity in health.* 20(1): pp.1-19.

Martin A, Saunders CL, Harte E, et al. (2018). Delivery and impact of the NHS Health Check in the first 8 years: a systematic review. *The British journal of general practice: the journal of the Royal College of General Practitioners*. 68(672): pp.e449-e459.

Martins T, Hamilton W and Ukoumunne OC. (2013). Ethnic inequalities in time to diagnosis of cancer: a systematic review. *BMC family practice.* 14(1): pp.1-8.

Mayland CR, Powell RA, Clarke GC, et al. (2021). Bereavement care for ethnic minority communities: A systematic review of access to, models of, outcomes from, and satisfaction with, service provision. *PloS one.* 16(6): pp.e0252188.

Mcfadden A, Siebelt L, Gavine A, et al. (2018). Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. *European journal of public health.* 28(1): pp.74-81.

Meads C, Hunt R, Martin A, et al. (2019). A Systematic Review of Sexual Minority Women's Experiences of Health Care in the UK. *International journal of environmental research and public health.* 16(17).

Mosquera I, Mendizabal N, Martín U, et al. (2020). Inequalities in participation in colorectal cancer screening programmes: a systematic review. *European journal of public health.* 30(3): pp.416-425.

Murfin J, Irvine F, Meechan-Rogers R, et al. (2020). Education, income and occupation and their influence on the uptake of cervical cancer prevention strategies: A systematic review. *Journal of clinical nursing*. 29(3): pp.393-415.

Nagata JM, Hernández-Ramos I, Kurup AS, et al. (2013). Social determinants of health and seasonal influenza vaccination in adults ≥65 years: a systematic review of qualitative and quantitative data. *BMC public health*. 13: pp.388.

Netuveli G, Hurwitz B, Levy M, et al. (2005). Ethnic variations in UK asthma frequency, morbidity, and health-service use: a systematic review and meta-analysis. *The Lancet.* 365(9456): pp.312-7.

Phung V-H, Asghar Z, Matiti M, et al. (2020). Understanding how Eastern European migrants use and experience UK health services: a systematic scoping review. *BMC health services research.* 20(1): pp.173.

Ricci-Cabello I, Ruiz-Perez I, De Labry-Lima AO, et al. (2010). Do social inequalities exist in terms of the prevention, diagnosis, treatment, control and monitoring of

diabetes? A systematic review. *Health & social care in the community.* 18(6): pp.572-587.

Robards F, Kang M, Usherwood T, et al. (2018). How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*. 62(4): pp.365-381.

Robertson J, Raghavan R, Emerson E, et al. (2019). What do we know about the health and health care of people with intellectual disabilities from minority ethnic groups in the United Kingdom? A systematic review. *Journal of Applied Research in Intellectual Disabilities.* 32(6): pp.1310-1334.

Ryan-Ndegwa S, Zamani R and Akrami M. (2021). Assessing demographic access to hip replacement surgery in the United Kingdom: a systematic review. *International journal for equity in health.* 20(1): pp.224.

Schröder SL, Richter M, Schröder J, et al. (2016). Socioeconomic inequalities in access to treatment for coronary heart disease: a systematic review. *International journal of cardiology.* 219: pp.70-78.

Smith D, Thomson K, Bambra C, et al. (2019). The breast cancer paradox: A systematic review of the association between area-level deprivation and breast cancer screening uptake in Europe. *Cancer epidemiology*. 60: pp.77-85.

Tobin J, Rogers A, Winterburn I, et al. (2022). Hospice care access inequalities: a systematic review and narrative synthesis. *BMJ Supportive & Palliative Care.* 12(2): pp.142-151.

Williams P, Murchie P and Bond C. (2019). Patient and primary care delays in the diagnostic pathway of gynaecological cancers: a systematic review of influencing factors. *The British journal of general practice: the journal of the Royal College of General Practitioners.* 69(679): pp.e106-e111.

Wilson C, Alam R, Latif S, et al. (2012). Patient access to healthcare services and optimisation of self-management for ethnic minority populations living with diabetes: a systematic review. *Health & social care in the community.* 20(1): pp.1-19.

Atodiad A: Rhestr o'r ffynonellau a chwiliwyd

Core Sources (not optional)	
Cochrane Library - https://www.cochranelibrary.com/cdsr/reviews *Systematic reviews on health care interventions, diagnostics and public health interventions.*	Searched, nothing found
NICE - https://www.nice.org.uk/guidance *Systematic evidence reviews that may underpin guidance.*	Searched, nothing found
Joanna Briggs Institute - https://journals.lww.com/jbisrir/pages/advancedsearch.aspx *Systematic and scoping reviews of both quantitative and qualitative evidence on healthcare and public health topics.*	Searched, nothing found
Prospero - https://www.crd.york.ac.uk/prospero/ *Database of systematic review protocols to see whether an up to date systematic review related to your question is in progress.*	Choose an item.
Public Health/ Wider Determinants Focus (select if relevant to your question)	
National Institute for Health Research (NIHR) Public Health Research - https://www.journalslibrary.nihr.ac.uk/phr/about-the-phr-journal.htm *Some reports in this journal are systematic reviews of interventions to improve public health.*	Searched, nothing found
The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) - http://eppi.ioe.ac.uk/cms/ *Publications list for systematic reviews in the fields of education, health promotion and public health, as well as social welfare and international development.*	Searched, nothing found
Campbell Collaboration systematic reviews - https://www.campbellcollaboration.org/better-evidence.html *Systematic reviews of the effects of social interventions in Crime & Justice, Education, International Development, and Social Welfare.*	Searched, nothing found
College of Policing What Works Centre for Crime Reduction - https://www.college.police.uk/research/what-works-centre-crime-reduction *Systematic reviews on crime reduction.*	Not searched, not relevant
What Works Centre for Wellbeing - https://whatworkswellbeing.org/about-us/ *Systematic reviews of the impacts of policies and projects on wellbeing.*	Searched, nothing found

What Works for Children's Social Care - https://whatworks-csc.org.uk/ *Systematic reviews relevant to children's social care.*	Searched, nothing found
What Works Clearinghouse (USA) - https://ies.ed.gov/ncee/wwc/ *Systematic reviews on what works in education.*	Not searched, not relevant
Early Intervention Foundation (EIF) - https://www.eif.org.uk/about *Systematic reviews about early interventions for tackling the root causes of social problems for children and young people.*	Searched, nothing found
What Works Centre for Local Economic Growth - https://whatworksgrowth.org/about-us/ *Systematic reviews on policies for local economic growth.*	Not searched, not relevant
Health Care Interventions and Technologies	
Health Technology Wales - https://healthtechnology.wales/ *Reports and guidance on use of medical devices, surgical procedures, psychological therapies, tele-monitoring or rehabilitation.*	Searched, nothing found
Health Technology Assessments (Ireland) - https://www.hiqa.ie/areas-we-work/health-technology-assessment *Health technology assessments on the clinical and cost-effectiveness of drugs, equipment, diagnostic techniques and public health activities.*	Searched, nothing found
National Institute for Health Research Health (NIHR) Technology Assessment (HTA) Journal - https://www.journalslibrary.nihr.ac.uk/hta/about-the-hta-journal.htm *Some reports in this journal are systematic reviews of interventions to, prevent and treat disease and improve rehabilitation and long-term care.*	Searched, nothing found
Agency for Healthcare Research and Quality (AHRQ) Search Evidence-Based Reports | Agency for Healthcare Research and Quality (ahrq.gov) *Effectiveness and comparative effectiveness reviews of health care interventions.*	Searched, nothing found
Canadian Agency for Drugs and Technologies (CADTH) - https://www.cadth.ca/evidence-bundles-view *Rapid response systematic reviews and meta-analyses of health technologies, including drugs and diagnostic tests, medical, dental and surgical devices and procedures.*	Searched, nothing found

Evidence Synthesis Program Reports (va.gov) - https://www.hsrd.research.va.gov/publications/esp/reports.cfm *Evidence syntheses of health care interventions of particular relevance to veterans.*	Searched, nothing found
Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines - https://www.sign.ac.uk/our-guidelines/ *Systematic evidence reviews that may underpin guidance.*	Searched, nothing found
Additional search	
Google Scholar - https://scholar.google.com/ *Search using your keywords AND "systematic review"*	Searched, results found
Medline – https://dialog.proquest.com/professional/medlineprof/advanced *Search strategy provided in below*	Searched, results found
UKHSA Library Service Evidence Briefings- https://ukhsalibrary.koha-ptfs.co.uk/briefings/	Searched, nothing found
Health equity resource database- https://health-inequalities.eu/resources/jwddb/	Searched, results found

Termau chwilio a ddefnyddiwyd (Medline):

Set#	Searched for	Results
S2	(ti,ab(access* OR utilis* OR utiliz* OR attend* OR uptake))	1911674*
S3	(MESH.EXACT("Health Services Accessibility"))	83607*
S4	(MJMESH.EXACT("Healthcare Disparities") OR MESH.EXACT("Medically Underserved Area"))	20929*
S5	S4 OR S3 OR S2	1963423*
S6	(ti,ab("primary care" OR NHS OR "general practi*" OR GP OR "family practi*" OR doctor OR healthcare OR "health care" OR "secondary care" OR "ambulatory care" OR "health service" OR nurse OR nursing OR outpatient* OR "out patient*" OR appointment* OR screen* OR clinic OR dentist* OR pharmacy))	2702642*
S7	(MJMESH.EXACT("Secondary Care") OR MJMESH.EXACT("Secondary Care Centers") OR MESH.EXACT(“Outpatients”))	20416*
S8	(MJMESH.EXACT("Primary Care Nursing") OR MJMESH.EXACT("Physicians, Primary Care") OR MJMESH.EXACT("Primary Health Care"))	57993*
S9	S8 OR S7 OR S6	2712931*
S10	(MESH.EXACT("Aged") OR ti,ab(elder* OR aged OR older OR "senior citizen" OR "senior citizens" OR retired OR retirement OR Retiree* OR pension*))	5004606*
S11	(ti,ab(BAME OR BME OR ("Black Asian" N/1 "minority ethnic") OR "minority ethnic*" OR "ethnic minorit*" OR "people of color" OR "people of colour" OR POC OR "racial* minorit*" OR “Black British” OR bangladeshi* OR bengali* OR indian* OR chinese OR pakistani* OR african* OR arab* OR "afro caribbean" OR "african caribbean" OR afrocaribbean OR "afro-caribbean" OR "south asian*" OR somali*))	685153*
S12	(MESH.EXACT("Emigration and Immigration") OR MESH.EXACT("Racial Groups") OR MESH.EXACT("Refugees") OR MESH.EXACT("Ethnic and Racial Minorities"))	61607*

S13	((ti,ab(Gypsy* or gypsies or gipsy* or gipsies)) OR (ti,ab(Roma or romas or romany or romani or romanis or romanies or romanian)) OR MESH.EXACT("Roma"))	8640*
S14	((ti,ab((vulnerable OR underserved OR “low income” OR rural OR sensitive OR disadvantaged) N/1 population*)))	37198*
S15	(ti,ab(rural N/1 communit*))	15849*
S16	(MJMESH.EXACT("Health Disparity, Minority and Vulnerable Populations") OR MJMESH.EXACT("Vulnerable Populations"))	5558*
S17	(MJMESH.EXACT.EXPLODE("Sexual and Gender Minorities"))	11189*
S18	(ti,ab(men OR male* OR women OR woman OR female* OR non-binary OR "gender neutral" OR pangender OR transgender))	3515217*
S19	((MJMESH.EXACT("Homeless Persons")))	7453*
S20	(ti,ab(homeless persons OR homeless* OR houseless OR rough n/1 sleep))	12659*
S21	S20 OR S19 OR S18 OR S17 OR S16 OR S15 OR S14 OR S13 OR S12 OR S11 OR S10	7584996*
S22	(ti,ab((systematic OR rapid OR scoping OR mapping) N/1 review) OR ti,ab(meta-analysis OR metaanalysis))	389193*
S23	(((MJMESH.EXACT("Systematic Reviews as Topic") OR MJMESH.EXACT("Meta-Analysis as Topic"))))	6583*
S24	S23 OR S22	389995*
S25	(((MESH.EXACT("United Kingdom"))) OR MESH.EXACT("Scotland") OR ((MESH.EXACT("Northern Ireland"))) OR MESH.EXACT.EXPLODE("Wales") OR ((TI,AB(Great Britain or Britain or England or Scotland or Wales or Ireland or UK or United Kingdom or welsh or english or scottish or irish))))	580638*
S26	S25 AND S24 AND S21 AND S9 AND S5	1181°

Atodiad B: Tabl o nodweddion yr astudiaethau a gynhwyswyd

Table 1. Population groups/ characteristics identified that might be associated with inequitable access to healthcare services

Key:
↑ denotes that the systematic review identified an inequality with the population group/ characteristic being more likely to access/ utilise the healthcare service;
↓ denotes that the systematic review identified an inequality with the population group/ characteristic being less likely to access/ utilise healthcare service;
↕ denotes that the systematic review identified mixed evidence i.e. it is unclear whether the population group/ characteristic is less likely to access/ utilise healthcare service;
↔ no evidence of inequality identified i.e. there is no difference in the likelihood of the population group/ characteristic affecting the access/ utilisation of the healthcare service.

	Access of NHS health checks	Access to primary care	Access to specialist care	Access of screening services	Referral to specialist care	Access of HPV vaccination
Age						
Older age	↑ (Bunten et al. 2020) ↑ (Martin et al. 2018)	↑ (Foster et al. 2019)	↓ (Asthana et al. 2018) ↓ (Brewster et al. 2020)	↑ (Jepson et al. 2000)	↓ (Ahmed et al. 2004) ↓ (Williams et al. 2019)	
Younger age	↓ (Asthana et al. 2018)		↓ (Brewster et al. 2020)	↑ (Elgalib et al. 2018)	↓ (Croxford et al. 2018)	
Education level						
Lower levels of education					↓ (Croxford et al. 2018)	↓ (Murfin et al. 2020)
Higher level of education				↑ (Jepson et al. 2000)	↑(Williams et al. 2019)	↑ (Murfin et al. 2020)

				↑ (Mosquera et al. 2020) ↑ (Murfin et al. 2020)		
Ethnicity/ immigration status						
Ethnic minority groups	↕ (Asthana et al. 2018) ↕ (Bunten et al. 2020) ↕ (Martin et al. 2018)	↕ (Foster et al. 2019)	↓ (Ahmed et al. 2004) ↕ (Asthana et al. 2018) ↕ (Ricci-Cabello et al. 2010) ↓ (Tobin et al. 2022)	↑ (Jepson et al. 2000)	↓(Ahmed et al. 2004) ↕ (Williams et al. 2019)	
Migrant status		↕ (Foster et al. 2019)				
Gender						
Women	↕ (Asthana et al. 2018) ↑ (Bunten et al. 2020) ↑ (Martin et al. 2018)	↑ (Foster et al. 2019)	↓ (Asthana et al. 2018) ↔ (Ricci-Cabello et al. 2010)	↕ (Mosquera et al. 2020)		
Men	↕ (Asthana et al. 2018)		↕ (Brewster et al. 2020) ↔ (Ricci-Cabello et al. 2010)	↑ (Elgalib et al. 2018) ↕ (Mosquera et al. 2020)		
Risk						
Shorter duration of diagnosis			↕ (Brewster et al. 2020)			
Low severity of symptoms at diagnosis				↑ (Jepson et al. 2000)	↓ (Croxford et al. 2018)	
Pre-existing health conditions	↑ (Martin et al. 2018)	↑ (Foster et al. 2019)				
Family history	↑ (Bunten et al. 2020)					
Smoking	↓ (Bunten et al. 2020)		↓ (Brewster et al. 2020)			
Non-smoking	↑ (Martin et al. 2018)					
Increased alcohol intake			↓ (Brewster et al. 2020)		↓ (Williams et al. 2019)	

Injecting drug use					↓ (Croxford et al. 2018)	
Rurality/ social deprivation						
Rural residents		↓ (Williams et al. 2019)	↓ (Ryan-Ndegwa et al. 2021)			
Urban residents		↑ (Foster et al. 2019)	↑ (Tobin et al. 2022)			
Closer proximity to service		↑ (Foster et al. 2019)	↑ (Tobin et al. 2022)			
Higher deprivation	↕ (Bunten et al. 2020)		↕ (Brewster et al. 2020) ↕ (Ryan-Ndegwa et al. 2021)			↓ (Fisher et al. 2013)
Lower deprivation	↑ (Martin et al. 2018)			↑ (Mosquera et al. 2020)		
Socio-economic status						
Low socio-economic status	↕ (Asthana et al. 2018)	↑ (Foster et al. 2019) ↔ (Hanratty et al. 2007)	↕(Asthana et al. 2018) ↓ (Brewster et al. 2020) ↕ (Ricci-Cabello et al. 2010) ↓ (Tobin et al. 2022)	↕ (Murfin et al. 2020)		↓ (Murfin et al. 2020)
Higher socio-economic status	↕ (Asthana et al. 2018)	↕ (Hanratty et al. 2007)	↕ (Asthana et al. 2018) ↕ (Ricci-Cabello et al. 2010)	↑(Mosquera et al. 2020)	↑ (Williams et al. 2019)	

Atodiad C: Echdyniad Data

Data extraction of the Systematic reviews identified in the scoping search (in alphabetic and chronological order)				
Reference: Abba-Aji M, Stuckler D, Galea S, et al. (2022). Ethnic/racial minorities' and migrants' access to COVID-19 vaccines: A systematic review of barriers and facilitators. *Journal of migration and health.* 5: pp.100086.	**Study design:** Systematic review **Search dates:** Jan 2020 – Oct 2021 **Types of included studies:** Quantitative Qualitative Mixed methods **Quality Appraisal tool used:** Newcastle Ottawa Scale CASP	**Review aim and setting:** To review ethnic minorities' and migrants' access to and acceptance of COVID-19 vaccines **Focus:** Ethnic minorities and migrants' access to and acceptance of COVID-19 vaccines **No. included studies:** 33 (10 UK)	**Groups identified and Authors conclusions:** Ethnic Minorities (UK specific data): • **Lower vaccine acceptance among Black/BAME minorities** compared to their White counterparts (6/8 studies) Migrants: • **Higher vaccine acceptance among migrants** compared to the general population **Barriers to COVID-19 vaccine uptake:** • Inability to understand (language and health literacy [n= 3]) • Geographical inaccessibility (n= 2) • Unaffordability (n= 1)	**Comments/Limitations:** Qualitative barriers have not been extracted. UK data has been extracted where results have been disaggregated in the review.
Reference: Anderson De Cuevas RM, Saini P, Roberts D, et al. (2018). A systematic review of barriers and enablers to South Asian women's attendance for asymptomatic screening of breast and cervical cancers in emigrant countries. *BMJ open.* 8(7): pp.e020892.	**Study design:** Systematic review **Search dates:** Database inception - 2018 **Types of included studies:** Qualitative Quantitative	**Review aim and setting:** The aim of this review was to identify the cultural, social, structural and behavioural factors that influence asymptomatic breast and cervical cancer screening attendance in South Asian populations	**Groups identified and Authors conclusions:** • 4/6 studies showed that South Asian women have lower screening rates compared to host populations **Lower screening rates were noted among:** • Women without health insurance • Younger women • Women with low levels of education	**Comments/Limitations:** Barriers and characteristics used interchangeably (i.e., low preference for the host countries language was described as a cultural barrier).

	Quality Appraisal tool used: CASP	**Focus:** Barriers and enablers to South Asian women's attendance for asymptomatic screening of breast and cervical cancers in emigrant countries **No. included studies:** 51 (5 UK)	• Those with low knowledge (health literacy) was not consistently associated with reduced likelihood of attendance • Less time spent in the host country was a strong predictor of non-attendance • Those with a lower preference for the host countries language (n= 1) • South Asian women were less likely to be attend mammography screening if their GP had qualified outside of the host country	
Reference: Asthana S, Moon G, Gibson A, et al. (2018). Inequity in cardiovascular care in the English National Health Service (NHS): a scoping review of the literature. *Health & social care in the community.* 26(3): pp.259-272.	**Study design:** Scoping review (with CA) **Search dates:** 2004-2016 **Types of included studies:** Quantitative **Quality Appraisal tool used:** Tool not stated	**Review aim and setting:** To synthesise and evaluate evidence relating to access to and/or use of English NHS services around (i) different points on the care pathway (i.e. presentation, primary management and specialist management) and (ii) different dimensions of inequality (socioeconomic, age- and gender-related, ethnic or geographical). **Focus:** Cardiovascular care (whole pathway)	**Groups identified and Authors conclusions:** **Variations across pathway:** Presentation of CVD (help-seeking behaviour, uptake of health checks): • Mixed evidence of inequity in **SES groups** and **gender** • **Youth** appeared to be a factor lowering rates of presentation and uptake of health checks • High levels of presentation among **South Asian** patients. No other ethnic differences were found Access to/use of specialist care for CVD (including CV rehab): • Lower use of CV rehab in **women** • Lower rates of access to/use of revascularisation, CV rehab and stroke care in **Older patients** • Higher levels of access to specialist care in **South Asians**	**Factors identified in table 1.** Access of NHS health checks Access to specialist services

		No. included studies: 174 UK studies (all conducted in England or UK-wide. Evidence focusing exclusively on Scotland, Wales or NI was however excluded)	• Mixed evidence for inequalities by **SES** • Mixed evidence on access for **black patients**	
Reference: Ahmed N, Bestall JC, Ahmedzai SH, et al. (2004). Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliative medicine.* 18(6): pp.525-42.	**Study design:** Systematic review **Search dates:** 1997-2003 **Types of included studies:** Quantitative, Qualitative, Mixed Methods Majority of the UK studies are qualitative: interview, questionnaires and surveys. Several retrospective review of records. **Quality Appraisal tool used:**	**Review aim and setting:** To determine the problems and issues of accessing specialist palliative care by patients, informal carers and health and social care professionals involved in their care in primary and secondary care settings. **Focus:** Palliative care in primary and secondary care settings **No. included studies:** 40 (18 UK)	**Groups identified and Authors conclusions:** • Black and ethnic minority: lower referral rate to PC services • **Ethnic minority groups:** lower utilisation rates of palliative care services vs white patients • **Older patients (65+)** were less likely to be referred to PC Referral Barriers to PC: <u>Patient or family issues:</u> refusal or lack of interest in hospice, lack of knowledge, family conflict about the best course of action for the patient, cultural or religious beliefs, failure to accept patients' prognosis.	**Factors identified in table 1.** Access to specialist services Referral to specialist care: palliative care

	Adapted from Payne et al. and Hawker et al. Majority of the included studies were of moderate quality.			
Reference: Best S, Vidic N, An K, et al. (2022). A systematic review of geographical inequities for accessing clinical genomic and genetic services for non-cancer related rare disease. *European Journal of Human Genetics.* 30(6): pp.645-652.	**Study design:** Systematic review **Search dates:** Jan 2010 – July 2021 **Types of included studies:** Quantitative, Qualitative and Mixed Methods **Quality Appraisal tool used:** Hawker tool	**Review aim and setting:** reveal what is known about geographical (in) equity in accessing clinical genomic or genetic services for people with a non-cancer related rare disease. **Focus:** Clinical genomic and genetic services **No. included studies:** 20 (4 UK)	**Groups identified and Authors conclusions:** • Rural communities (focus of article) **Barriers to equitable service provision:** • Distribution of workforce (centered in Urban areas) • Lack of investment in rural services • Duration of travel to services for patients (especially for those dependent on public transport) • Time required leading to opportunity costs (time off work, childcare issues etc) • Workforce capacity in rural areas leading to lack of genetic/genomic expertise	**Comments/Limitations:**
Reference: Brewster S, Bartholomew J, Holt RIG, et al. (2020). Non-attendance at diabetes outpatient appointments: a systematic review. *Diabetic medicine: a journal of the British Diabetic Association.* 37(9): pp.1427-1442.	**Study design:** Systematic review **Search dates:** Up to Feb 2019 **Types of included studies:**	**Review aim and setting:** This review summarises the literature on non-attendance at diabetes healthcare appointments. The	**Groups identified and Authors conclusions:** **Non-attendance at appointments associated with:** • **Young age** • **Older age** (> 70y) • **Shorter duration of diagnosed diabetes** • **Financial pressures**	**Comments/Limitations:** Authors note that a number of studies used univariate analyses, which fail to address possible confounding factors.

	Qualitative and quantitative **Quality Appraisal tool used:** Hawker et al - tool for appraising disparate studies	objectives were 3-fold: 1. To establish the features of missed diabetes healthcare appointments, the characteristics associated with those not attending and the impact on health outcomes. 2. To explore factors that influence attendance or non-attendance at diabetes appointments. 3. To describe interventions to improve attendance at diabetes appointments. **Focus:** Non-attendance at diabetes appointments **No. included studies:** 34 (16 UK)	• **Smoking** • **Increased alcohol intake** • **Parenthood** (in particular being a single parent) **Mixed findings on non-attendance in:** • **Men** **Social deprivation** was only found to be mildly associated with non-attendance(one Scottish study) **Author's conclusions:** Studies of characteristics of non-attenders provide conflicting information, but in most instances, non-attendance was more likely in young adults, those from a lower socio-economic background, and those who smoke.	**Factors identified in table 1.** Access to specialist care
Reference: Bunten A, Porter L, Gold N, et al. (2020). A systematic review of factors influencing NHS health check	**Study design:** Systematic review	**Review aim and setting:** The aim of this systematic review is to highlight	**Groups identified and Authors conclusions:** **Socio-demographic factors for uptake of NHSHC's:**	**Factors identified in table 1.** Access of NHS health checks

uptake: invitation methods, patient characteristics, and the impact of interventions. *BMC public health.* 20(1): pp.93.	**Search dates:** no limit stated (included articles published 2011-2016) **Types of included studies:** Quantitative (RCTs, Quasi-experimental) **Quality Appraisal tool used:** Adapted version of EPHPP tool	interventions and invitation methods that increase the uptake of NHSHCs, and to identify whether the effectiveness of these interact with broader patient and contextual factors **Focus:** NHS Health checks uptake (for 40-74 y) **No. included studies:** 9 UK studies	• All studies found that **older patients** were more likely to attend than younger patients • One study found a significant interaction between age and gender, with women in the youngest age-group (35–54 years) more likely to attend than men of the same age-group • The majority of studies found that uptake was highest for **female patients** • Effect of **deprivation** on uptake varied across studies. • Findings on **ethnicity** and uptake were mixed. Association between level of risk and uptake varied according to the specific risk factor under investigation, with medical risk (e.g. family history) being associated with higher uptake and lifestyle risk (e.g. smoking status) being associated with lower uptake.	
Reference: Crawshaw AF, Farah Y, Deal A, et al. (2022). Defining the determinants of vaccine uptake and undervaccination in migrant populations in Europe to improve routine and COVID-19 vaccine uptake: a systematic review. *The Lancet. Infectious diseases.* 22(9): e254-e266.	**Study design:** Systematic review **Search dates:** 2000 – 2021 **Types of included studies:** Any primary research, identified studies were cross-sectional, cohort, case-control,	**Review aim and setting:** To explore barriers and facilitators of vaccine uptake and sociodemographic determinants of under vaccination among migrants in the EU and European Economic Area, the UK, and Switzerland.	**Groups identified and Authors conclusions:** **Under-vaccinated migrant groups:** • children of foreign-born Pakistani mothers were more likely to be fully immunised than Pakistani children whose mothers were UK-born (n= 1) • Asylum-seeker children have lower vaccine uptake compared to the general population. Differences also exist between sites (n= 1 Welsh study) **Barriers:** Access to vaccination:	**Comments/Limitations:** Only 2 UK studies related to 'Groups' were included in analysis so the UK data has been extracted and the (large proportion of non-UK data) omitted

	qualitative, or other **Quality Appraisal tool used:** JBI Critical Appraisal Tools	**Focus:** Barriers to vaccine uptake for migrants in EU countries (& UK) **No. included studies:** 67 (not stated how many from UK)	• Low literacy • Language/ communication barriers • Lack of accessible, tailored, or translated information about vaccination for migrant populations • Lack of interpreting services • Insecure housing and frequent change of address/no fixed address Possibly relevant other barriers, extracted in case • Digital exclusion (1 study) • Fears and uncertainty around legal entitlement (not clear if quant/qual or mixed) • Location of delivery, e.g., schools inaccessible to European Roma • fear of being charged for care or asked about immigration status when accessing car • difficulties registering with a general practitioner (GP) • being refused care • Poor HCP knowledge of migrants' entitlements to health care and vaccination guidelines (resulted in patients being wrongly refused access to primary care or not offered recommended catch-up vaccinations variability in local procedures and resource allocation between asylum dispersal sites, including differences in accepting verbal history as proof of vaccination status, staff allocation, and follow-up procedures	

Reference: Croxford S, Yin Z, Burns F, et al. (2018). Linkage to HIV care following diagnosis in the WHO European Region: A systematic review and meta-analysis, 2006-2017. *PloS one.* 13(2): pp.e0192403.	**Study design:** systematic review and meta-analysis **Search dates:** Database inception to December 2017, but inclusion criteria was: published between 1st of January 2006 and 27th of February 2017 **Types of included studies:** Observational studies using data collected for surveillance or research purposes and qualitative studies including quantitative outcome data on linkage to care **Quality Appraisal tool used:** AXIS (For cross-sectional studies, but authors state adapted to cover longitudinal study designs)	**Review aim and setting:** To synthesise the evidence to achieve a better understanding of what proportion of patients are linked to care and what factors impact linkage **Focus:** Linkage to HIV care following diagnosis in the WHO European region **No. included studies:** 24 (7 UK)	**Groups identified and Authors conclusions:** **Factors associated with delayed linkage or not being linked to care:** • Acquiring **HIV through heterosexual contact** • **Injecting drug use** • Being of **younger age at diagnosis** • Having **lower levels of education** • Being or **feeling well at diagnosis** • Being **diagnosed outside an STI clinic** **Authors conclusions:** Overall, few countries in the WHO European Region have produced estimates on this essential HIV quality of care indicator. Where available, linkage estimates vary and reflect diverse healthcare systems, as well as political and socioeconomic factors that may hinder people living with HIV from seeking care such as migrants and people who inject drugs.	**Factors identified in table 1.** Referral to specialist care: HIV care

Reference: Chamberlain C, Owen-Smith A, Donovan J, et al. (2016). A systematic review of geographical variation in access to chemotherapy. *BMC cancer.* 16(1): pp.1-15.	**Study design:** Systematic review **Search dates:** Up to July 2015 **Types of included studies:** Quantitative: Cohort, correlational, and before and after **Quality Appraisal tool used:** Reporting clarity was evaluated with the STROBE observational checklist and methodological quality with the NICE adapted Graphical Appraisal Tool for Epidemiological studies (GATE)	**Review aim and setting:** To systematically identify published studies considering geographical barriers to use of cancer pharmaceuticals in the UK NHS. **Focus:** Geographical barriers to cancer pharmaceuticals in the UK **No. included studies:** 26 UK Studies	**Groups identified and Authors conclusions:** • Geographical inequities (focus of article) Authors identified a considerable variation in chemotherapy prescribing between healthcare boundaries. The absence of associations with natural geographical characteristics (e.g. rurality) and receipt of chemotherapy suggests that local treatment habits, capacity and policy are more influential.	**Comments/Limitations:** Authors note included studies may be subject to confounding due to an absence of case-mix adjustment.
Reference: Durà-Vilà G and Hodes M. (2012). Ethnic factors in mental health service utilisation among people with intellectual disability in high-income countries: systematic review. *Journal*	**Study design:** Systematic review **Search dates:** 1950 – 2009	**Review aim and setting:** to investigate whether there is ethnic variation in uptake of mental health	**Groups identified and Authors conclusions:** UK studies: **Inconsistent findings:**	**Comments/Limitations:**

of intellectual disability research: JIDR. 56(9): pp.827-42.	**Types of included studies:** all studies that reported quantitative or qualitative data **Quality Appraisal tool used:** quality appraisal performed but not with a tool	services by people with intellectual difficulties in high-income countries **Focus:** ethnic variation in uptake of mental health services by people with intellectual difficulties **No. included studies:** 9 (7 UK)	• **South Asians:** two studies suggest South Asians use MH services less than whites. One study found similar patterns of access. • **Ethnic minority groups with ID & a psychiatric disorder** (compared to white) more likely to be referred to MH services in one study (increase most marked in people of African Caribbean origin), but fewer admitted from minority ethnic communities to an assessment and treatment unit for adults with ID and mental health problems and/or challenging behaviour in another study. **Less access/utilisation:** • CAMHS uptake was statistically significantly lower for **South Asians** than for White British and for South Asians when compared to Black group. • **Family structure predicted CAMHS service utilisation:** two-parent families used this service less than single-parent/foster families Authors conclude that most of the studies in the review suggest an association between ethnicity and mental health service utilisation.	
Reference: Elgalib A, Fidler S and Sabapathy K. (2018). Hospital-based routine HIV testing in high-income countries: a systematic literature review. *HIV medicine.* 19(3): pp.195-205.	**Study design:** Systematic Review **Search dates:** 2006-2015	**Review aim and Setting:** Identify the facilitators and barriers to HIV screening in Emergency	**Groups identified & Authors conclusions:** • **Younger age groups:** Higher uptake of HIV testing • **Male sex:** Increased uptake of HIV testing	**Factors identified in table 1.** Access to screening services: HIV testing Barrier to uptake of HIV testing

	Types of included studies: Quantitative, Qualitative, Mixed Methods. **Quality Appraisal tool used:** Mixed methods appraisal tool (MMAT)	Departments (EDs) in the US and Acute Medical Units (AMU's) in the UK. **Focus:** HIV testing **No. included studies:** 14 (7 UK)	Barriers to HIV testing: <u>Patient-specific factors:</u> Perception of low HIV risk	
Reference: Foster H, Moffat KR, Burns N, et al. (2020). What do we know about demand, use and outcomes in primary care out-of-hours services? A systematic scoping review of international literature. *BMJ open.* 10(1): pp.e033481.	**Study design:** Scoping review **Search dates:** 1995 to March 2019 **Types of included studies:** All study designs **Quality Appraisal tool used:** CASP tools for observational, RCTs, and systematic reviews	**Review aim and setting:** To synthesise international evidence for demand, use and outcomes of primary care out-of-hours health services (OOHSs) **Focus:** demand, use, and outcomes in primary care OOHSs **No. included studies:** 105 (37 UK)	**Groups identified and Authors conclusions:** **Demographics of OOHS users:** • The most frequent users of OOHS were **children**, especially those **under 5 years old** • Although not always apparent when absolute numbers of contacts were reported, **older adults** (65 and over) had higher rates of contact than younger adults • **Women** tended to use OOHS more than **men**, but men were more likely than women to use the ED out of hours • **Lower SES** was associated with higher use of OOHS • Having a **chronic disease** was associated with increased use of OOHS • Mixed evidence for an association between **ethnicity or migrant status** and OOHS use (small no. studies) • In England, TTA data found that, following contact with NHS Direct, **white British or Bangladeshi children** were most likely to be	**Factors identified in table 1.** Access to primary care: OOHSs

			referred to urgent care services including OOHS while children of **Indian and 'other white' ethnicity** were least likely to be referred • Six studies reported **that proximity to an OOHS** was associated with higher use. Three studies showed higher rates of OOHS use in more **urban areas**. Conversely, routine data in Ireland found **rural cooperatives** had higher OOHS use than **urban cooperatives**. In Finland, a retrospective review comparing three models of care found that OOHS use was higher where patients were able to attend their local primary care centre during out of hours compared with a model where OOHS access was more centralised	
Reference: Fisher H, Trotter CL, Audrey S, et al. (2013). Inequalities in the uptake of human papillomavirus vaccination: a systematic review and meta-analysis. *International journal of epidemiology.* 42(3): pp.896-908.	**Study design:** Systematic review and meta-analysis **Search dates:** Inception to 9 March 2012 **Types of included studies:** Designs not clearly stated, appears to be any observational study where vaccine uptake in women <18yrs was reported	**Review aim and setting:** to summarize evidence on the uptake of HPV vaccination programmes in adolescent young women by ethnicity and socioeconomic status **Focus:** HPV vaccination **No. included studies:** 29 publications related to 27 studies (1 UK)	**Groups identified and Authors conclusions:** **Groups identified as less likely to initiate HPV Vaccination:** • **Black young women** (less likely than White young women) • **Young women living in the most deprived areas** were less likely to initiate HPV vaccination than those living in the least (UK specific; when combined with 3 non-UK studies no strong association was found). • **Young women who had no healthcare insurance** (USA studies only) **Groups where no difference in uptake has been identified:** • No difference identified between **White and Asian young women** (UK outcome).	**Comments/Limitations:** Authors note considerable heterogeneity between studies. **Factors identified in table 1.** Access to HPV vaccination

	Quality Appraisal tool used: CASP for observational studies		• **Young women by primary caregiver educational attainment category** **Inconsistent findings regarding differences in uptake between:** • **Latina and White young women** • by **religious faiths** and/or frequent service attendance Additional outcomes available on HPV vaccination completion	
Reference: Forrest LF, Adams J, Wareham H, et al. (2013). Socioeconomic inequalities in lung cancer treatment: systematic review and meta-analysis. *PLoS medicine*. 10(2): pp.e1001376.	**Study design:** Systematic review and meta-analysis **Search dates:** Up to Sept 2012 **Types of included studies:** Cohort studies (quantitative) **Quality Appraisal tool used:** Tool adapted from SIGN (2011) & Vandenbroucke et al. (2007)	**Review aim and setting:** To examine the association between socioeconomic position (SEP) and receipt of lung cancer treatment. **Focus:** SEP & Lung Cancer treatment **No. included studies:** 46 (17 UK)	**Groups identified and Authors conclusions:** Association shown between low SEP and reduced likelihood of receipt of any type of treatment, surgery and chemotherapy. *Universal healthcare system data extracted:* • Significant negative effect of **lower SEP** on the likelihood of receiving surgery (meta-analysis, 16 populations) • Significant negative effect of **lower SEP** on the likelihood of receiving chemotherapy (meta-analysis, 10 populations) • No association between **SEP** and receipt of radiotherapy was seen in the meta-analysis.	**Comments/Limitations:** SEP outcomes detail: An individual measure of SEP (**education leve**l) was used in one study. All other studies used area-level measures of deprivation, income, poverty, or education level.
Reference: Goode J, Hoang H and Crocombe L. (2018). Homeless adults' access to dental services and strategies to improve their oral health: a	**Study design:** Systematic literature review **Search dates:**	**Review aim and setting:** To determine how and where homeless adults living in	**Groups identified and Authors conclusions:** • One study reports that the rate of failing to return for a second appointment is associated with drug use, ethnicity and receipt of government benefits.	**Comments/Limitations:** Review includes both quantitative and qualitative studies. Where possible, we have only

systematic literature review. *Australian journal of primary health.* 24(4) 287-298	2003-2017 **Types of included studies:** Qualitative and quantitative **Quality Appraisal tool used:** Mixed Methods Appraisal Tool (MMAT)	developed countries receive oral health care, the barriers that prevent homeless adults accessing dental care and find strategies to promote oral health to homeless adults. **Focus:** Homeless adults' access to dental services **No. included studies:** 22 (8 UK)	• One study reports that "Only 27% sought oral health care when they had a perceived need" (note USA study) • Homeless people are 2.27-fold more likely to use an ED for a non-traumatic dental problem compared with a matched low-income Population (Canadian study) Barriers: • Inability to pay for dental care • Homeless people found the process of registering for government assistance onerous (n= 1)	extracted the findings from quantitative studies.
Reference: Giebel CM, Zubair M, Jolley D, et al. (2015). South Asian older adults with memory impairment: improving assessment and access to dementia care. *International journal of geriatric psychiatry.* 30(4): pp.345-56.	**Study design:** Systematic review **Search dates:** 1984-2012 **Types of included studies:** Qualitative and quantitative **Quality Appraisal tool used:** Study quality was assessed using a modified eight criteria scale comprising of appropriate	**Review aim and setting:** This review explores facilitators and barriers to accessing mental health services by South Asian older adults as a minority ethnic group. **Focus:** South Asian older adults' barriers and facilitators in the pathway to culturally appropriate mental health care **No. included studies:**	**Groups identified and Authors conclusions:** • South Asian older adults display limited service usage and delayed approach to services (n= 1) Barriers: • Poor health literacy (n= 1) • Bilingual and ethnic staff (n=1) • Service sensitive to needs of ethnic minorities (n=1)	**Comments/Limitations:** Mostly qualitative studies included in the review. Data has been extracted from quantitative studies (n= 3)

	standardised tools (Boyle, 1998; CASP, 1999; Connolly et al.,2012).	18 (15 UK)		
Reference: Halvorsrud K, Nazroo J, Otis M, et al. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC medicine*. 16(1): pp.1-17.	**Study design:** Systematic review and meta-analysis **Search dates:** Database inception-2017 (SRs and meta-analyses) A supplementary up-to-date evidence (primary studies) search was conducted, obtaining evidence from 2012-2017 **Types of included studies:** Systematic reviews, meta-analyses, quantitative primary studies **Quality Appraisal tool used:** AMSTAR	**Review aim and setting:** To conduct a systematic review and meta-analysis of research on ethnic inequalities in pathways to care for adults with psychosis living in England and/or Wales **Focus:** Ethnic inequalities in pathways to care for adults with psychosis living in England and/or Wales **No. included studies:** 40 UK studies	**Groups identified and Authors conclusions:** **More likely to access/contact GP:** • South Asian people (compared to white people) • **Less likely to access/contact GP:** • Black people (compared to white people)	**Comments/Limitations:** General practitioner (GP) involvement in the patients' pathways to care typically results from referral to GPs from a range of actors such as family members or the patients themselves.
Reference: Heslehurst N, Brown H, Pemu A, et al. (2018). Perinatal health outcomes	**Study design:** Systematic review of reviews	**Review aim and setting:** To summarise the	**Groups identified and Authors conclusions:** **Migrant women**:	**Comments/Limitations:**

and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC medicine.* 16(1): pp.89.	**Search dates:** 2007-2017. Included SRs published between 2009 and 2017 and the publication years of the included studies were from 1956 to 2016 **Types of included studies:** Systematic reviews with a quantitative, qualitative, or mixed methods evidence synthesis 14 quantitative, 9 qualitative and 6 mixed methods. **Quality Appraisal tool used:** The JBI Critical Appraisal Checklist for Systematic Re-views and Research Syntheses	current evidence base on perinatal health outcomes and care among women with asylum seeker or refugee status. **Focus:** Perinatal health outcomes among asylum seekers and refugees **No. included studies:** 29 (14 UK)	• All systematic reviews reported that access to perinatal care, including routine care and specialist care such as mental health support for postnatal depression, was worse amongst migrant women **Migrant women** Barriers: • Unfamiliarity with local healthcare provision, culture and systems • lack of information provision about how to get support • language barriers to accessing perinatal healthcare • Physician availability, long waiting lists for services, especially those specialising in migrant care • poverty, safe housing, employment and caring for their other children (migrant women) • Financial constraints were frequently reported including a lack of health insurance, cost of care and wider poverty issues such as having no phone, childcare, or transport • unplanned pregnancy, being single and maternal education level • lack of culturally appropriate therapists and services available and a preference for female health professionals due to religious reasons and the intimacy of body areas during pregnancy (from qual and mixed methods only – 2 reviews) **Asylum seekers and refugees:**	

			• language / communication • Assumptions amongst refugees and asylum seekers that they would have to pay for healthcare when they were entitled to free care (from mixed methods and qual reviews – 2 reviews)	
Reference: Hanratty B, Zhang T and Whitehead M. (2007). How close have universal health systems come to achieving equity in use of curative services? A systematic review. *International Journal of Health Services.* 37(1): pp.89-109.	**Study design:** Systematic review **Search dates:** 1980-2006 **Types of included studies:** Any study design **Quality Appraisal tool used:** Downs and Black checklist for measuring quality	**Review aim and setting:** Aimed to analyse the use of services by some measure of socioeconomic group and ask how close universal health systems have come to achieving equity in use of curative services? **Focus:** use of curative health services in universal systems **No. included studies:** 26 (8 UK)	**Groups identified and Authors conclusions:** The authors found a pro-rich bias in use of specialist hospital services and a reasonably equitable access to primary health care by different socioeconomic groups. There was a wide inter-study variation in the difference in utilisation rates between people of high and low socioeconomic groups. **Primary care:** • There was little or no overall evidence of any variation in use of primary care by **socioeconomic group**, after adjusting for differential need, in 9 of the 13 studies • Higher use of primary care by **lower socioeconomic groups** described in two UK studies • Fewer visits to the (GP) by people of **lower socioeconomic groups over 65 years of age** described in a UK study • Of the studies that looked specifically at GP services, the three most substantial ones were from the UK and Canada. They found use of GP services by people of **lower socioeconomic groups** to be higher than or about the same as use by other	**Comments/Limitations:** Authors note that although included studies aimed to investigate use of health services, in almost all cases data was drawn from surveys designed for wider purposes. Authors note none of included studies had any major sources of bias. **Factors identified in table 1.** Access to primary care Access to specialist care

			socioeconomic groups in the United Kingdom. **Specialist care:** • Evidence of inequalities in care found for outpatient and inpatient specialist services, though the extent of the differences varied greatly from country to country. **Use of specific hospital specialities:** • The included studies relate to revascularization procedures for ischemic heart disease, and generally show some evidence of a **pro-rich bias** in use of specialist care (UK outcomes) **Children:** • Assessments of use of primary care for **children** from different socioeconomic backgrounds found it to be equitable.	
Reference: Jepson R, Clegg A, Forbes C, et al. (2000). The determinants of screening uptake and interventions for increasing uptake: a systematic review. *Health technology assessment (Winchester, England).* 4(14): pp.i-vii, 1-133.	**Study design:** Systematic review **Search dates:** Database inception to October 1998 **Types of included studies:** studies of determinants of screening uptake:	**Review aim and setting:** to evaluate the determinants of screening and interventions to increase uptake. **Focus:** Screening uptake **No. included studies:** 65 determinant studies	**Groups identified and Authors conclusions:** **Women more likely to attend mammography:** • They had **attended previous** mammograms • They had the **Intention to attend** • They had **health insurance** • Received **recommendation from GP** **Women more likely to attend Papanicolaou Smear testing if:** • They had **health insurance**.	**Factors identified in table 1.** Access to screening services: mammography, cervical screening, faecal occult blood test, prostate cancer screening

	Randomised controlled trials (RCTs), controlled trials, cohort studies or case–control studies where there was a prospective time barrier between the measurement of determinants and the uptake of screening <u>Studies of interventions to increase screening uptake</u> Any experimental study that evaluated the effectiveness of an intervention(s) that was intended to increase the uptake of a screening programme **Quality Appraisal tool used:** Checklists from the Centre for Reviews and Dissemination (no 4, 2000)	(3 UK), 190 intervention studies	• Unclear whether older or younger women were more likely to attend. **Determinants associated with participation in faecal occult blood test screening:** • **Older than 65yrs** • **Previous participation** in screening • Able to carry out the **activities of daily living** **Determinants found to predict attendance at prostate cancer screening:** • Higher level of **education** • **African-American**, as opposed to Caucasian. It was not possible to ascertain which factors were important for other specific screening tests (e.g., cystic fibrosis, tuberculosis, well-child and HIV screening) due to a lack of evidence.	

Reference: Kamal A, Hodson A and Pearce JM. (2021). A Rapid Systematic Review of Factors Influencing COVID-19 Vaccination Uptake in Minority Ethnic Groups in the UK. *Vaccines*. 9(10).	**Study design:** Rapid systematic review **Search dates:** Jan 2020 – May 2021 **Types of included studies:** Quantitative (cross-sectional and cohort studies), qualitative and mixed methods **Quality Appraisal tool used:** Mixed Methods Appraisal Tool	**Review aim and setting:** To identify factors influencing, and barriers to COVID-19 vaccination uptake between minority ethnic groups in the UK. **Focus:** Uptake and barriers to COVID-19 vaccination between minority ethnic groups in the UK **No. included studies:** 21 UK studies	**Groups identified and Authors conclusions:** • Lower vaccine uptake in minority ethnic groups • Lower uptake Black groups in comparison with other minority ethnic groups (Black African had the lowest uptake in subgroup analyses) • Higher uptake was reported for Indian (6 studies), Bangladeshi (3 studies) and Chinese (3 studies) groups compared to other ethnic minority groups but uptake was lower than in White British groups Barriers • Location of vaccine centres (1 study) • Having to use public transport (1 study) • People from minority ethnic backgrounds were more likely than White British groups to have received misinformation encouraging them not to have the vaccine • Lack of access to information also resulted in communication barriers largely due to low health literacy, poor other language provision, and increased digitalisation of communications. This was particularly an issue for migrant groups due to lack of access to, or knowledge of, technology	**Comments/Limitations:** Hesitancy outcomes not extracted
Reference: Kapadia D, Brooks HL, Nazroo J, et al. (2017). Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative	**Study design:** Systematic review **Search dates:** 1960 – 2014	**Review aim and setting:** to clarify usage rates, and describe the nature of Pakistani women's social networks and how they may	**Groups identified and Authors conclusions:** **Pakistani women:** • Less likely to use specialist mental health services compared to white British women • Lower rates of admission to inpatient mental health units (2/3 studies)	**Comments/Limitations:** Barriers data is exclusively qualitative and therefore, has not been extracted.

research. *Health & social care in the community.* 25(4): pp.1304-1317.	**Types of included studies:** Qualitative and quantitative **Quality Appraisal tool used:** For quantitative papers the Study Quality Tool (Zazaet al.2000) was used; for qualitative papers, the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2014a); for mixed-methods papers, the Mixed Methods Appraisal Tool (MMAT) (Pluyeet al.2011) and for systematic reviews, the CASP Systematic Review Checklist (CASP, 2014b)	influence mental health service use in the UK. **Focus:** Mental health service use among Pakistani women in the UK **No. included studies:** 21 UK studies	• Mixed findings in relation to use of outpatient services compared to white women • Less likely to have most recently visited the GP about a mental illness, but over the last 12 months, there was no difference in their consultation rates compared to white women	
Reference: Knight A and Lindfield R. (2015). The relationship between socio-economic status and access to eye health services in the UK: a systematic review. *Public health.* 129(2): pp.94-102.	**Study design:** Systematic review **Search dates:** 1990 – March 2013	**Review aim and setting:** To determine the existence and nature of an association between socio-economic status and	**Groups identified and Authors conclusions:** Evidence was mixed, with equal evidence of a positive association between lower socio-economic status and reduced access to eye health services, and no association existing.	**Comments/Limitations:** Authors note that no two papers assessed the relationship between SES and access to eye care in the same way.

	Types of included studies: Not clearly stated, seems to be quantitative only (studies from the UK that assessed the relationship between any marker of SES and access to, use of, or provision of, eye health) **Quality Appraisal tool used:** Adapted STROBE checklist	access to eye health services in the UK **Focus:** Eye health services in the UK **No. included studies:** 37 UK Studies	Several papers found different types of association between SES and access depending on the measures used.	
Reference: Lueckmann SL, Hoebel J, Roick J, et al. (2021). Socioeconomic inequalities in primary-care and specialist physician visits: a systematic review. *International journal for equity in health.* 20(1): pp.1-19.	**Study design:** Systematic review **Search dates:** 2004 – Jan 2019 **Types of included studies:** Quantitative **Quality Appraisal tool used:** RoBANS risk of bias tool	**Review aim and setting:** To summarize the evidence on socio-economic inequalities in consulting primary-care and specialist physicians in the general adult population in high-income countries. **Focus:** **No. included studies:**	**Groups identified and Authors conclusions:** • The probability of utilising primary care was often not influenced by SES in the general population, but the disadvantaged visited their primary-care physician more frequently The **highest-SES groups** often had higher probabilities for specialist visits, but studies often found no associations of SES with (conditional) frequencies of specialist visits.	**Comments/Limitations:** **SES indicators included** income, education, occupation, social class, or any combination of these indicators.

		57 (five studies were analyses from multiple EU countries which included the UK)		
Reference: Mayland CR, Powell RA, Clarke GC, et al. (2021). Bereavement care for ethnic minority communities: A systematic review of access to, models of, outcomes from, and satisfaction with, service provision. *PloS one.* 16(6): pp.e0252188.	**Study design:** Systematic review **Search dates:** 1995 to 2020 **Types of included studies:** any study design **Quality Appraisal tool used:** Mixed Method Appraisal Tool	**Review aim and setting:** to synthesize the existing evidence on bereavement care for ethnic minority populations **Focus:** bereavement care for ethnic minority populations **No. included studies:** 7 UK studies	**Groups identified and Authors conclusions:** Ethnic minority populations (focus of article) Barriers: • Lack of awareness of bereavement care • Variability in support (i.e. access to interpreting services and psychological support) • Lack of bereavement support on offer (e.g. type and format of support services not always suitable for ethnic minority communities.	**Comments/Limitations:**
Reference: Mosquera I, Mendizabal N, Martín U, et al. (2020). Inequalities in participation in colorectal cancer screening programmes: a systematic review. *European journal of public health.* 30(3): pp.416-425.	**Study design:** Systematic review **Search dates:** 2000 – July 2018 **Types of included studies:** Quantitative and/or qualitative primary study that analysed gender	**Review aim and setting:** To identify the social inequalities in the participation in CRC screening programmes **Focus:** colorectal cancer screening participation	**Groups identified and Authors conclusions:** • **Women** participated more than men (reported in UK studies and others). Nevertheless, there were also studies that found no significant differences by sex, and some in which the attendance rate was higher among men, all of these using sigmoidoscopy • In general, **educational level** was positively associated with screening participation • There was a significant gradient favouring those in a **most advantaged position**, and it	**Factors identified in table 1.** Access to screening services: colorectal cancer screening

	and/or socioeconomic inequalities in the participation in CRC screening programmes (opportunistic or organised) implemented by public and private institutions and addressing 45- to 75-year-old population **Quality Appraisal tool used:** study quality assessment tools of the National Heart, Lung, and Blood Institute for quantitative studies, and the NICE quality appraisal checklist for qualitative studies	**No. included studies:** 96 studies from 102 articles (29 UK)	seemed there was a higher attendance rate for **men** than for women • **Area deprivation** was strongly associated with screening attendance, being higher among the **least deprived areas** using FOBT, sigmoidoscopy, and in colonoscopy after positive test Results also available for residence, employment, and ethnicity, but no clear trends across all studies. Although men are at a higher risk of developing CRC, they generally were less likely to participate in screening programmes. Screening attendance was higher among the least deprived areas	
Reference: Meads C, Hunt R, Martin A, et al. (2019). A Systematic Review of Sexual Minority Women's Experiences of Health Care in the UK. *International journal of*	**Study design:** Systematic review **Search dates:** 2010 -2018	**Review aim and setting:** To evaluate studies on health experiences of UK sexual minority women	**Groups identified and Authors conclusions:** **lesbians and bisexual women:** • Less likely to visit the GP than heterosexual women (one study)	**Comments/Limitations:**

environmental research and public health. 16(17).	**Types of included studies:** quantitative and qualitative **Quality Appraisal tool used:** CASP	**Focus:** Sexual minority women's experiences of health care **No. included studies:** 26 UK studies	• Have low uptake of cervical screening (comparative information for heterosexual women not reported) **Adolescent Sexual minority girls**: • Visited GP more than heterosexual, but reported feeling more uncomfortable than heterosexual girls (one study) Barriers: Sexual minority women: • Have lower trust than straight women • Misinformation about need for cervical screening • Refused or discouraged from cervical screening	
Reference: Martin A, Saunders CL, Harte E, et al. (2018). Delivery and impact of the NHS Health Check in the first 8 years: a systematic review. *The British journal of general practice: the journal of the Royal College of General Practitioners*. 68(672): pp.e449-e459.	**Study design:** **S**ystematic review **Search dates:** up to November 2016 **Types of included studies:** Quantitative observational data or analyses (cross-sectional or longitudinal)	**Review aim and setting:** To review quantitative evidence on coverage (the proportion of eligible individuals who attend), uptake (proportion of invitees who attend), and impact of the NHS Health Check **Focus:** NHS health check	**Groups identified and Authors conclusions:** • Odds of taking up an invitation increased significantly with older **age, being female and lower deprivation.** Where reported, uptake was higher in **non-smokers**, those with **higher CVD risk**, and those with **hypertensio**n or **raised cholesterol** **Ethnicity:** Only two studies reported the effects of ethnicity. One was in 29 practices in Ealing (West London), and found invitees of South Asian or mixed ethnicity were more likely to attend than white British, while there was no difference for black	**Factors identified in table 1.** Access to NHS health checks

	Quality Appraisal tool used: CASP checklists	**No. included studies:** 26 UK studies (with one additional dataset)	or other groups, and those with missing data were less likely to attend. The other was across four general practices in the East of England and found no difference in uptake between participants of white and non-white ethnicity.	
Reference: Mcfadden A, Siebelt L, Gavine A, et al. (2018). Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. *European journal of public health.* 28(1): pp.74-81.	**Study design:** Systematic review **Search dates:** 2000 – 2015 **Types of included studies:** 30 Quantitative, 44 qualitative and 25 mixed methods **Quality Appraisal tool used:** Quantitative studies were assessed for risk of bias according to individual elements: not a validated checklist	**Review aim and setting:** to examine empirical studies of Gypsy, Roma and Traveller access to and engagement with health services; and to identify the best evidence for ways to enhance Gypsy, Roma and Traveller peoples' engagement with health services. **Focus:** Gypsy, Roma and Traveller access to and engagement with health services. **No. included studies:** 121 publications reporting 99 studies (49 UK)	Gypsy, Roma and Traveller (focus of article) **Barriers:** Health service issues: • Difficulties registering with health services, especially primary care • Lack of correct documentation (e.g. proof of identity) • Refused services or site visits from healthcare professionals • Difficulties accessing services (e.g. distance to reach services and inflexibility of services) Discrimination and negative attitudes of health service personnel: • Attitudes of health service personnel • Poor communication and relationships between health service staff and Gypsy service-users Culture and language: • Cultural issues e.g. role of family and numbers of family visitors, gender of health care professional, sensitive topics • Need for better cultural awareness and diversity training • Mobile lifestyle (e.g. lack of continuity of follow-up care)	**Comments/Limitations:**

			Health literacy barriers: • Difficulties understanding how to access dental, mental health and sexual and reproductive health services Service user attributes: • men have more difficulty talking about health Economic barriers: • lack of financial resource to afford transport to health services or to be able to use a phone to make appointments	
Reference: Martins T, Hamilton W and Ukoumunne OC. (2013). Ethnic inequalities in time to diagnosis of cancer: a systematic review. *BMC family practice.* 14(1): pp.1-8.	**Study design:** Systematic review **Search dates:** 2000 – 2012 **Types of included studies:** 7 Quantitative (observational, retrospective cohort studies) **Quality Appraisal tool used:** Critical Appraisal Skills Programme (CASP) checklist for cohort studies	**Review aim and setting:** To systematically review evidence on ethnic inequalities in cancer diagnosis, focussing on patient and primary care intervals of diagnosis (in the UK and countries where access to healthcare is comparable to the NHS) **Focus:** inequalities in cancer diagnosis by ethnic groups in the UK and in countries with a similar health care	**Groups identified and Authors conclusions:** Five studies focused on breast cancer with one study also including several other cancer sites in addition to breast: lung, prostate, colorectal non-Hodgkin's lymphoma (NHL) and ovarian. One study focused on prostate and one on oesophagogastric cancer. Three studies investigated ethnic differences in patient delay (delay occurring in the interval between first symptom and first GP presentation). Two studies investigated delays between GP presentation and specialist care visits, and two studies investigated both. There was insufficient evidence to confirm or refute ethnic inequalities in diagnostic intervals of cancer. Conversely, the review found no evidence to suggest that ethnic minority groups were doing better at any stage of cancer diagnostic pathway.	**Comments/Limitations:** Evidence for ethnic inequalities in cancer diagnosis was limited and methodologically weak

		system - in terms of costs, availability, and access **No. included studies:** 7 (6 UK)		
Reference: Murfin J, Irvine F, Meechan-Rogers R, et al. (2020). Education, income and occupation and their influence on the uptake of cervical cancer prevention strategies: A systematic review. *Journal of clinical nursing*. 29(3): pp.393-415.	**Study design:** Systematic review **Search dates:** 2006 - 13 June 2018 **Types of included studies:** cross-sectional **Quality Appraisal tool used:** AXIS (Appraisal tool for Cross-Sectional Studies)	**Review aim and setting:** To report a systematic review of the literature exploring how education, in-come and occupation influence the uptake of cervical screening and HPV vaccination among eligible women in developed countries, including the UK, USA, Spain, Germany and Norway **Focus:** cervical screening and HPV vaccination among eligible women **No. included studies:** 10 (1 UK)	**Groups identified and Authors conclusions:** **Cervical Screening:** • Girls with **higher levels of education** more likely to participate in screening • Inconsistent evidence for an association between income and screening uptake. **HPV Vaccination:** • Mothers with **lower education** less likely to initiate the vaccine for their daughters • Relationship between **highest levels of education** and vaccination uptake compared to lowest educational levels but there were no significant differences between similar levels of education, such as high school and college or primary and lower secondary. • Evidence for an association between income and vaccination uptake with majority of the studies suggesting girls from lower income household were less likely to have initiated the vaccine. Findings do seem to suggest difference between highest and lowest group but little variation between groups of similar income. • **Employment status** – neither study found occupation/ employment status to be statistically significant in vaccination initiation.	**Factors identified in table 1.** Access to screening services: cervical screening Access to HPV vaccination

			Authors conclude that socioeconomic factors are associated with cervical cancer screening uptake and the initiation of the HPV vaccination. The strength and direction of their relationships is variable between countries, potentially stemming from different methods of implementing prevention strategies. Education appears to have more impact on prevention uptake than income, and occupation shows no significance. However, limited research into occupation and its association makes this difficult to confirm.	
Reference: Nagata JM, Hernández-Ramos I, Kurup AS, et al. (2013). Social determinants of health and seasonal influenza vaccination in adults ≥65 years: a systematic review of qualitative and quantitative data. *BMC public health*. 13: pp.388.	**Study design:** Systematic review **Search dates:** 1980 -2011 **Types of included studies:** 42 quantitative (descriptive studies and cross-sectional surveys, two ecologic studies, and one controlled trial), 13 qualitative and 3 mixed methods **Quality Appraisal tool used:** Quality Assessment and	**Review aim and setting:** To assess the social determinants of health preventing adults ≥ 65 years old from accessing and accepting seasonal influenza vaccination **Focus:** Vaccine coverage and barriers (and linked social determinants) to influenza vaccination uptake in adults ≥65 **No. included studies:** 58 (can't tell how many UK). Nine studies were multinational,	**Groups identified and Authors conclusions:** **All relating to older adults (>65+)** • **Mixed evidence for Gender** having an effect on uptake • **Older aged older adults more likely** to get vaccinated than younger (75+ vs 65-74) • **Mixed evidence for Marital status** (Being married and having social support versus single/ widowed) and uptake • **Mixed evidence for Higher education** being associated with higher uptake • **Ethnic minorities reported as having lower vaccination rates** (studies from USA) • **Mixed evidence for Socioeconomic status. Lower SES** has been correlated	**Comments/Limitations:** Review includes LMIC's and it is difficult to establish what countries outcomes relate too, however the review does state that most reports in the review are focused on high income countries.

	Review Instrument (QARI) checklist	including countries from Asia, Europe, Latin America, and the Middle East. > 50% studies from developed countries and 6 from rural areas.	with **lower vaccination uptake**; however, other reports showed no difference, or even reverse gradient. • In the UK, **likelihood of vaccination increased as the number of chronic diseases increased,** adjusted by gender, age, health status, and hospital visits (consistent with general trend). • **Mixed evidence for Rurality/ social deprivation** and access to vaccination Barriers: • **Behavioural beliefs about consequences:** Behavioural beliefs are based on the patient's probability calculation of susceptibility to and severity of influenza, their knowledge about vaccine effectiveness, and their healthcare and social cost of the vaccine. • **Accessibility:** Different aspects of accessibility for the elderly are distance to the health centre, convenience of its location, transportation, language, access to healthcare, and legal status. • **Insufficient availability** of seasonal influenza vaccine available is a major health system barrier, (particularly in low- and middle-income countries)	
Reference: Netuveli G, Hurwitz B, Levy M, et al. (2005). Ethnic variations in UK asthma frequency, morbidity, and	**Study design:** Systematic review and meta-analysis	**Review aim and setting:** Ethnic variations in the UK for asthma	**Groups identified and Authors conclusions:**	**Comments/Limitations:** Barriers were not investigated

health-service use: a systematic review and meta-analysis. *The Lancet.* 365(9456): pp.312-7.	**Search dates:** 1981 – 2002 **Types of included studies:** Quantitative **Quality Appraisal tool used:** Not stated. However, study quality was assessed using criteria for internal and external validity. Both an individual and scale approach was used and studies judged to be at high risk of bias were excluded.	frequency, morbidity, and health-services use, and to understand possible reasons for any differences. **Focus:** Ethnic variations in health-service use for individuals with asthma **No. included studies:** 13 UK studies [7 studies in children (5-15 years)]	• Age adjusted GP consultation rate for asthma per 1000 people was higher in South Asian and Afro-Caribbean groups compared to white groups. When adjusted for age, sex, and social class, ORs for South Asians were still significant (n= 1) • Patients born outside the UK had significantly lower risk of consultation for asthma. These results indicate that immigrant status is an important determinant of health-service use for some minority ethnic communities in the UK (n=1). • South Asian children had increased risk of admission (n=2). • Compared with white people, south Asian and black people of all ages had greater risk of admission (n=3)	
Reference: Phung V-H, Asghar Z, Matiti M, et al. (2020). Understanding how Eastern European migrants use and experience UK health services: a systematic scoping review. *BMC health services research.* 20(1): pp.173.	**Study design:** Systematic scoping review **Search dates:** 1980 – 2016 **Types of included studies:** 7 Quantitative, 5 qualitative, and 1 mixed methods	**Review aim and setting:** to build on existing knowledge of how Eastern European migrants use and experience UK healthcare services to inform ser-vice delivery improvements this population.	**Groups identified and Authors conclusions:** • Polish migrant women are more likely to visit their GP compared to Polish men, especially those aged 25-44. The reasons for visiting the GP were not significantly associated with age (n= 1) • Eastern European migrants return to their countries of origin to use healthcare services (n= 1 quant study) • Recent Polish migrants were more likely to use A&E inappropriately compared to the indigenous population. The study found that	**Comments/Limitations:**

	Quality Appraisal tool used: JBI check list for cross-sectional studies, CASP qualitative checklist, The Mixed Methods Appraisal Tool	**Focus:** Eastern European migrants' use and experiences of UK health services **No. included studies:** 13 UK studies Of the quantitative/ mixed methods studies: 4 focused on sexual health, 1 on family planning, 2 on primary care and 1 on ED use by Polish migrant workers.	ED attendances at a hospital in Telford, a town in the UK West Midlands, increased from an average of 134 from 2000 to 2003 to 357 in 2005. Of these 357, 152 (43%) were not registered with a GP. The overall rate of ED attendance for unregistered patients was 7.4% (n=1). Barriers: • Limited understanding of how the NHS worked, particularly what healthcare services they were entitled to and when they were meant to use them • Language and communication barriers and their (sometimes negative) experiences of it influenced the extent of accessing NHS. • Concerns about the availability and suitability of interpreting services compounding the language barrier • Role of social networks: When appropriate interpretation or translation services were unavailable, EE migrants with limited command of English sometimes needed familial and social networks, including children to mediate in healthcare encounters.	
Reference: Ryan-Ndegwa S, Zamani R and Akrami M. (2021). Assessing demographic access to hip replacement surgery in the United Kingdom: a systematic review. *International journal for equity in health.* 20(1): pp.224.	**Study design:** Systematic review **Search dates:** December 2005 – 4 February 2021 **Types of included studies:**	**Review aim and setting:** to 1) determine which patients experience inequalities in access to hip replacement surgery; 2) determine where these patients are located in the UK	**Groups identified and Authors conclusions:** Socioeconomic inequalities was the most widely measured variable affecting access to hip replacement surgery. • One study found that in England the most deprived patients received 70% lower surgical provision relative to need compared to the least-deprived.	**Factors identified in table 1.** Access to specialist services: hip replacement surgery

	Observational designs (cross-sectional, ecological and longitudinal) **Quality Appraisal tool used:** a checklist adapted from Mújica-Mota et al (doi 10.1186/1472-6963-12-225)	and 3) explore other variables that influence the observations, such as differences between hospitals **Focus:** Hip replacement surgery **No. included studies:** 16 UK studies	• One study found that when adjusted for age and sex, hip replacement rates were higher in the least-deprived quintile (Q1) than the **most-deprived** (Q5), with a Q5/Q1 ratio of 1.35 (CI: 1.25–1.45); that is,Q1 patients were 35% more likely to undergo surgery than Q5 patients • One study found greater access inequality in the **West Mid-lands, London and the north of England**, with patients in the south of England experiencing greater provision relative to need. Increased **rurality** in England was associated with greater provision relative to need, as were **longer road travel** times for care (one study).	
Reference: Robertson J, Raghavan R, Emerson E, et al. (2019). What do we know about the health and health care of people with intellectual disabilities from minority ethnic groups in the United Kingdom? A systematic review. *Journal of Applied Research in Intellectual Disabilities.* 32(6): pp.1310-1334.	**Study design:** Systematic review **Search dates:** 1990 - 2018 **Types of included studies:** Quantitative research, qualitative research, evaluation or audit **Quality Appraisal tool used:** Mixed Methods Appraisal Tool	**Review aim and setting:** to summarise what is known about the health status of those with intellectual disabilities from minority ethnic, and the physical or mental health care of people with intellectual disability from minority ethnic communities in the UK **Focus:** ethnic minority groups with intellectual disabilities	**Groups identified and Authors conclusions:** • **Service receipt higher** if the person with **intellectual disabilities** is from a household with **higher income** • For **children with mild or moderate intellectual disabilities** attending special schools in London, **access to speech and language therapy highest** for the **Middle East/Arab group**, followed by **White Europeans**, and **Mixed ethnic group/Other ethnic** groups, and **lowest** for **Black groups** • **South Asian** (on the LIDR in one study) less likely to use specialist intellectual disability psychiatric services than white • For **children with mild or moderate intellectual disabilities** attending special schools in London, child and adolescent	**Comments/Limitations:** Barriers not extracted as exclusively from qualitative studies.

		No. included studies: 25 UK studies	mental health service use was significantly lower for **South Asian** children than for the **White British** group • trend for lower CAMHS use for **South Asian children** than the **Black group** • **Young South Asian people with intellectual disabilities**, lower use of mental health services, and professionals such as psychiatrists, clinical psychologists or behaviour nurse specialists. Conclusion: People with intellectual disabilities from minority ethnic communities in the UK experience significant inequalities in access to health care	
Reference: Robards F, Kang M, Usherwood T, et al. (2018). How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*. 62(4): pp.365-381.	**Study design:** Systematic review **Search dates:** 2006 – 2017 **Types of included studies:** Qualitative, quantitative and mixed methods **Quality Appraisal tool used:** Qualitative studies: CASP Quantitative: Glasziou (2001) Mixed methods studies were	**Review aim and setting:** To examine how marginalized young people access and engage with health services and navigate health-care systems in high-income countries. **Focus:** Marginalised young people barriers and/or facilitators to access, engagement, and/or navigation of health-care systems. **No. included studies:** 68 (7 UK)	**Groups identified and Authors conclusions:** Marginalised young people (focus of article) **Barriers:** • Language and communication barriers (inclusive language) • Professionals' knowledge • Practical barriers: Transport, Cost, Location of programme • Not knowing where or which service to use, or perceived limited availability of services • Staff competency in relating to gender and sexuality diverse young people was identified as a gap	**Comments/Limitations:**

	assessed using both checklists			
Reference: Ricci-Cabello I, Ruiz-Perez I, De Labry-Lima AO, et al. (2010). Do social inequalities exist in terms of the prevention, diagnosis, treatment, control and monitoring of diabetes? A systematic review. *Health & social care in the community.* 18(6): pp.572-587.	**Study design:** Systematic review **Search dates:** 1967 to December 2007 **Types of included studies:** Observational designs (cross-sectional, cohort and case control) **Quality Appraisal tool used:** Strengthening the reporting of observational studies in Epidemiology (STROBE) checklist.	**Review aim and setting:** to establish the possible existence of social inequalities in the prevention, diagnosis, treatment, control and monitoring of diabetes in OECD countries which have universal healthcare systems **Focus:** Prevention, diagnosis, treatment, control and monitoring of Diabetes **No. included studies:** 25 (11 UK)	**Groups identified and Authors conclusions:** **Inconsistent findings for:** • **Gender** inequalities in access to healthcare and use of education services for diabetes management (DM) (UK study - no gender inequalities with respect to adherence to diabetic retinopathy screening services) • Mixed evidence for inequalities in access to DM services for **ethnic minorities.** • **Mixed evidence for Socioeconomic** inequalities in access to healthcare services for control of DM. (Spanish and German studies found **lower SES** associated with more frequent visits to GP, but UK study reported **higher SES** associated with more visits, and lower SES associated with lower adherence to retinopathy screening service (One UK study did not report this). This review shows that even in countries with a significant level of economic development and which have universal healthcare systems in place which endeavour to provide medical care to the entire population, socioeconomic and ethnic inequalities can be identified in the provision of healthcare to DM sufferers. However, higher quality and follow-up articles are needed to confirm these results.	**Factors identified in table 1.** Access to specialist care: diabetes management
Reference: Smith D, Thomson K, Bambra C, et al. (2019). The breast cancer paradox: A systematic review of the association between area-	**Study design:** Systematic review	**Review aim and setting:** to examine the association between area-level	**Groups identified and Authors conclusions:** • 11/13 studies (of which 10 were statistically significant) demonstrated a negative	**Comments/Limitations:**

level deprivation and breast cancer screening uptake in Europe. *Cancer epidemiology*. 60: pp.77-85.	**Search dates:** 1st January 2008 and 28th January 2019 **Types of included studies:** Observational designs **Quality Appraisal tool used:** JBI checklist for analytical cross-sectional studies	socio-economic deprivation and breast cancer screening uptake in Europe **Focus:** breast cancer screening uptake **No. included studies:** 13 studies from 14 articles (4 UK)	association between area-level deprivation and screening, with **women living in more socio-economically deprived neighbourhoods** less likely to attend breast cancer screening • All four studies from England also found a negative association between screening uptake and area-level deprivation.	
Reference: Schröder SL, Richter M, Schröder J, et al. (2016). Socioeconomic inequalities in access to treatment for coronary heart disease: a systematic review. *International journal of cardiology.* 219: pp.70-78.	**Study design:** Systematic review **Search dates:** 1996 - 2015 **Types of included studies:** Quantitative studies (all studies are observational) **Quality Appraisal tool used:** RoBANS	**Review aim and setting:** to summarize the existing evidence on the relationship between socioeconomic inequality and access to treatment for Coronary Heart Disease (CHD) **Focus:** Treatment for CHD **No. included studies:** 57 (8 UK)	**Groups identified and Authors conclusions:** • Patients with low socioeconomic status had lower rates for any invasive coronary procedure compared to patients with high socioeconomic status (18 of 22 studies) • Inconsistent evidence of socioeconomic inequalities in access to drug treatment and Cardiac Rehabilitation. Compared to countries without a Universal health coverage (UHC), access to treatment in countries with UCH was less often associated with SES.	**Comments/Limitations:**
Reference:	**Study design:** Systematic review	**Review aim and setting:** to	**Groups identified and Authors conclusions:**	**Factors identified in table 1.**

Tobin J, Rogers A, Winterburn I, et al. (2022). Hospice care access inequalities: a systematic review and narrative synthesis. *BMJ Supportive & Palliative Care.* 12(2): pp.142-151.	**Search dates:** 1987 – 2019 **Types of included studies:** Any **Quality Appraisal tool used:** Gough's 'Weight of Evidence' criteria	investigate the characteristics of those who access hospice services, focusing on the evidence concerning the presence and nature of any inequalities **Focus:** Access/use of hospice care **No. included studies:** 130 (90 UK)	• Reduced access reported in UK for: Pakistani/Indian/Bangladeshi Caribbean Chinese African • **Geography:** Access greater for those living in Urban areas, closer proximity to a hospice. • **Socioeconomic status:** lower hospice access for people living in areas of lower-SES **Barriers to service referral:** • Availability of services in specific regions may act as a barrier to GP referral	Access to specialist services: hospice care Referral to specialist care: hospice care Barriers to referral
Reference: Williams P, Murchie P and Bond C. (2019). Patient and primary care delays in the diagnostic pathway of gynaecological cancers: a systematic review of influencing factors. *The British journal of general practice: the journal of the Royal College of General Practitioners.* 69(679): pp.e106-e111.	**Study design:** Systematic review **Search dates:** 2000-2017 **Types of included studies:** Controlled and uncontrolled quantitative studies, qualitative studies. **Quality Appraisal tool used:**	**Review aim and setting:** Aimed to address the research question: what factors influence patient and primary care delay in the diagnostic pathway of gynaecological Cancer? **Focus:** Referrals to secondary care Gynaecological services, diagnostic delay.	**Groups identified and Authors conclusions:** More likely to present earlier to primary care: • Females Over 75s • Housebound • Retired • Women undergoing regular screening **More likely to delay presentation to primary care:** • Females of working age • Rurality/distance from Health Care Diagnostic delay • Higher education associated with less delay Referral to specialists	**Comments/Limitations:** Heterogeneity of included studies Lack of common methodology does not permit definitive conclusions. **Factors identified in table 1.** **Access to specialist services:** Referral to specialist care: gynaecological cancer care

	CASP study specific tools	**No. included studies:** 37 (21 UK studies)	• Increasing age increased delay in referral • GPs less likely to delay referral of women with higher SES (in Denmark) • Rurality increased delay (only one study) Inconsistent findings /no clear trends for referral • Ethnicity • Socioeconomic status Shorter system delays were seen in wealthy females and patients referred by GPs who did not see them routinely. Patients described as 'less compliant' and those who had a high alcohol intake had greater system delays, as did patients referred by a female GP	
Reference: Wilson C, Alam R, Latif S, et al. (2012). Patient access to healthcare services and optimisation of self-management for ethnic minority populations living with diabetes: a systematic review. *Health & social care in the community.* 20(1): pp.1-19.	**Study design:** Systematic review **Search dates:** 1995–2010, including relevant hand-searched literature pre-dating 1995 **Types of included studies:** Quantitative and qualitative **Quality Appraisal tool used:** CASP qualitative, CASP RCT, DARE York Manual for other	**Review aim and setting:** to synthesise and evaluate evidence relating to patient self-management and access to healthcare services for ethnic minority groups living with diabetes **Focus:** ethnic minority groups living with diabetes **No. included studies:** 47 (32 UK)	**Groups identified and Authors conclusions:** • **African patients** have **more frequent annual check-ups in secondary care** but **lower use of preventative services** (1 USA Study) • **Caribbean and Black African patients** have reported **higher utilisation of health-check ups than white patients in primary care** settings (1 UK study) Barriers: • Providers' lack of cultural understanding and effective communication may be a barrier to improving access in ethnic minority populations • **Limited English** language is a barrier in accessing services for many **South Asian groups**, but	**Comments/Limitations:** Authors do state that "whilst some evidence points to lower uptake of preventive services by ethnicity, there appears to be little difference in utilisation by ethnic group" however this is not referenced, and we are unsure where this finding has come from.

	quantitative studies		perhaps **less so for African and Caribbean** where English is regarded as a common language	

ISBN: 978-1-83766-129-9