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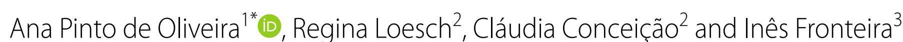
Exploring the perspectives of professionals involved in refugee and asylum seekers' reception and integration on access and utilization of healthcare: a qualitative study

Ana Pinto de Oliveira[1*] , Regina Loesch[2], Cláudia Conceição[2] and Inês Fronteira[3]

Abstract

Background In recent years, the number of displaced persons due to conflict, persecution, and environmental crises has significantly increased, leading to a large influx of refugees and asylum seekers in European countries, including Portugal. While the Portuguese National Health Service guarantees universal access to healthcare, numerous barriers still hinder the effective access and use of health services by refugee populations, particularly for the prevention and management of non-communicable diseases. This qualitative study aimed to explore the perspectives of professionals involved in refugee reception and integration regarding barriers to accessing and utilizing healthcare, with a particular focus on non-communicable diseases.

Methods A qualitative study informed by phenomenological principles was conducted. Semi-structured interviews were conducted with individual participants from December 2022 to March 2023, transcribed verbatim, and analysed using reflexive thematic analysis, informed by phenomenological principles.

Results Thirteen professionals from healthcare, reception, and integration sectors participated. Participants described a high burden of non-communicable diseases, particularly mental health conditions, alongside common risk factors such as unhealthy diets, sedentary lifestyles, and psychosocial distress. Barriers to healthcare access included cultural and linguistic challenges, bureaucratic complexity, and socioeconomic constraints. Facilitators - though less mentioned - included the involvement of cultural mediators, flexible service delivery, and intersectoral collaboration. Both refugees and professionals were described as adopting informal strategies to navigate systemic barriers.

Conclusion This study provides insight into how professionals perceive refugees and asylum seekers' health needs and their access to healthcare in Portugal. Findings highlight the interplay of structural, linguistic, cultural, and socioeconomic factors shaping healthcare utilisation, informing the development of more equitable and culturally responsive health strategies.

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Keywords Refugees, Asylum seekers, Healthcare access, Qualitative research, Non-communicable diseases, Portugal, Reception and integration

Text box 1. Contributions to the literature

• Highlights how structural, behavioral, and contextual determinants jointly shape refugees and asylum seekers' healthcare trajectories in Portugal, with specific implications for non-communicable diseases (NCD) prevention and management.

• Extends existing evidence by documenting healthcare professionals', reception and integration actors' perspectives, offering a system-level view that complements refugee-focused studies.

• Illuminates the intersectional nature of barriers—such as language, culture, and bureaucracy—showing how they interact to compound health inequities.

• Identifies practical facilitators, including cultural mediation, intersectoral collaboration, and social networks, that can inform policies for more equitable and culturally responsive care delivery.

Introduction

Since 2015, prolonged and complex humanitarian crises have triggered some of the largest waves of forced displacement since World War II, resulting in the arrival of over one million refugees in Europe. According to the United Nations High Commissioner for Refugees (UNHCR), by 2021, more than 89 million people were forcibly displaced worldwide, including over 27 million refugees and more than 4 million asylum seekers awaiting decisions on their claims [1, 2]. Europe emerged as a principal destination for these movements, particularly during the peak years of the so-called "refugee crisis", prompting substantial transformations in migration governance, asylum systems, and public service provision across the region.

Forced migration is a dynamic and multifaceted process that affects both individual health and the capacity of host countries' health and social systems. While many individuals begin their migration journey in relatively good health, exposure to precarious living conditions, violence, disrupted care, and prolonged uncertainty during transit and displacement may increase vulnerability to a wide range of physical, mental, and social health challenges [3–6]. Consequently, refugees frequently arrive with complex health needs shaped by the cumulative effects of displacement.

Among these challenges, NCDs represent an increasingly important yet often under-recognised dimension of refugee health. Effective NCD prevention and management depend on continuity of care, regular monitoring, and stable access to treatment—conditions that are frequently disrupted throughout forced migration. Interruptions in treatment, delayed diagnoses, and inconsistent follow-up may therefore contribute to worsening disease progression and poorer long-term outcomes.

Health risks are closely intertwined with broader social vulnerabilities. Refugees and asylum seekers often experience inadequate housing, financial insecurity, social isolation, discrimination, and legal uncertainty, which may exacerbate existing conditions and hinder timely access to care [7–11]. These intersecting factors influence both immediate health status and longer-term integration trajectories.

Although the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol do not explicitly guarantee the right to healthcare, more recent international frameworks—including the International Organization for Migration's (IOM) Migration Governance Indicators, the United Nations Sustainable Development Goals (SDGs), and the Global Compact on Refugees—have increasingly emphasised equitable access to healthcare as central to refugee protection, health equity, and social inclusion [12–14]. Within the European context, the operationalisation of these international commitments into national health policies has been uneven. While European Union legal instruments and broader human rights frameworks recognise access to healthcare as a fundamental component of social protection, the scope, timing, and conditions of healthcare entitlements for refugees and asylum seekers vary substantially across member states [15]. For example, countries such as Sweden and Germany have historically provided relatively broad access to healthcare, including early inclusion in mainstream services. However, recent reforms have introduced administrative constraints and conditionalities [16–18]. In contrast, more restrictive models have been documented in countries such as Italy and Greece, where access may be limited by legal status, documentation requirements, or reliance on emergency-only coverage during the initial phases of the asylum process [19–21]. Comparative analyses indicate that even in healthcare systems with formally universal entitlements, refugees and asylum seekers frequently encounter barriers such as documentation requirements, delays in registration with primary care services, administrative complexity, and discretionary practices at the point of care [15, 18, 22–24].

Between 2015 and 2021, Portugal received 9,750 asylum applications, reflecting a gradual yet sustained increase in forced migration flows. In 2021 alone, 1,540 individuals applied for asylum, of whom 650 were granted protection [25–31].

In the country, access to healthcare for refugees and asylum seekers is formally guaranteed through the National Health System (NHS), a tax-funded universal health system grounded in constitutional principles of

universality and equity. National legal frameworks establish entitlement to a comprehensive range of services, including primary and specialised care, alongside financial protection measures such as exemptions from user fees and subsidised medication. However, emerging evidence suggests that effective access may remain mediated by administrative procedures, documentation requirements, linguistic barriers, and challenges in navigating healthcare services. These discrepancies between formal entitlements and lived experiences highlight the need to better understand system-level factors shaping healthcare accessibility and responsiveness for refugee populations [32, 33]. However, equity in healthcare access is constitutionally guaranteed and reinforced by the Basic Health Law and the National Health Plan 2030 [34, 35]. Enhancing cultural competence among healthcare providers is widely recognised as essential to ensuring that services are responsive to refugees' diverse cultural backgrounds, beliefs, and health practices, thereby improving both access to and the quality of care [36, 37].

To address these gaps, this study draws on interviews with physicians, nurses, administrative staff, and reception and integration professionals. It explores their perspectives on refugees' health needs, access to healthcare, and system-level challenges in Portugal, with particular emphasis on non-communicable diseases. By capturing professional experiences and interpretations, this study aims to contribute to a more nuanced understanding of the barriers, facilitators, and opportunities to strengthen equitable and culturally responsive refugee healthcare.

Methods

Qualitative approach and research paradigm

This study adopted an interpretivist qualitative design informed by phenomenological principles to explore how professionals make sense of refugee health and healthcare access through their lived experiences.

Researcher characteristics and reflexivity

The principal investigator (APO), a female public health physician with prior professional experience in refugee health, reception, and integration, conducted all interviews. Reflexivity was considered throughout the research process.

A reflexive journal was maintained during data collection and analysis to document preconceptions, methodological decisions, and reflections on researcher–participant interactions. Pre-existing professional relationships with some participants were acknowledged before the interviews.

During analysis, assumptions were critically examined through iterative reflection and constant comparison between participants' narratives and emerging interpretations. Peer debriefing with members of the research team experienced in qualitative research supported the review of coding decisions and the development of themes.

Context

This study was conducted at the Reception and Temporary Shelter Centre (Centro de Acolhimento Temporário para Refugiados – CATR) in Lisbon, Portugal. Established in 2015, CATR provides temporary accommodation and multidisciplinary support to refugees and asylum seekers, including access to healthcare services. The centre hosts individuals granted international or subsidiary protection, as well as asylum seekers, and offers up to 4 months of individualised support.

CATR operates within Lisbon's Municipal Refugee Reception Program, an 18-month initiative structured in two phases: an initial reception period at CATR followed by relocation to temporary housing units to support integration. The centre collaborates with local healthcare providers and third-sector organisations, including the Jesuit Refugee Service (JRS), which delivers psychosocial support, integration assistance, and advocacy.

This setting involves continuous interaction between healthcare and social support professionals working with a culturally diverse refugee population.

This study is situated within this specific institutional and municipal context in Lisbon and does not aim to represent the Portuguese context. Rather, it reflects the experiences of professionals working within this reception and integration setting.

Although the empirical work was conducted in a single institutional context, the findings are interpreted considering the broader Portuguese healthcare framework to contextualise the identified barriers and facilitators to healthcare access.

The study aimed to explore the experiences and perspectives of healthcare, reception, and integration professionals working with refugees and asylum seekers within this specific reception context in Lisbon.

Sampling strategy

Participants were health professionals engaged in the reception and integration of refugees accommodated at the CATR. Eligibility criteria require at least five years of relevant professional experience. This requirement was established to prioritise information-rich cases and capture perspectives grounded in prolonged practical engagement, in line with purposive sampling principles commonly adopted in qualitative inquiry [38, 39].

Participants were recruited through purposive, non-probabilistic snowball sampling. The sample comprised healthcare professionals from five primary and specialised care institutions, as well as reception and integration professionals from two third-sector organisations.

Recruitment was initiated via key informants, specifically CATR coordinators, who facilitated access to and identification of additional eligible participants. A total of 13 professionals participated in the study. Data collection continued until thematic sufficiency was reached. Thematic sufficiency was assessed iteratively during analysis and was defined as the point at which no substantially new codes, themes, or interpretative insights were identified in successive interviews, and the coding framework had stabilised.

Data Collection

Data on participants' age, gender, nationality, educational qualifications, employment status, workplace location, and the interview date and time were collected using a sociodemographic questionnaire. In addition, the interview guide was developed based on the authors' prior research, including a study on risk factors for NCDs among refugees and asylum seekers in Portugal [40] and an ongoing scoping review examining mental health as an NCD in forcibly displaced populations. These studies provided empirical and conceptual grounding for the interview domains, which explored: (i) refugees' perceived health needs, particularly in relation to NCDs; (ii) barriers to healthcare access and utilisation; and (iii) strategies employed to mitigate these barriers.

The individual interviews were conducted remotely via the Zoom platform to accommodate geographic dispersion and scheduling constraints. All interviews were audio-recorded upon participant consent.

Interviews ranged from 25 to 60 min, with an average of approximately 40 min. All interviews were transcribed verbatim. The transcripts were reviewed against the audio recordings to ensure accuracy and completeness before analysis.

Data analysis and reporting

Data were analysed using reflexive thematic analysis, as outlined by Braun and Clarke [41]. Reflexive thematic analysis was considered epistemologically consistent with the study's interpretivist orientation, and its experiential focus was informed by phenomenological principles. This approach enabled the systematic identification of patterns of meaning while maintaining analytic sensitivity to participants' lived experiences and subjective interpretations. The analysis followed a predominantly inductive orientation, privileging themes grounded in participants' narratives rather than imposing predefined analytic categories derived from existing frameworks. The research objectives functioned as sensitising concepts rather than deductive coding frames. These sensitising concepts did not operate as predefined coding categories but served only as broad orienting lenses during interpretation.

Analysis proceeded through iterative stages: (1) familiarisation with the data through repeated reading of transcripts; (2) identification and coding of meaningful data segments; (3) development of preliminary themes through iterative comparison across interviews; (4) refinement and organisation of themes and subthemes; and (5) synthesis and interpretation of patterns across the dataset.

The coding process was conducted by APO, who performed the initial coding of all transcripts. To enhance analytic rigour, coding decisions and theme development were reviewed by a second researcher (CC), who is experienced in qualitative methods. The second researcher examined coded transcripts, category structures, and emerging themes. Differences in interpretation were discussed through reflexive dialogue rather than consensus-seeking for reliability, with the aim of deepening interpretive insight and strengthening analytic reflexivity. Analytic decisions, code adjustments, and theme development were documented through reflexive and analytic memos throughout the process.

Phenomenological principles informed analytic sensitivity by emphasising participants' meanings, experiential accounts, and interpretative perspectives, rather than imposing rigid a priori thematic structures.

Data saturation was assessed concurrently with data collection and analysis. Saturation was considered achieved when successive interviews yielded no substantially new themes or conceptual insights. This point was reached after 13 interviews, when thematic redundancy was observed.

The analysis was supported by the qualitative data analysis software webQDA v3.0, which facilitated data organisation, coding management, and theme development.

The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [42].

Ethical Considerations

The study received ethical approval from the IHMT-ITQB Ethics Committee (Opinion 21.22). Informed consent was obtained from all participants both verbally and in writing. Anonymity was maintained by assigning participant codes (I1–I13, where "I" stands for "Interview") and removing identifying information from transcripts. Video files are deleted immediately following transcription, while audio recordings are securely stored for up to five years.

Results

Findings are organised into two overarching interpretative themes reflecting how professionals conceptualise refugee health and healthcare access. The themes represent higher-level interpretative constructions that

Table 1 Main themes, upper themes, and interpretations derived from qualitative analysis of interviews with healthcare, reception, and integration professionals working with refugees in Portugal

Main Theme	Upper Theme	Interpretation
Perspectives on refugee health problems	Non-communicable diseases (NCDs) problems	Participants consistently reported a high prevalence of cardiovascular disease (CVD), chronic kidney disease (CKD), type 2 diabetes (DM2), cancer, and mental health conditions among refugees. Mental health issues - particularly depression, anxiety, and trauma-related disorders - were highlighted as pervasive and often underdiagnosed.
	Risk factors for NCDs	Professionals identified smoking, alcohol use, physical inactivity, and unhealthy dietary habits as common, alongside obesity, hypertension, and elevated cholesterol or glucose levels. Psychosocial factors such as isolation, unemployment, and exposure to traumatic events were also noted as risk factors for mental illness.
	Refugees' self-perceptions of health	Some refugees were perceived as having limited awareness or differing interpretations of symptoms, often shaped by cultural health beliefs or previous healthcare experiences.
	Professionals' perspectives on health status before and after migration	Professionals observed a decline in refugees' health status during and following migration, with changes influenced by interrupted treatment in transit, differences in healthcare systems, and stressors related to reception and integration.
Perspectives on access and utilization of healthcare	Challenges identified by reception and integration professionals in refugees' access to healthcare	Participants reported difficulties in coordinating care, navigating complex referral systems, and ensuring continuity of treatment for refugees.
	Barriers identified by health, reception, and integration professionals in refugees' access to healthcare: Cultural competence Linguistic Administrative and bureaucratic Socioeconomic	Cultural competence, noted as the lack of organizational and individual cultural competence within healthcare services, was seen as limiting effective care; Linguistic communication barriers were described as a persistent challenge, often requiring interpreters or bilingual staff. Administrative and bureaucratic issues, such as difficulties in obtaining health numbers, registering with primary care, or navigating paperwork, and delayed access; Socioeconomic constraints, including limited financial resources, housing instability, and employment insecurity, limit refugees' ability to attend appointments or follow treatment plans.
	Facilitators identified by health, reception, and integration professionals in refugees' access to healthcare	The availability of mediators, flexible appointment scheduling, and collaboration between healthcare providers, reception, and integration services were cited as positive enablers.
	Strategies adopted by refugees and asylum seekers to overcome barriers in accessing and using healthcare	Participants described refugees relying on community networks, peer support, and informal interpretation to overcome barriers.
	Strategies adopted by health, reception, and integration professionals to overcome barriers in accessing and using healthcare	Health, reception, and integration professionals reported using advocacy, direct communication with healthcare units, and adapting care pathways to bridge gaps.

emerged through iterative analysis rather than a direct alignment with the predefined study objectives. Together, they capture how professionals construct patterns of vulnerability, interpret structural and systemic conditions shaping healthcare access - particularly in relation to non-communicable diseases—and make sense of the adaptive responses enacted within constrained institutional contexts (Table 1).

Participant characteristics

The study included 13 professionals, with a mean age of 41.5 years (range: 28–67), of whom seven (54%) were female. Participants were recruited from NHS hospital care units ($n=5$), NHS primary healthcare units ($n=3$), and third-sector organizations ($n=5$). The sample comprised six physicians, two psychologists, one nurse, one administrative staff member, and three project managers.

Perspectives on refugee and asylum seekers' health problems

NCD problems

Participants reported that many of the most frequently observed health conditions among refugees were NCD-related. Although several professionals noted that refugees often present with health profiles like those of the general population, they emphasized that chronic conditions are common and clinically relevant. CVD, DM2, CKD, cancer, and mental health disorders were repeatedly mentioned. As one participant observed, "most refugees present problems very similar to those we see in the general population" (I2). However, others stressed that chronic diseases were far from rare, noting that "*non-communicable diseases are clearly an important issue*" (I5).

Mental health conditions, particularly depression, anxiety, and trauma-related disorders, were perceived as especially prevalent and often insufficiently diagnosed or addressed. Several participants described psychological

distress as pervasive among newly arrived refugees. One professional stated, "*In terms of mental health, I can say that all of them arrive with some issue*" (I3), while another emphasized that "*mental health is an absolute necessity for most of them*" (I1).

Participants' perceptions of refugees' overall health needs varied. Some professionals considered that most refugees did not require extensive medical care, suggesting that urgency often stemmed from limited prior access to healthcare rather than severe pathology. As one participant explained, "*they may not necessarily need extensive help*" (I1). Others, however, highlighted that a considerable proportion of refugees eventually presented with health problems requiring follow-up and intervention, noting that "*most of these people eventually have some health problem*" (I10). Across interviews, participants consistently underscored the heterogeneity of refugee health profiles and cautioned against generalized assumptions.

Mental health emerged as a dominant concern. Depression was described as the most common condition, alongside anxiety disorders, sleep disturbances, panic episodes, and post-traumatic stress disorder (PTSD). Participants referred both to refugees arriving with pre-existing psychiatric diagnoses and to symptoms developing after displacement. One professional noted, "*we often receive cases with serious mental health diagnoses made before departure*" (I3), while another highlighted that "*almost all arrive with some mental health issue*" (I5). PTSD was frequently associated with exposure to war-related violence.

Participants linked mental health problems to experiences occurring before migration, during transit, and after arrival. Prolonged exposure to instability, violence, and uncertainty was described as contributing to compounded vulnerabilities. As one participant stated, "*mental health issues often stem from migration itself — whether from traumatic events before departure or during the migration process*" (I3).

At the same time, several professionals noted that not all refugees presented enduring psychological symptoms. Transient stress reactions associated with adaptation were also reported. One participant remarked, "*Some symptoms are part of a normal adaptation process*" (I1), while another observed that "*after a week or two, many no longer need care*" (I7).

In addition, participants reported that health concerns were not always expressed immediately. Refugees were perceived as prioritizing survival and basic needs. As one professional explained, "*only later do they reveal health problems — the priority is survival, food, money, not health*" (I11).

Risk factors for NCDs

Professionals identified multiple behavioral and social factors perceived as contributing to refugees' vulnerability to NCDs. Smoking and alcohol consumption were frequently mentioned. Several participants described tobacco use as highly prevalent, with one noting that "*smoking is completely normalised*" (I3). Alcohol use was described as varying across nationalities and sometimes increasing after migration. As one participant stated, "*they drink to get drunk*" (I3), while another observed that "*for some groups, alcohol consumption begins only after arrival*" (I5).

Dietary habits were described as shaped by both cultural traditions and post-migration constraints. Participants referred to diets characterized by high carbohydrate intake and low fruit consumption. One professional described a diet consisting mainly of "*rice, vegetables, eggs… with very low fruit intake*" (I2), whereas another highlighted "*a lot of fried food and very high sugar intake*" (I3). Food insecurity was also reported, with some refugees perceived as limiting personal expenditure to support family members abroad.

Physical inactivity was another recurrent theme. While some refugees engaged in exercise, others were perceived as sedentary. One participant noted that "*only those previously active tend to maintain exercise*" (I4), whereas another observed that "*physical activity is often not a priority*" (I5).

Beyond lifestyle behaviors, participants emphasized psychosocial determinants of health. Social isolation, unemployment, and prolonged uncertainty regarding legal status were described as contributing to both mental and physical health vulnerabilities. As one professional stated, "*tobacco and alcohol are coping strategies for discomfort in their present reality*" (I12).

Refugees and asylum seekers' self-perceptions of health

Participants reported that prior healthcare experiences and cultural beliefs frequently shaped refugees' perceptions and interpretations of health and illness. Several professionals described limited awareness or differing interpretations of symptoms, particularly in relation to mental health. Psychological distress was perceived as "*often unaddressed — due to unawareness or shame*" (I6).

Mental health symptoms were frequently described as being expressed through somatic complaints. As one participant explained, "*they present physical symptoms that mask psychological distress*" (I8). Professionals emphasized that such presentations could complicate clinical assessment.

Professionals' perspectives on health status before and after migration

Participants consistently described migration as a process associated with deterioration in health. Refugees were perceived as arriving with worsened health status due to interrupted treatment, loss of follow-up, and adverse living conditions. One professional noted that "*many arrive with deteriorated chronic conditions due to treatment interruptions*" (I3).

Differences between healthcare systems and integration-related stressors were described as influencing disease management. Variations in health profiles were frequently associated with country of origin and migration trajectories.

Perspectives on access and utilization of healthcare

Challenges identified by healthcare, reception, and integration professionals

Participants described substantial challenges related to refugees' navigation and use of healthcare services. Difficulties in coordinating care, managing referrals across multiple institutions, and ensuring treatment continuity were frequently reported. As one participant explained, "*the system is already complex for us; for them it becomes extremely confusing*" (I3). Another professional highlighted the operational burden associated with fragmented services, noting that "*you end up taking groups of refugees to multiple places just to complete different exams*" (I11).

The complexity of the healthcare system was perceived as particularly burdensome for refugees unfamiliar with bureaucratic procedures and institutional structures. Participants emphasized that refugees often struggled to understand appointment systems, referral pathways, and administrative requirements. One professional observed, "*they don't understand why they must first go to primary care before accessing a specialist*" (I6).

A mismatch between refugees' expectations and the functioning of the Portuguese NHS was also described. Professionals reported that unmet expectations often led to frustration, confusion, and dissatisfaction. As one participant stated, "*people arrive with very high expectations about Europe and our services*" (I9), while another remarked, "*the challenge of expectations is terrible… we don't have a perfect healthcare system*" (I5).

Barriers to healthcare access

Participants identified multiple interconnected barriers affecting refugees' access to healthcare. Cultural competence emerged as a central issue, with professionals frequently describing a lack of organizational and individual preparedness to address refugees' cultural and experiential contexts. One participant stated unequivocally, "*there is no cultural competence, period*" (I4), while another argued that "*cultural sensitivity is the biggest barrier for this population*" (I3). Participants described how insufficient cultural awareness could negatively affect communication and trust. A professional recounted situations where "*healthcare providers reacted inappropriately because they didn't understand cultural practices*" (I9).

Linguistic barriers were described as persistent and structurally significant. Limited availability of interpreters and communication difficulties with healthcare providers were repeatedly mentioned. As one professional explained, "*I encountered doctors who refused to attend because we needed a translator*" (I2). Others highlighted the risks of informal translation chains, noting that "*sometimes three or four people are translating, and the doctor still doesn't understand*" (I13).

Administrative and bureaucratic barriers were also emphasized. Participants reported difficulties obtaining NHS numbers, delays in registration, and complex paperwork requirements. One participant stated, "*access is not always easy because not all refugees have an NHS number*" (I2), while another described "*significant delays in registration and allocation of a patient number*" (I3). Restrictions affecting accompaniment during consultations were also perceived as problematic, particularly for vulnerable patients.

Socioeconomic constraints further compounded access challenges. Limited financial resources, unstable housing, and employment insecurity were described as limiting refugees' ability to attend appointments and adhere to treatments. As one participant noted, "*some refugees give up exams because they simply cannot afford them*" (I4), while another emphasized that "*out-of-pocket costs become a real barrier*" (I13).

Facilitators of healthcare access

Despite these barriers, participants described several facilitating factors. The presence of cultural mediators and interpreters was perceived as critical for improving communication and navigating healthcare services. One participant stated, "*Without the cultural mediator, we might interpret things completely differently*" (I1). Another professional highlighted that "*having someone explain the patient's story to the medical team makes an enormous difference*" (I7).

Collaboration between healthcare providers, reception centers, and third-sector organizations was also identified as an important enabler. Participants frequently emphasized the supportive role of professional integration. As one participant explained, "*when refugees are connected to an organisation, things become much easier*" (I7).

Flexible appointment scheduling and supportive professionals were described as contributing positively to access and continuity. Several participants referred to

"*empathetic doctors who try to adapt consultations*" (I12) and "*healthcare staff who actively help speed up care*" (I3).

Strategies adopted by refugees and asylum seekers

Participants described that refugees frequently relied on informal strategies to overcome barriers. Community networks, peer support, and assistance from other refugees were perceived as important mechanisms for navigating healthcare. As one participant noted, "*those who have been here longer help newcomers understand how the system works*" (I6). Informal interpretation was also described as common, with refugees "*often bringing another refugee to translate or accompany them*" (I4).

Some professionals observed adaptive behaviors aimed at bypassing administrative difficulties. One participant reported that "*when unsure about appointments, refugees sometimes go directly to the emergency department*" (I2).

Strategies adopted by professionals

Healthcare, reception, and integration professionals reported adopting various strategies to mitigate systemic barriers. Advocacy and direct communication with healthcare institutions were described as recurrent practices. One participant explained, "*We often need to contact services directly to unblock situations" (I4), while another stated, "We rely heavily on informal networks within the system*" (I12).

Professionals also described adapting care pathways and supporting refugees' autonomy. As one participant noted, "*for chronic diseases, we teach patients each step needed to reach autonomy*" (I12). Several professionals positioned themselves and their institutions as key facilitators. One participant emphasized, "*if support technicians did not exist, many refugees would be completely blocked from accessing care*" (I4).

Discussion

Perspectives on refugee and asylum seekers' health problems

NCD problems

Participants' accounts suggest that healthcare, reception, and integration professionals increasingly recognise NCDs as a significant component of refugee health needs. Although some respondents described refugees' health profiles as broadly resembling those of the general population, the recurrent identification of CVD, DM2, chronic kidney disease, cancer, and mental health disorders reflects wider global epidemiological patterns.

This observation aligns with the global epidemiological transition, whereby NCDs have become the leading causes of morbidity and mortality worldwide, including in low- and middle-income countries from which many refugees originate [43]. Recent global burden of disease analysis indicates that NCDs now account for most premature deaths across most world regions, reshaping the health needs of mobile and displaced populations [44].

Historically, refugee health has been framed predominantly in relation to infectious diseases and acute conditions. However, emerging evidence challenges this paradigm. Studies conducted in European host countries demonstrate that refugees frequently present with chronic conditions that were either pre-existing, undiagnosed, or poorly managed prior to displacement [17, 43]. Displacement-related treatment interruptions, reduced access to continuous care, and adverse living conditions during transit may further aggravate disease progression.

Participants' emphasis on heterogeneity is particularly important. Refugees are not a homogeneous group, and disease profiles vary substantially depending on country of origin, age, socioeconomic background, and migration trajectory. Recent European research highlights marked differences in NCD prevalence between refugee subgroups, shaped by prior epidemiological exposures and post-migration determinants [16]. These findings reinforce the need for host health systems to move beyond one-size-fits-all approaches and adopt differentiated, context-sensitive screening and management strategies.

Mental health burdens

Mental health emerged as the most salient concern across interviews, with participants consistently describing high levels of psychological distress among refugees. Depression, anxiety disorders, sleep disturbances, and PTSD were perceived as highly prevalent, particularly during early stages of resettlement. The strong emphasis placed by professionals on mental health concerns may also reflect Western biomedical and psychosocial conceptualisations of distress. In many European healthcare systems, the psychological consequences of forced displacement are foregrounded within trauma-informed frameworks, as outlined by the Substance Abuse and Mental Health Services Administration [45], which positions mental health as a central domain of vulnerability among refugee populations. However, experiences of suffering, resilience, and well-being are culturally embedded and may not fully align with Western psychiatric nosologies or individualised models of distress, as critically discussed by Kleinman [46].

While trauma-informed approaches have contributed significantly to recognising displacement-related adversity and promoting sensitive care practices [45], scholars such as Summerfield (1999) and Miller and Rasmussen (2010) caution against the potential over-pathologisation of refugee experiences or the implicit assumption of psychological fragility [47, 48]. Miller and Rasmussen (2010) further argue that an exclusive focus on trauma may obscure the role of ongoing structural stressors in

shaping mental health outcomes [48]. A critical and culturally responsive lens therefore requires balancing recognition of trauma exposure with attention to agency, structural determinants of health, and diverse explanatory models of illness. This position resonates with resilience scholarship, which cautions against reducing refugee experiences to trauma narratives and instead emphasises adaptive capacities, collective coping practices, and culturally grounded forms of resilience that may not be fully captured within individualised trauma paradigms.

This perception is strongly supported by international evidence. Meta-analyses and umbrella reviews demonstrate that refugees and asylum seekers exhibit substantially higher prevalence rates of depression, anxiety, and PTSD compared with host populations [49, 50]. A recent Lancet Public Health synthesis further confirms that forced displacement is associated with elevated risks of common mental disorders, mediated by cumulative trauma and ongoing stressors [51].

Participants linked mental health problems to experiences occurring before migration, during transit, and after arrival. This temporal framing aligns with migration health theories, which emphasise that health outcomes are shaped by exposures across the entire displacement continuum [52, 53]. Pre-migration trauma, violence, loss, and deprivation intersect with post-migration stressors such as legal insecurity, unemployment, discrimination, and social isolation.

Importantly, professionals also recognised variability in symptom persistence, noting that not all refugees develop chronic psychiatric disorders. This nuance is consistent with contemporary literature highlighting resilience, adaptive coping, and recovery trajectories among forcibly displaced populations [43, 54].

Participants' observations that mental health concerns may be underreported or disclosed later echo studies showing that refugees often prioritise immediate survival needs (housing, income, legal stability) over psychological care [23].

Risk factors for NCDs

Participants identified multiple behavioural and psychosocial factors perceived as contributing to NCD vulnerability, including tobacco use, alcohol consumption, physical inactivity, and unhealthy dietary patterns.

These findings are consistent with recent global and European research. Forced migration has been associated with disruptions in lifestyle behaviours, shaped by stress, poverty, environmental constraints, and acculturation processes [43, 44]. Evidence indicates that displacement-related adversity may increase the likelihood of smoking and harmful alcohol use, particularly as coping mechanisms for psychological distress [55, 56].

Participants' accounts of dietary challenges align with studies demonstrating that food insecurity, limited financial resources, and restricted access to culturally familiar foods influence the nutritional quality of refugees' diets [57]. Similarly, physical inactivity has been linked to mental health problems, unsafe neighbourhoods, lack of recreational opportunities, and social marginalisation [43].

Professionals' recognition of the bidirectional relationship between mental and physical health aligns with growing literature documenting how mental disorders increase NCD risk through behavioural, neuroendocrine, and inflammatory pathways [58, 59].

Refugees and asylum seekers self-perceptions of health

Participants described refugees' health perceptions as shaped by cultural beliefs, stigma, and prior healthcare experiences. Somatic presentations of psychological distress were frequently noted.

This pattern is widely documented in transcultural psychiatry and migrant health research [50, 60]. Cultural frameworks influence symptom interpretation, help-seeking behaviours, and acceptance of mental health diagnoses. Stigma surrounding mental illness remains a significant barrier across many cultural contexts [61]. Applying Levesque et al.'s conceptual framework, these challenges may reflect limitations in refugees' ability to perceive need, seek care, and engage with services [62].

Professionals' perspectives on health status before and after migration

Participants framed migration as a process frequently associated with deterioration in health. Treatment interruptions, unstable housing, nutritional insecurity, and prolonged uncertainty were highlighted.

These observations align with European and global evidence demonstrating that displacement and resettlement conditions significantly influence health trajectories [17, 43, 63]. Structural vulnerabilities and social determinants play a critical role in shaping both disease progression and access to care [64].

Perspectives on access and utilisation of healthcare

Challenges identified by healthcare, reception, and integration professionals

Participants described substantial challenges in navigating the Portuguese NHS, particularly in referral complexity, care coordination, and treatment continuity. These perceptions reflect structural characteristics of healthcare systems that, although designed to ensure universal coverage, may remain difficult to navigate for populations unfamiliar with administrative procedures and organisational pathways.

Evidence from the Portuguese context indicates that migrants frequently encounter barriers related to

bureaucratic processes, institutional fragmentation, and limited responsiveness of the system to diversity [65–70]. Despite Portugal's strong legislative framework guaranteeing universal access to healthcare, disparities between formal entitlements and effective utilisation have been repeatedly documented [67, 71].

International literature similarly highlights that universal health coverage does not automatically translate into equitable access, particularly for refugees and asylum seekers whose healthcare engagement is shaped by legal status, health literacy, prior system experiences, and social vulnerability [16, 43]. Complex referral systems, long waiting times, and discontinuities between primary and specialised care have been associated with reduced satisfaction, delayed care, and lower trust in institutions [17, 23].

Participants' observations regarding mismatches between refugees' expectations and service functionality align with studies showing that unmet expectations may negatively affect healthcare-seeking behaviour, adherence, and perceptions of care quality [23, 43]. Refugees often arrive with idealised perceptions of European healthcare systems, which may contrast with experiences of procedural delays, limited appointment availability, and communication difficulties.

Barriers to healthcare access

Participants identified multiple, intersecting barriers consistent with contemporary access-to-care frameworks that conceptualise access as a multidimensional process involving availability, affordability, acceptability, and appropriateness [62].

Cultural competence

Insufficient cultural competence emerged as a central barrier. Recent European evidence indicates that deficits in organisational and provider-level cultural competence contribute to miscommunication, stereotyping, reduced patient satisfaction, and inequitable care experiences [43, 72]. Lack of training in intercultural communication and refugee health has been associated with lower diagnostic accuracy, weaker therapeutic alliances, and increased risk of inappropriate care [73].

Portuguese studies similarly report that healthcare professionals may feel underprepared to address culturally diverse populations, particularly regarding mental health, gender-sensitive care, and culturally shaped illness narratives [69, 74].

Language barriers

Language discordance remains one of the most robustly documented barriers to migrant healthcare access. Recent systematic reviews confirm that language barriers adversely affect communication quality, comprehension of medical advice, patient safety, and trust in providers [75, 76]. Inadequate interpreter availability has been linked to diagnostic errors, reduced utilisation of preventive care, and lower adherence to treatment plans [43].

Within Southern European health systems, including Portugal, interpreter and mediation services remain inconsistently implemented, often relying on informal strategies [43].

Administrative and bureaucratic barriers

Administrative barriers described by participants align with international evidence demonstrating that legal status, registration procedures, documentation requirements, and eligibility ambiguities can significantly delay or prevent healthcare utilisation [17, 77, 78]. Even in universal systems, complex administrative procedures disproportionately affect refugees and asylum seekers, particularly those with limited language proficiency or system knowledge.

Portuguese research has documented difficulties obtaining NHS numbers, navigating registration processes, and understanding entitlements, especially during early stages of resettlement [70, 71].

Socioeconomic barriers

Participants' emphasis on unemployment, housing instability, and financial insecurity reflects a well-established body of evidence linking social determinants to healthcare utilisation. Recent studies confirm that socioeconomic disadvantage constrains healthcare engagement through competing priorities, transport limitations, unstable living conditions, and affordability challenges [43, 64].

Low health literacy — frequently observed among forcibly displaced populations — further compounds access barriers by limiting individuals' ability to recognise needs, navigate services, and engage in preventive care [79].

Facilitators of healthcare access

Participants highlighted the role of cultural mediators, interpreters, and inter-institutional collaboration as key facilitators. These findings are consistent with growing evidence supporting mediation and navigation models as mechanisms that enhance healthcare accessibility, patient satisfaction, and continuity of care [43, 73].

Studies show that professional interpreters and cultural mediators improve communication accuracy, reduce misunderstandings, increase adherence, and strengthen trust between patients and providers [72, 76]. Organisational partnerships between healthcare services and third-sector organisations have also been associated with improved referral coordination and reduced administrative delays [78].

Strategies adopted by refugees and asylum seekers

Participants described refugees relying on informal networks and peer support. This adaptive behaviour has been widely documented in migrant health research and is often interpreted as a response to structural and informational barriers [23, 43].

While such strategies may facilitate short-term navigation, reliance on informal interpretation and community mediation raises concerns regarding confidentiality, accuracy, and patient safety [76].

Strategies adopted by professionals

Professionals' advocacy, informal coordination, and system navigation roles highlight institutional gaps. Although these practices may mitigate immediate barriers, literature increasingly emphasises that equity-oriented healthcare systems should rely on structural solutions rather than discretionary efforts by individual professionals [43, 64].

Sustainable improvements require organisational investment in interpreter services, culturally competent care models, administrative simplification, and workforce training [73, 78].

Strengths, limitations, and future research directions

This study contributes to the qualitative understanding of refugee health and healthcare access by incorporating the perspectives of healthcare, reception, and integration professionals, thereby offering a system-level view that complements refugee-centred research. The inclusion of actors operating at different levels of the healthcare and reception system enhances the depth and contextual richness of the analysis. Methodological rigour was supported through purposive sampling, reflexive journaling, iterative coding, and team-based analytical discussions.

Nevertheless, several limitations should be acknowledged. First, the study was conducted within a single-country context and in an institutionally bounded setting (CATR). Although Portugal provides a relevant framework for examining refugee health within a formally universal healthcare system, the findings may have limited transferability to contexts characterised by different entitlement regimes, organisational structures, and migration dynamics. In line with qualitative research principles, the aim was analytical rather than statistical generalisation.

Second, the study may be subject to a twofold bias. On the one hand, social desirability bias may have influenced participants' accounts, as professionals reflected on their own practices and institutional environments. Despite efforts to foster open and reflexive dialogue, participants may have framed responses in ways consistent with professional norms or organisational expectations. On the other hand, the study design is inherently biased toward professionals' viewpoints, as the analysis exclusively captures their perspectives. The absence of refugees and asylum seekers' direct voices may have shaped the interpretation of barriers and facilitators through an institutional lens, potentially overlooking experiential nuances and alternative understandings of access.

Third, selection bias may have occurred, as participants were primarily professionals actively engaged in refugee health and integration processes. While this ensured information-rich accounts grounded in experience, it may have underrepresented the perspectives of less-involved providers and may have inadvertently overestimated system responsiveness or adaptive practices.

Fourth, as with most qualitative research, interpretations are shaped by the researchers' positionality. Although reflexive practices and peer debriefing were employed to enhance credibility and confirmability, complete bracketing of prior assumptions is neither feasible nor epistemologically consistent with interpretivist inquiry.

Future research should incorporate refugees and asylum seekers lived experiences to enable triangulation of perspectives and deepen understanding of healthcare navigation processes. Longitudinal qualitative designs could explore how access trajectories evolve, particularly in relation to legal status transitions and integration milestones. Comparative multi-country studies would further enhance transferability and inform the development of migrant-sensitive, equity-oriented health policies.

Conclusion

This study highlights that healthcare, reception, and integration professionals perceive refugee health needs as characterised by a dual reality: similarities with the general population alongside heightened vulnerabilities shaped by displacement, trauma, and socioeconomic precarity. NCDs, particularly cardiometabolic conditions, emerged as clinically relevant, while mental health concerns — notably depression, anxiety, and trauma-related disorders — were consistently described as pervasive. These findings reinforce the growing recognition that refugee health can no longer be framed primarily through acute or infectious disease paradigms but must incorporate chronic disease management and mental health as central components of care.

The results further reveal that interrelated structural, linguistic, cultural, and socioeconomic barriers constrain access to healthcare. Administrative complexities, difficulties navigating the healthcare system, limited interpreter availability, and insufficient cultural competence were perceived as critical obstacles that undermine the continuity, quality, and equity of care. Importantly, professionals also identified facilitators and adaptive strategies, including the role of cultural mediators, intersectoral collaboration, and provider flexibility,

underscoring that organisational practices and institutional support mechanisms can meaningfully mitigate systemic constraints.

These findings have several implications for health policy and service delivery. First, refugee health strategies should prioritise integrating NCD prevention and management into primary care, alongside systematic, culturally responsive mental health services. Second, reducing bureaucratic barriers — particularly those related to registration and entitlement procedures — is essential to ensure that legal rights translate into effective access. Third, strengthening linguistic support systems, including sustainable interpreters and mediation services, is fundamental for safe and person-centred care. Fourth, embedding cultural competence at both professional and organisational levels — through training, protocols, and institutional accountability — is necessary to enhance trust, communication, and therapeutic relationships.

Beyond the healthcare sector, the study underscores the importance of addressing social determinants of health. Employment insecurity, housing instability, financial constraints, and social isolation were perceived as directly influencing health outcomes and healthcare utilisation. Policies aimed at refugee integration must therefore adopt a whole-of-government and whole-of-society approach, recognising that health equity is inseparable from broader inclusion policies.

While this study contributes nuanced qualitative insights through professional perspectives, future research should incorporate refugees' and asylum seekers' lived experiences, longitudinal analyses of healthcare trajectories, and evaluations of policy implementation. Such work is essential to inform evidence-based interventions that strengthen migrant-sensitive, equitable, and resilient health systems.

These findings underscore that ensuring equitable healthcare for refugees requires more than formal entitlements; it requires structural responsiveness, cultural and linguistic competence, and sustained intersectoral collaboration.

Abbreviations

CATR	Reception and Temporary Shelter Centre
CRD	Chronic respiratory diseases
CVD	Cardiovascular diseases
DM2	Diabetes mellitus type 2
IOM	International Organization for Migration's
NCD	Non-communicable diseases
NHS	National Health Service
PTSD	Post-Traumatic Stress Disorder
SDG	Sustainable Development Goals
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Authors' contributions

A.P.O., I.F., and C.C. conceived the study and contributed to the interpretation of the results. A.P.O. and C.C. conducted the reflexive thematic analysis, and A.P.O. drafted the initial manuscript. R.L. transcribed the audio interviews. C.C. and I.F. contributed to the critical review and revision of the manuscript. All authors read and approved the final version of the manuscript.

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Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

The study was approved by the IHMT-ITQB Ethics Committee (Opinion 21.22). Participants were provided with a clear verbal explanation of the study's objectives and procedures, after which informed consent was obtained from each. All research activities involving human participants were conducted in full compliance with the principles outlined in the Declaration of Helsinki before their participation.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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