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Health Status and Barriers to Healthcare for Syrian Refugees in Portugal

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Source: Papadopoulou, 2016

Years of suffering, escaping from death to face an ambiguous fate that may also be death, and a continuing intractable crisis; this is all summarized in a picture of Aylan Kurdi's corpse on the Turkish shores.

Aylan Kurdi -a three years old boy- was found dead from drowning. Aylan and his father, mother, and older brother were trying to reach Europe by crossing the Mediterranean Sea using an elastic boat. This crossing was ended by a tragedy represented by the death of Aylan, the mother, and the older brother. Where only the father, Abdullah Kurdi, has survived.

Acknowledgement:

In the first place, I would like to thank the *Global Platform for Syrian Students* for the Opportunity I have been given to attend and complete a master's degree in public health and for their financial support throughout the program.

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I want to thank my sisters, Sarah and Budour, for their unconditional love and unlimited support, and the one, Akram, for always being there for me.

Dedication:

I would like to dedicate this thesis to the UNHCR. All the good things they have been doing for refugees are highly appreciated.

To all the refugees who died trying to seek safety in Europe…

We will never forget you…

Table of contents

List of figures ..………………………………………………………..……... I

List of abbreviations…………………………………………………….….... II

Resumo ……………….………………………………………………..…… III

Abstract ……………………………………………..………….……….. IV

1. Introduction ……………………………………................................ 1

1.1 Definitions …………………………………………………………..…..... 1

1.2 Migration trends in Europe ……………………………………..……... 3

1.3 Migration and health ……………………………………………….…….. 6

1.4 Refugee statistics ……………………………………………….……….. 9

1.5 Access and barriers to healthcare ………………………...………….. 11

1.6 Barriers to healthcare for refugees in Europe ...………………….…. 13

1.7 Portugal as a state of relocation and resettlement ..……………..….…15

2. Aim and objectives ………………………………………………………. 20

3. Methodology …………………………………………………………… 21

- Study design …………………………………………………….... 21
- Data Collection ………………………………………………….... 21

4. Results/Findings ……………………………………………………….... 22

5. Discussion ………………………………………….......................... 26

6. Recommendations ……………………………………………………. 29

7. Limitations………………………………………………………………… 30

References …………………………………………........................ 31

List of figures:

Figure 1.1: Annual rate of change of the international migrant stock and total population of the WHO European Region, 1997-2017

Figure 1.2: Total population and total international migrant stock in the WHO European Region stratified by age and by sex, 2017

Figure 1.3: Trends in refugee (including asylum seekers) and total migrant population in the WHO European Region, 2000-2017

Figure 2: Major source countries of refugees, end-2017 to end-2018

Figure 3.1: Distribution of asylum seekers by citizenship

Figure 3.2: Distribution of asylum seekers under the EU schemes among hosting entities

List of abbreviations:

ACM: High Commission for Migration

CPR: Portuguese Refugee Council

CVP: Portuguese Red Cross

EEA: European Economic Area

EU: European Union

IOM: International Organization for Migration

ISS: Institute of Social Security

MHPSS: Mental Health and Psychological Support

NCDs: Non-Communicable Diseases

OAU: Organization of African Unity

PAR: Refugee Support Platform

SEF: Immigration and Border Service

SNS: Portuguese National Health System

TTS: Telephone Translation Services

UMP: Union of Portuguese Mercies

UNHCR: United Nations High Commissioner for Refugees

UN: United Nations

WHO: World Health Organization

Resumo:

A deslocação forçada de pessoas cresceu significativamente nas últimas duas décadas. Esse crescimento foi impulsionado principalmente pelo conflito sírio que eclodiu em 2011, resultando na maior crise humanitária e de refugiados desde a Segunda Guerra Mundial. Um número significativo de refugiados sírios foi reinstalado em muitos países europeus, incluindo Portugal. Esta tese tem como objetivo avaliar o estado de saúde física e mental dos refugiados sírios em Portugal. Além disso, visa identificar as barreiras mais percebidas ao Serviço Nacional de Saúde Português.

Esta pesquisa utiliza dados primários de um inquérito a trinta e oito refugiados sírios com 18 ou mais anos de idade e residentes em Portugal. Os participantes foram recrutados usando uma amostragem em bola de neve. Os resultados revelam saúde física precária e altos níveis de estresse psicossocial entre os refugiados pesquisados. As necessidades de saúde não atendidas foram amplamente relatadas. As barreiras mais frequentes aos cuidados de saúde são o tempo de espera, os custos elevados e as dificuldades linguísticas. Havia um conflito entre a autoavaliação da saúde do refugiado e sua saúde real. Embora os participantes relatassem altos níveis de stresse psicossocial, psicólogos, psiquiatras e psicoterapeutas foram menos consultados do que outros profissionais de saúde. As barreiras ao atendimento odontológico são financeiras.

A resposta dos serviços de saúde deve conduzir a melhor acesso aos refugiados sírios. Recomendamos fornecer atendimento odontológico subsidiado, serviços de tradução melhorados e atenção à saúde mental como parte da rotina de recepção de refugiados. Também recomendamos a realização de uma avaliação médica para os refugiados na chegada e o compartilhamento dos resultados com os profissionais de saúde para considerar suas necessidades enquanto lhes fornece atendimento médico.

Abstract:

Forced displacement has grown significantly during the past two decades; this growth was driven mainly by the Syrian conflict that broke out in 2011, resulting in the biggest humanitarian and refugee crisis since the Second World War. Significant numbers of Syrian refugees have resettled in many European countries, including Portugal. This thesis aims to assess the physical and mental health status of Syrian refugees in Portugal. It also aims to identify the most perceived barriers to the Portuguese National Health System.

This research uses primary data from a survey of thirty-eight Syrian refugees aged 18 or more and based in Portugal. Participants have been recruited using a snowball sampling approach. The results reveal poor physical health and high levels of psychosocial stress among the surveyed refugees. Unmet health needs were highly reported. The most frequent barriers to healthcare are long waiting time, high costs, and language difficulties. There was a conflict between the refugee’s self-rated health and their actual health. Although the participants reported high levels of psychosocial stress, psychologists, psychiatrists, and psychotherapists were less consulted than other health services. Barriers to dental care are financial.

Service-response should be made to improve access to healthcare services for Syrian refugees. We recommend providing subsidized dental care, improved translation services, and meeting with a psychiatric as a part of the reception routine for refugees. We also recommend conducting a medical assessment for refugees upon arrival and sharing the results with healthcare providers to consider their needs while providing them with healthcare.

1. Introduction:

1.1 Definitions:

Responsibility for protecting the legitimate rights of citizens rests with the government of their country. When a government is unable or unwilling to do so, citizens may be forced to flee their country and seek safety elsewhere. In such a case, another state has to step in to ensure that those persons' fundamental rights are protected; this is called **"international protection"** (Nicolson & Kumin, 2017)**.**

There are significant differences that should be considered while defining the terms **"migrant"** and **"refugee"**, and they cannot be used interchangeably (UNHCR, 2015). The term **"refugee"** is defined under the international legal framework represented by (Nicolson & Kumin, 2017):

- The 1951 Convention and its 1967 Protocol, which are the core of the international protection for refugees;
- Regional refugee laws and standards as they relate to Africa, Latin America, and Europe;
- Other relevant standards contained in international human rights law, international humanitarian law, and international criminal law; and
- Further sources of law and guidance.

According to the 1951 Convention, several criteria should be met for a person to qualify as a refugee (Zimmermann, Dörschner, & Machts, 2011). A refugee is defined as "a person who has a well-founded fear of persecution for his or her race, religion, nationality, membership of a particular social group or political opinion; is outside his or her country of origin or habitual residence; is unable or unwilling to avail him- or herself of the protection of that country or to return there for fear of persecution; and is not explicitly excluded from refugee protection, or whose refugee status has not ceased because of a change of circumstances" (Nicolson & Kumin, 2017) (Zimmermann, Dörschner, & Machts, 2011).

The Organization of African Unity (OAU) 1969 Convention Governing the Specific Aspects of Refugee Problems in Africa incorporates a regional **refugee** definition to also include any person forced to move out of his or her country "owing to external aggression,

occupation, foreign domination, or events seriously disturbing public order in either part or the whole of his or her country of origin or nationality" (Nicolson & Kumin, 2017; OAU, 1969).

The 1984 Cartagena Declaration added another regional definition of the term **"refugee"**, complementing the definition of the 1951 Convention to incorporate persons who flee their countries "because their lives, safety, or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights, or other circumstances which have seriously disturbed public order" (Nicolson & Kumin, 2017; Jubilut, Espinoza, & Mezzanotti, 2019).

The term "**migrant**" is not defined under international law (IOM, 2019). According to the International Organization for Migration (IOM), a **migrant** is "a person who is moving or had moved away from his or her habitual place of residence, whether within a state or across an international border, for various reasons and regardless of (1) the person's legal status, (2) whether the movement is voluntary or involuntary, (3) what the causes of the movement are, or (4) what the length of the stay is" (IOM, Glossary on Migration, 2019).

The main difference between refugees and migrants is that migrants still have the protection of their country while refugees do not. Another difference is that migrants, unlike refugees, do not have fear of persecution in their nations and can make the decision to return.

The term **"international migrant"** indicates any person outside his or her country of citizenship or the state of birth or usual residence in the case of stateless people (IOM, Glossary on Migration, 2019).

The term "**Asylum seeker**" denotes a person who is seeking international protection (Nicolson & Kumin, 2017). From a policy perspective, many governments use this term to denote persons who are waiting for a final decision on their asylum claim (Bradby, Humphris, Newall, & Phillimore, 2015). Asylum claims are usually examined in a fair procedure. Not every asylum claim will ultimately be approved (Nicolson & Kumin, 2017).

1.2 Migration trends in Europe:

The WHO European Region has witnessed a flow of migrants and refugees since the late 2000s (WHO, 2018). In 2010, the number of international migrants in the Region made up 8.7% of the total population (almost 72.6 million international migrants) (Rachel, Mladovsky, Ingleby, Mackenbach, & Mckee, 2013). This flow recorded a rapid increase in 2015 (WHO, 2018). In 2017, the number of international migrants in the Region estimated at 90 million (approximately 10% of the host population and 35% of the world's international migrants) (WHO, 2018). Many of these migrants were escaping natural disasters, conflicts, persecution, or other human rights violations (WHO, 2018). The WHO European Region is witnessing an important change in the number of migrants and refugees against slower change in the local population (Fig.1.1); this reflects the aging population and a shrinking birth rate (WHO, 2018).

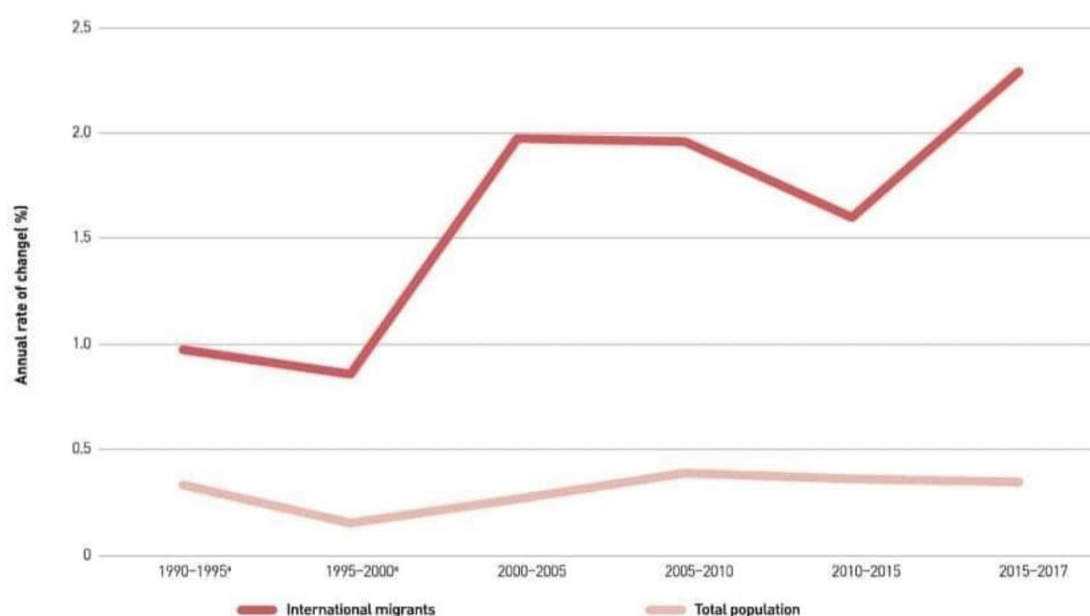

Figure 1.1: Annual rate of change of the international migrant stock and total population of the WHO European Region 1990-2-17

Source: United Nations Department of Economic and Social Affairs, 2017 (1).

Although migrants in the age group 25-50 years made up the vast majority of international migrant stock in the WHO European Region in 2017 (Fig. 1.2) (WHO, 2018), the number of elderly, minors (including unaccompanied children), and disabled people arriving in the Region is remarkably increasing (PAHO, 2018).

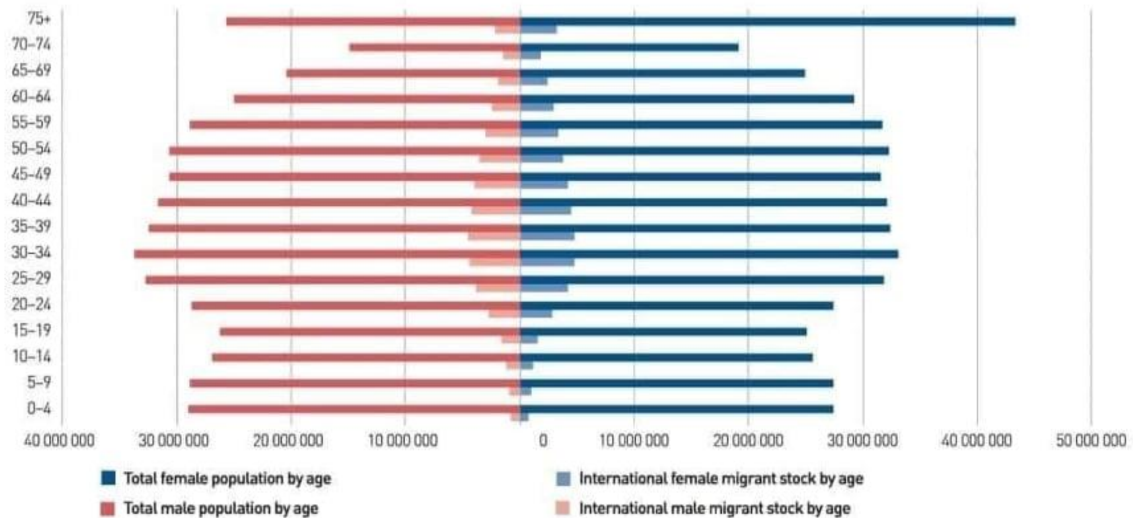

Figure 1.2 Total population and total international migrant stock in the WHO European Region stratified by age and by sex, 2017

Source: United Nations Department of Economic and Social Affairs, 2017 (1).

In conjunction with global growth in the number of labour migrants (WHO, 2018), forced migration has grown due to conflicts, political instability, or poverty in many countries in the Middle East and Africa (Park, 2015) (Matlin, Depoux, Schütte, Flahault, & Saso, 2018). The proportion of forcibly displaced people has increased from five in 1,000 of the world's population in 1997 to nine in 1,000 in 2017, with an important rise starting in 2011 (Fig. 1.3) (WHO, 2018).

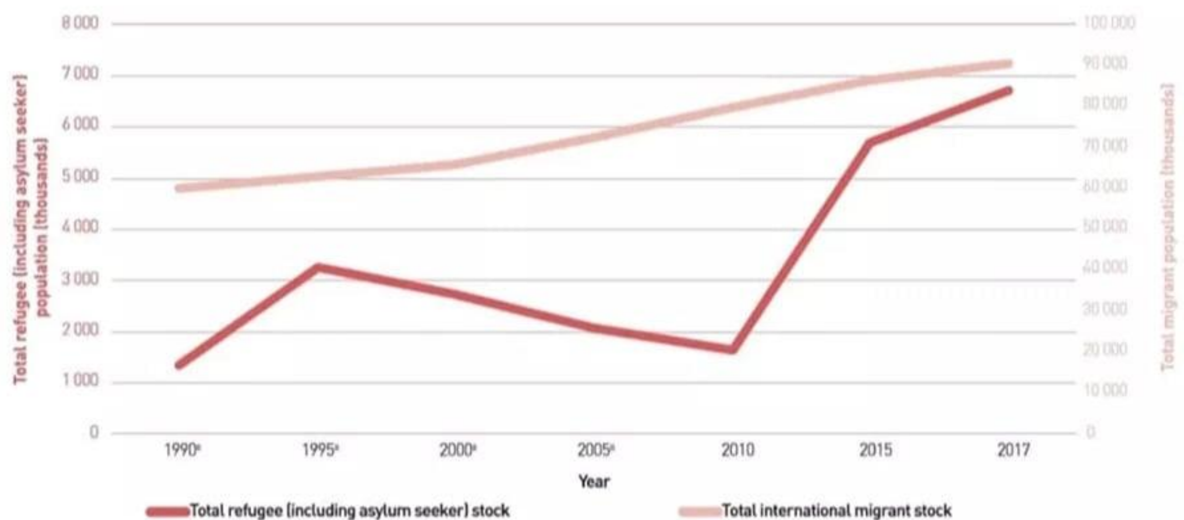

Figure 1.3 Trends in refugee (including asylum seekers) and total migrant population in the WHO European Region, 2000-2017

Source: United Nations Department of Economic and Social Affairs, 2017 (1).

Mixed migration has grown recently (WHO, 2018). The United Nations High Commissioner for Refugees (UNHCR) defines **mixed migration** as “a situation where a number of people are travelling together, generally in an irregular manner, using the same routes and means of transport, but for different reasons” (IOM, 2019). People on the move have different needs and profiles, including refugees, asylum seekers, victims of trafficking, unaccompanied children, or economic migrants (IOM, Glossary on Migration, 2019). The legal status of migrating persons after resettlement in a new destination is a key factor that determines their entitlements and accessibility to healthcare service (WHO, 2018).

According to the IOM 2015 estimates, more than a million irregular migrants and refugees arrived in Europe by land and sea, mostly from Syria, Africa, and South Asia; this number represents four times increase than in 2014 (Kentikelenis & Shriwise, 2016). In 2014, the central Mediterranean border between Libya and Italy ranked the most common route used by irregular immigrants to reach Europe (Park, 2015). By July 2015, Greece became once again the preferred Mediterranean entrance to Europe to irregular migrants escaping conflicts and poverty (Park, 2015). Syrians and Afghans made up the vast majority of illegal migrants crossing to Greece from Turkey (Park, 2015). However, refugees and asylum seekers still constitute less than 10% (7.4%) of the international migrant population in the Region (WHO, 2018). Turkey ranks the top country regarding the number of refugees worldwide (WHO, 2018). In Europe, Germany and Sweden have received and approved massive numbers of asylum applications (Park, 2015).

1.3 Migration and health:

Migration is defined as “the movement of persons away from their place of usual residence, either across an international border or within a state” (IOM, 2019; Manuel & Nerukart, 2001). Migration -whether voluntary or forced- poses a challenge to public health. Even when the process of migration is done under the best conditions, it is still associated with stressors that pose a threat to migrants’ health (Manuel & Nerukart, 2001). Migration involves uprooting, separation from family and friends, and adaptation to new language and culture in a new destination where legal security, social integration, and job opportunities may be little or none (Manuel & Nerukart, 2001). Many migrants find social integration challenging, and for some, it seems to be impossible (Manuel & Nerukart, 2001).

Risks to the health of migrants emerge at every step of migration: pre-departure; during travel; at points of transit and destination (Matlin, Depoux, Schütte, Flahault, & Saso, 2018). The risks depend on the specifics of the origin country (socioeconomic status, educational level, environmental push factors, and local disease profile), host country (legal status, access to healthcare services, social integration, entitlements and accessibility to basic survival needs), and the mode of travel (exposure to violence, detention, sexual violation, legal or illegal border crossing, living in unsanitary conditions or overcrowding) (Matlin, Depoux, Schütte, Flahault, & Saso, 2018). Migration is regarded as a social determinant of health; this is explained by the implications of any harm to migrants’ health on the host population (Davies, Anna, & Frattini, 2009).

Refugees and asylum seekers among the total migrant population are at higher risk of health problems (Keidar, Srivastava, Pikoulis, & Exadaktylos, 2019). Refugees are vulnerable to infectious diseases due to the devastating healthcare systems (including vaccination services) and destructive public health infrastructures (potable water networks and housing) in their countries of origin (Pavli & Maltezou, 2017; Hameed, Sadiq, & Din, 2018). Also, many factors are involved in refugees being at great risk of infectious diseases, such as living in unsanitary conditions, overcrowding, malnutrition, lack of personal and food hygiene, and minimal or interrupted access to basic healthcare services during travel (Pavli & Maltezou, 2017; Hameed, Sadiq, & Din, 2018).

A study based on the report “Key Infectious Diseases in Migrant Populations in the European Union and the European Economic Area” (Williams, et al., 2016) revealed that 25% of the 73 996 tuberculosis cases in the EU/EEA in 2010 were identified in people of foreign origin (Odone, et al., 2015). Also, almost 40% of new HIV infections in EU/EEA were reported

in people of foreign origin (WHO, 2018). There is a suggestion that a large number of refugees and migrants with HIV, including those who originate from countries where HIV is highly prevalent, acquired the infection after arriving in the Region (WHO, 2018).

Health problems among refugees and migrants upon arrival are associated with events and circumstances previously experienced in their countries of origin or during travel. Health issues found in migrants and refugees upon arrival include hypothermia, accidental injuries, gynaecological and obstetric complications, gastrointestinal and respiratory diseases, dermatological problems, and metabolic illnesses (Pavli & Maltezou, 2017). The prevalence of non-communicable diseases (NCDs) among refugees and migrants upon arrival is lower than in the host population (WHO, 2018). However, the longer migrants stay in the host country, the prevalence rates of NCDs start to converge between migrants and the host population (WHO, 2018). A retrospective cohort study was conducted in Italy to quantify the prevalence of diabetes, congestive heart failure, and coronary heart disease among 1,948,622 adults aged 16 years or more by their citizenship. The results revealed that the age-standardized prevalence of diabetes among immigrants from high migratory pressure countries was higher than among Italian citizens and immigrants from highly developed countries (Buja, et al., 2013).

Mental disorders pose a great challenge to the health of migrants. Migration is regarded as a stress-inducing phenomenon, and migrating individuals -whether children or adults- are susceptible to mental disorders (Bempong, et al., 2019; Bhugra, 2004). Exposure to violence and unaccompanied movement are the main risk factors for children's mental health (Bempong, et al., 2019). Also, there is a suggestion that the lack of social integration is an important factor that affects mental health in adults (Bempong, et al., 2019).

In a world that remains affected by armed conflict, massive numbers of forcibly displaced people with increased mental health needs and illnesses have resettled around the world. Europe has a large share of refugees and asylum seekers. War and torture rank among the most traumatic events an individual may experience (Abu Suhaiban, Grasser, & Javanbakht, 2019). Exposure to traumatic events is associated with a higher risk of a spectrum of mental disorders, most commonly post-traumatic stress disorders, depression, higher risk of suicide (Abu Suhaiban, Grasser, & Javanbakht, 2019), and substance or alcohol misuse (Almoshmosh, 2016).

Evidence on mental disorders in migrants varies among different studies (Rachel, Mladovsky, Ingleby, Mackenbach, & Mckee, 2013). Refugee, asylum-seeker, and undocumented migrant groups are considered at higher risk of mental illness owing to exposure to mental health risk factors (exposure to war and violence in origin countries,

challenges during travel, stressors during resettlement) (Rachel, Mladovsky, Ingleby, Mackenbach, & Mckee, 2013; Bogic, Njoku, & Priebe, 2015).

1.4 Refugee statistics:

During the past two decades, the world has witnessed a significant increase in the number of forcibly displaced persons (UNHCR, 2017). This increase was most remarkable between 2012 and 2015 (UNHCR, 2017). It was driven mainly by the Syrian conflict along with other conflicts in Iraq and Yemen, as well as in sub-Saharan Africa (UNHCR, 2017). Forcibly displaced population swelled from 33.9 million forcibly displaced persons in 1997 to 65.6 million in 2016; 22.5 million were classified as refugees (UNHCR, 2017). In 2017, there were 44,400 persons forced to flee their homes daily due to new conflicts that broke out in the Democratic Republic of Congo and Myanmar, as well as the ongoing Syrian conflict (UNHCR, 2018). At the 2017 year's end, an estimated 2.9 million were added to the forcibly displaced population, raising the cumulative total to 68.5 million (UNHCR, 2018). Forced displacement remains at a record high, where approximately 25 people were forcibly displaced every minute in 2018 (UNHCR, 2019). At the end of 2018, the forcibly displaced population swelled to reach 70.8 million around the world, including 25.9 million refugees (UNHCR, 2019).

"Syria is the biggest humanitarian and refugee crisis of our time, a continuing cause of suffering for millions which should be garnering a groundswell of support around the world", said United Nations High Commissioner for Refugees Filippo Grandi (UNHCR, 2016).

Millions of Syrians hurriedly packed their luggage and fled across borders to escape the bombs and bullets since the onset of the war in 2011; this made Syria the country with the highest forcibly displaced population worldwide (UNHCR, 2017). At the end of 2016, there were 12 million forcibly displaced Syrians (650 out of every 1,000 of the national population) (UNHCR, 2017). In 2017, Syria remained the country with the highest forcibly displaced population with an estimated 12.6 million at the year's end, 6.3 million of them were classified as refugees; this number represents nearly one-third of the world's refugee population under the UNHCR's mandate, it also reflects a 14 percent increase since 2014 (UNHCR, 2018). In 2018, Syrians ranked the second largest newly displaced population (889,400 people); of these, 632,700 were displaced outside the Syrian borders (UNHCR, 2019). At the end of the year, the number of Syrian refugees grew, raising the cumulative total to 6.7 million (UNHCR, 2019). In 2018, as has been the case since 2014, Syria remained the country from which the largest group of refugees originate (Fig. 2.1) (UNHCR, 2019).

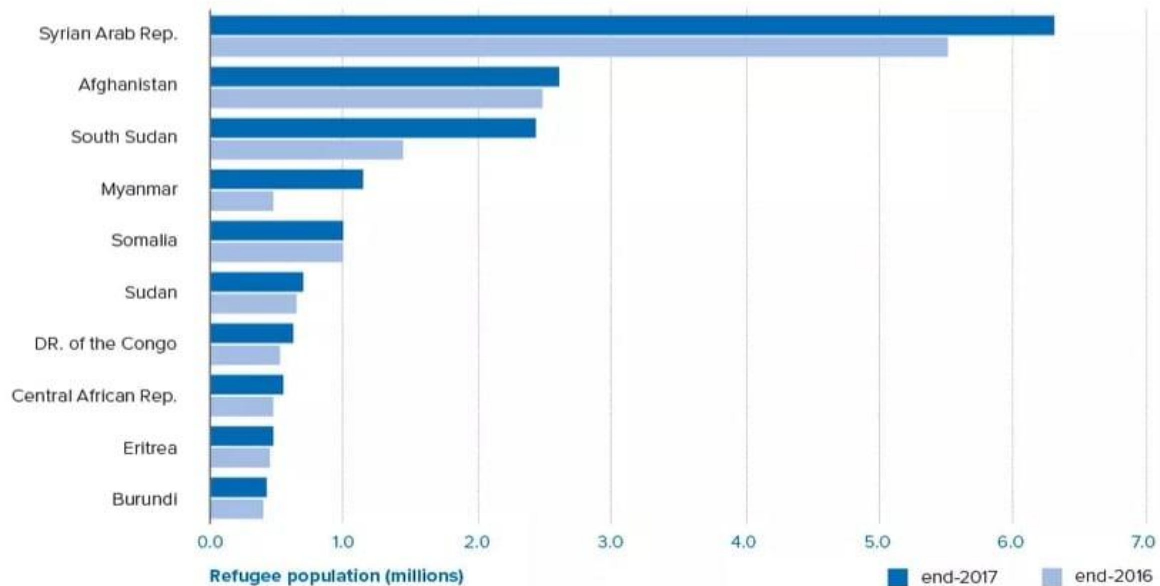

Figure 2: Major source countries of refugees

Source: United Nations High Commissioner for Refugees, 2018.

The vast majority of refugees remain close to their countries. According to the UNHCR 2018 statistics, 98 percent of the 3.7 million refugees in Turkey originate from Syria (UNHCR, 2019). Moreover, almost all of the 1.4 million refugees hosted in Pakistan in 2016 were from Afghanistan (UNHCR, 2017). However, remarkable numbers of displaced people seek protection abroad, taking dangerous routes and risking their lives. Many Syrians have arrived at the European shores since the war had started; they made up the single largest refugee group arriving in Europe, followed by Afghans (UNHCR, 2015). In 2014, Syrians made up 32% of arrivals (69,000 reached Europe using maritime routes) (UNHCR, 2015). In the first half of 2015, 43,900 arrived in Europe, constituting 34% of arrivals (UNHCR, 2015).

Syrian refugees are hosted by 127 countries on six continents (UNHCR, 2019). Turkey has the “lion share” of Syrian refugees (3.6 million by the 2018 year’s end) (Park, 2015). Also, significant numbers of Syrian refugees are hosted in Lebanon (944,200), Jordan (676,300), Iraq (252,500), and Sudan (93,500) (UNHCR, 2019). The top European receiving countries for Syrian refugees are Germany (532,100) and Sweden (109,300) (UNHCR, 2019).

1.5 Access and barriers to healthcare:

Access to healthcare is confusing to define and measure. According to the 1983 President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioural Science Research, societies are responsible for providing equitable access to healthcare as follows: "Equitable access to healthcare requires that all citizens be able to secure an adequate level of care without excessive burdens" (Millman, 2015). The President's Committee definition is associated with many conceptual problems; these conceptual problems revolve around defining what an adequate level of care is, what to consider an excessive burden, and how to know when these standards are met or even exceeded (Millman, 2015). The IOM Committee set up a new definition of the term "**Access**" as follows: "the timely use of personal health services to achieve the best health outcomes" (Toscos, Carpenter, Flanagan, Kunjan, & Doebbeling, 2018); this definition overcomes the conceptual problems related to the description provided by the President's Commission, it also clarifies that health outcomes are as integral to access as services utilization is (Millman, 2015).

Many variables play a role in healthcare access, such as age, gender, race, ethnicity, socioeconomic means, and geographic location (2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy, 2016). Good access to healthcare requires access to basic healthcare services (Toscos, Carpenter, Flanagan, Kunjan, & Doebbeling, 2018). Also, it requires an adequate allocation of healthcare providers (Toscos, Carpenter, Flanagan, Kunjan, & Doebbeling, 2018). Healthcare providers should have the potentials to meet their patients' individual needs; they should also have the ability to build trustful relationships with patients (Toscos, Carpenter, Flanagan, Kunjan, & Doebbeling, 2018).

Access to healthcare can be measured using many variables that go beyond health insurance or sufficient services allocation, such as the contact accessibility (how easy is it to contact a healthcare provider in order to book an appointment?), appointment accessibility (how long the time is to get an appointment?), and geographical accessibility (can patients physically reach the health facility or not?) (Hall, Lemak, Steingraber, & Schaffer, 2018).

Barriers to healthcare are structural, financial, or cognitive (Carrillo, et al., 2011). Healthcare barriers hamper access to curative, diagnostic, or preventive care; this might result in health disparities and poor health outcomes among vulnerable populations (Carrillo, et al., 2011). Structural barriers can be defined as the gaps in a health system's availability in terms

of number, type, concentration, location, or organizational configuration of clinics and hospitals (Millman, 2015; Carrillo, et al., 2011). Structural barriers are represented by the lack of transportation, long waiting time in clinics or to get an appointment, and absence of continuity in healthcare provision (Carrillo, et al., 2011; Levesque, Harris, & Russell, 2013). Financial barriers are related to healthcare costs and health insurance status (uninsured persons) (Carrillo, et al., 2011). Financial barriers can lead to inability of patients to pay directly for needed health services or discourage healthcare providers from treating patients of low or limited means (Millman, 2015). Cognitive barriers are associated with knowledge and communication. Communication barriers result from language and cultural differences (Carrillo, et al., 2011). Knowledge barriers are associated with health literacy and the ability of patients to understand the diagnosis or treatment (Carrillo, et al., 2011).

1.6 Barriers to healthcare for refugees in Europe:

The vast majority of refugees -both from Syria or other countries- reach Europe by sea (Clayton, Holland, & Gaynor, 2015). People on the move extremely lack access to primary healthcare, and even after resettlement in Europe, there is no guarantee for their safety or health (Daynes, 2016). During resettlement, refugees struggle to access health services due to financial, administrative, and legislative challenges that the different actors responsible for providing them with healthcare face (Chiarenza, Dauvrin, Chiesa, Baatout, & Verrept, 2019). As a result, refugees' access to specific health services is limited; these services include mental care, sexual and reproductive care, and child and adolescent care (Chiarenza, Dauvrin, Chiesa, Baatout, & Verrept, 2019).

According to data from a sample of 23,040 patients gathered at Doctors of the World clinics in 25 European cities, only 45.8% of pregnant women had access to antenatal care (Daynes, 2016). Also, only 34.5% of children were vaccinated against mumps, measles, and rubella, while 42.5% were vaccinated against tetanus (Daynes, 2016). One in five patients gave up trying to seek medical care or treatment due to inadequate understanding of their entitlements, language difficulties, and financial and administrative barriers (Daynes, 2016).

Many studies have been conducted to address the barriers to healthcare services for refugees in Europe. A systematic review was conducted by Satinsky E et al. (2019) to investigate the access and barriers to Mental Health and Psychosocial Support (MHPSS) services for refugees and asylum seekers in the European Union Single Market countries. The results revealed that various barriers, such as language, help seeking behaviours, lack of awareness, stigma, and negative attitudes by providers and towards them lead to inadequate access to and utilization of MHPSS services (Satinsky, Fuhr, Woodward, Sondorp, & Roberts, 2019).

Of around one million Syrian refugees in Germany, only one percent had previous knowledge of the German language before arriving (Green, 2017). Inability to communicate fluently was a challenge for refugees to obtain quality healthcare and meet the various physical and mental health needs acquired while fleeing the war (Green, 2017).

A study was conducted by Kohlenberger J et al. (2019) to investigate the barriers to healthcare for refugees in Austria. The study used data from the Refugee Health and Integration Survey (ReHIS). ReHIS sample included 515 refugees; 54% of them were Syrians (Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019). Although participants

expressed high satisfaction with the healthcare provided in Austria, 20% of males and 40% of females reported unmet health needs (Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019). Barriers to healthcare were long waiting times, language difficulties, and inadequate knowledge about healthcare providers (Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019).

A study was also conducted to illuminate the experience of newly arrived refugees with the Swedish healthcare system (Mangrio, Carlson, & Zdravkovic, 2018). More than 70% of newly arrived refugees in the province of Scania were in need of healthcare (Mangrio, Carlson, & Zdravkovic, 2018). The reasons for not seeking healthcare were the high costs, long waiting times, and language barriers (Mangrio, Carlson, & Zdravkovic, 2018). Some newly arrived refugees were denied medical care while seeking emergency treatment for stomach problems; they were also denied follow-up care for diabetes (Mangrio, Carlson, & Zdravkovic, 2018).

1.7 Portugal as a state of relocation and resettlement:

The European Commission, adhering to the principles of solidarity and burden-sharing, established the Relocation Scheme in 2015 to address the recent refugee crisis in the European Member States (Atanasova, 2016). The Relocation Scheme is an intra-EU mechanism to relocate 160,000 eligible asylum seekers from Greece and Italy -the most affected EU countries by the crisis of refugees- to the other EU Member States to ease the burden on these frontline countries (Relocation and Resettlement: EU Member States urgently need to deliver, 2016; Sabic, 2017; Atanasova, 2016). Also, the Commission showed solidarity with non-European countries evenly affected by the influx of refugees, such as Turkey and Egypt, by establishing a resettlement scheme for 20,000 persons in need of international protection (Relocation and Resettlement: EU Member States urgently need to deliver, 2016). The Resettlement Scheme includes the transfer of persons in definite need of international protection (defined and referred by the UNHCR) from a non-European country to an EU Member State that approved admitting them as refugees (UNHCR, 2015). Resettlement is a durable solution that provides refugees with legal and safe routes, thus preventing them from the risk of putting their lives in the hands of smugglers.

Portugal has not escaped the surge of refugees in the region. Between the years 2014 and 2017, the number of asylum applications in Portugal tripled after the yearly average was constant during the fifteen years from 2000 to 2014 (200 asylum applications per year) (Damas de Matos, 2019). The number of asylum requests recorded 1,750 in 2017 and 1,285 in 2018 (Neto, et al., 2019; Damas de Matos, 2019). Refugees and asylum seekers arrive in Portugal through four different routes (Neto, et al., 2019; Damas de Matos, 2019; IOM, 2018):

- Spontaneous asylum seekers independently made the journey to Portugal and claimed asylum upon arrival.
- Taking part in the EU Relocation Scheme, Portugal relocated 356 asylum seekers from Italy and 1,192 from Greece between late 2015 and March 2018.
- 142 Syrian refugees were resettled from Turkey to Portugal under the EU-Turkey 1:1 Agreement -which states that for every Syrian refugee that will be returned from Greece to Turkey, another would be resettled from Turkey to Europe.
- Under the EU Resettlement Scheme, almost 80 persons resettled from transit countries like Egypt and Morocco from 2015 to 2017.

The vast majority of asylum seekers and refugees who arrived in Portugal under the EU schemes originate from three countries: Syria, Iraq, and Eritrea (Damas de Matos,

2019). On the other hand, spontaneous asylum seekers usually come from the countries from which there is an immigrant population in Portugal, like Angola and Ukraine (fig. 3.1) (Damas de Matos, 2019).

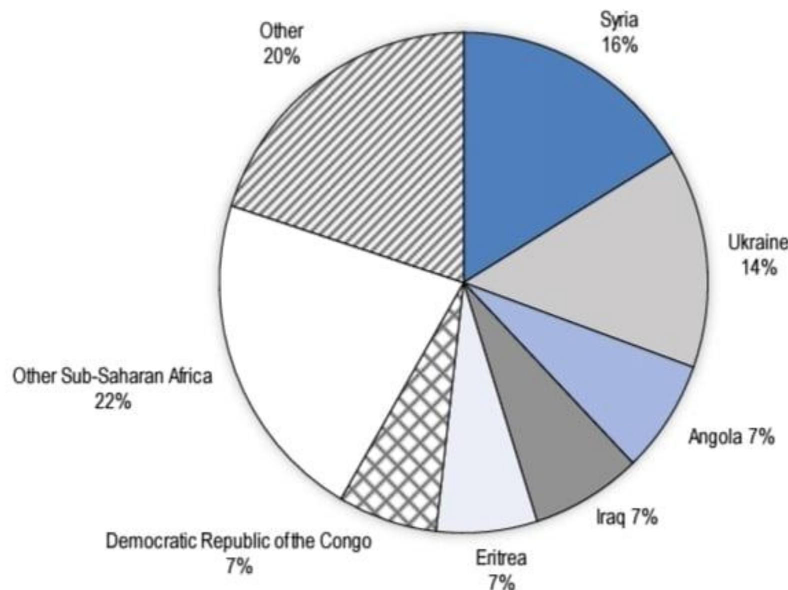

Figure 3.1: The distribution of asylum seekers by citizenship

Source: Damas de Matos, 2019.

The reception and integration of asylum seekers and refugees cover the first needs of healthcare, accommodation, and monthly living allowance. However, the procedure differs between those who arrive in Portugal spontaneously or under the EU schemes. There are many parties involved in the process of reception and integration of spontaneous asylum seekers. The process starts when an asylum seeker submits an asylum application to the Immigration and Border Services (SEF) (Damas de Matos, 2019). The SEF notifies the Portuguese Refugee Council (CPR) of all the asylum applications (Damas de Matos, 2019). The CPR then steps in the process by providing asylum seekers with legal counselling, accommodation, and monthly living allowance (Carreirinho, 2019). It also provides early integration support services, such as language courses and different workshops (Damas de Matos, 2019). After asylum seekers receive a temporary residence permit, a steering committee led by the Institution of Social Security (ISS) will plan their integration (Damas de Matos, 2019).

The integration system of refugees and asylum seekers who come to Portugal through the EU schemes was designed in 2015 by the inter-departmental Working Group for the European Agenda on Migration (Damas de Matos, 2019). Asylum seekers have to fill an asylum claim after arrival, and then they get referred to a hosting entity responsible for their

integration for 18 months (Damas de Matos, 2019). Some hosting entities, like those belonging to the Refugee Support Platform (PAR), offer longer integration programs that last up to 24 months (Damas de Matos, 2019). Refugees resettled to Portugal under the EU Resettlement Scheme do not have to submit an asylum application, and they are immediately referred to a hosting entity upon arrival (Damas de Matos, 2019).

Between 2015 and 2018, 36% of asylum seekers were hosted by the Refugee Support Platform (PAR), 22% by the Portuguese Refugee Council (CPR), 16% by municipalities, 9% by the Union of Portuguese Mercies (UMP), 10% by the Portuguese Red Cross (CVP), and 10% by other institutions (fig. 3.2) (Damas de Matos, 2019).

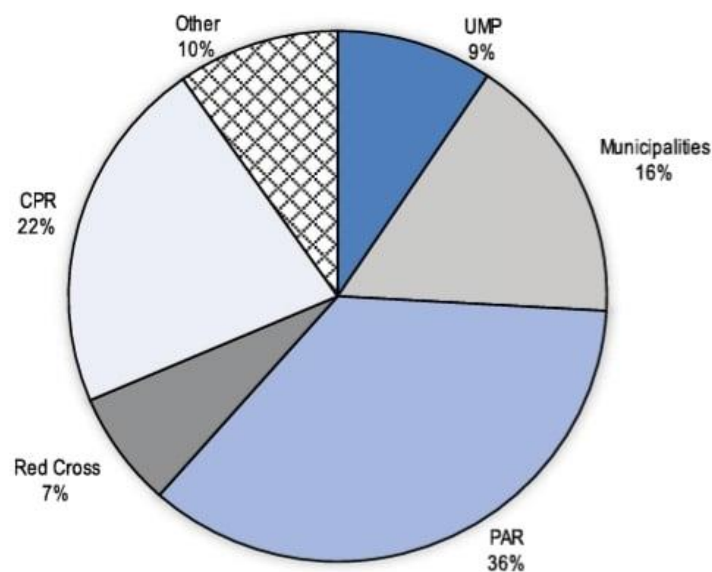

Figure 3.2: Distribution of asylum seekers under the EU schemes among hosting entities

Source: Damas de Matos, 2019.

The integration system's main objectives are: learning the local language, getting familiar with the culture, understanding how the local institutions work, and getting a job. Thus, helping asylum seekers and refugees integrate into society and develop means of subsistence and future independence (Neto, et al., 2019). Three months before the integration program finishes, there is a phasing out of the program —the ISS will then be in charge of integrating beneficiaries of international protection (Damas de Matos, 2019).

The Portuguese Ministry of Health plays a significant role in integrating asylum seekers and refugees by providing them with healthcare services according to needs (Damas de Matos, 2019). According to the Asylum Act in Portugal, refugees and asylum seekers and their dependents are covered by the Portuguese National Health System (SNS) under the same conditions as natives; they have access to primary, specialist, and emergency

healthcare free of charge (Carreirinho, 2019). Also, they have the right to medicines subsidized by the SNS to be provided by the health services of their residence area (Carreirinho, 2019). However, there are out of pocket payments that must be done for some types of specialized care (ophthalmologists) and dental care.

Health coverage for asylum seekers and refugees expands to include the right to tailored healthcare for vulnerable persons, including mental treatment, under the same conditions as natives (Carreirinho, 2019). From the moment an asylum seeker or a refugee arrives in Portugal, the hosting entity in charge of his/her integration coordinates his/her registration in a local health centre (Damas de Matos, 2019). While providing healthcare for refugees and asylum seekers in Portugal, the unique needs of vulnerable persons (those exposed to violence or torture) are considered (Carreirinho, 2019). The provision of healthcare for torture survivors lies with the ISS (Carreirinho, 2019). Refugees and asylum seekers are provided with information regarding their entitlements and how to access SNS services upon arrival.

In practical terms, many challenges face the Portuguese National Health System in providing healthcare for the refugee population (Damas de Matos, 2019; Neto, et al., 2019). According to previous research, these challenges are defined by the lack of knowledge about entitlements and how to access healthcare services (Neto, et al., 2019), linguistic and cultural barriers (Neto, et al., 2019) (Damas de Matos, 2019), and stigma (Damas de Matos, 2019). Refugees' access to diagnostic procedures and medications covered by the SNS is limited due to bureaucratic constraints (Carreirinho, 2019). Access to specialized healthcare and dental care is also restricted (Carreirinho, 2019).

The High Commission for Migration (ACM) –the governmental body responsible for providing integration services for refugees and migrants in Portugal- hired Arabic, Farsi, and Tigrinya translators to address language barriers (Damas de Matos, 2019). Healthcare providers can use the ACM's Telephone Translation Services (TTS) by pre-reserved appointments; it can also be used on the spot depending on a translator's availability (Damas de Matos, 2019). However, language remains a barrier for refugees while seeking healthcare (Carreirinho, 2019); this can be attributed to restrictions on healthcare providers' access to translation services (there is no priority line for them) (Damas de Matos, 2019). Healthcare providers are sometimes reluctant to use TTS services (Damas de Matos, 2019).

Providing adequate mental treatment for the heterogeneous and culturally dynamic refugee group in Portugal poses a significant challenge (Neto, et al., 2019). Apart from some small-scale initiatives, there is no special provision of mental care targeting refugees (Damas de Matos, 2019). An example of these initiatives is the practice at the

Temporary Reception Centre for Refugees in Lisbon (refugees meet a psychologist as a part of their reception routine) (Damas de Matos, 2019). Another example is establishing a protocol between the ACM and the Portuguese Psychologist Professional Order (Damas de Matos, 2019). The protocol states that a network of psychologists is willing to support the ACM or other hosting entities with providing need-based mental health services (Damas de Matos, 2019).

2. Aim and objectives:

• Aim:

This thesis aims to assess the health status of Syrian refugees in Portugal. Also, it seeks to identify the perceived barriers to the Portuguese National Health System (SNS).

• Objectives:

1) To assess Syrian refugees' subjective wellbeing.
2) To assess Syrian refugees' physical and mental health.
3) To address the unmet health needs of Syrian refugees.
4) To assess Syrian refugees' utilization of SNS healthcare services.
5) To identify the common barriers to SNS services faced by Syrian refugees.
6) To assess Syrian refugees' satisfaction with healthcare provided by the SNS.

3. Methodology:

• Study design:

This research uses primary data from a survey of Syrian refugees aged 18 or more and based in Portugal. A quantitative self-administered questionnaire was used for data collection. The questionnaire was administered online using Google Forms as a survey tool. The researcher attached all the information about the study, participants' rights, privacy, and confidentiality on the first page of the survey. The ethics committee of the Institute of Public Health of the University of Porto (ISPUP) has approved the study, and participants' consent was obtained through presenting the consent in the questionnaire as an item that must be endorsed so the survey can be completed. Refugees were initially invited to participate in the study by uploading informative posts in Facebook groups assigned to them, where interested participants have contacted the researcher and expressed their interest in the study. Also, phone calls were made to invite potential participants of the researcher's acquaintances who meet the eligibility criteria. Thereafter, each participant was asked to nominate one or more other potential participants; thus, a snowball sample of 38 Syrian refugees was approached for the research. The URL hosting the questionnaire was sent via email or social media (depending on each participant's preference).

• Data collection:

For the survey, we used a large part of the same questionnaire used for the Refugee Health and Integration Survey (ReHIS) in its Arabic Version. ReHIS is an interim survey incorporated into a panel study on the participation of Syrian, Iraqi, and Afghan refugees in the labor market in Austria, one of the most heavily affected countries by the crisis of refugees in Europe. The questionnaire addresses the following main themes: self-rated health, access to healthcare services, satisfaction with healthcare services, psychosocial stress and resulting restrictions, discrimination experiences and demography (Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019). Of these, we selected twenty eight questions that address self-rated health, physical health status, mental wellbeing and mood, unmet health needs, utilization of healthcare services, the most frequent barriers to healthcare, and satisfaction with the Portuguese National Health System (SNS).

4. Results:

Thirty-eight persons were invited to take part in the study; thirty-six (94.7%) have completed the survey, while two (5.3%) have not shown an interest in participating in the study. The sample included seventeen males (47.2%) and nineteen females (52.8%). The age of respondents ranged from 18 to 62 years; the vast majority were in the age group 20 - 46. There was a balance in the distribution of married and single refugees (each constitutes 36.1% of the sample), while 19.4% were in a relationship and 8.3% were divorced. High school was the highest education that 41.7% of participants achieved, 38.9% acquired tertiary, while 5.6% have not received any education. Most of the sampled refugees were unemployed (86.1%). Lisbon, Porto, and Coimbra ranked the top receiving provinces for refugees, 33.3%, 27.8%, and 13.9%, respectively. In contrast, few refugees are based in Setúbal, Leiria, Beja, Viana do Castelo, Braga, Aveiro, and Vila Real.

- ## Subjective wellbeing:

Participants' subjective wellbeing was assessed using the question "*would you describe your current state of health as*: *1) very good, 2) good, 3) satisfactory, 4) not very good, 5) poor"* that was developed as a part of the SF-36 survey (Ware JR, 2000). Answering options "don't know" and "refusal" were also included. Many refugees rated their health as very good (30.6%) and good (36.1%), while 11.1%, 5.6 %, and 11.1% reported satisfactory, not very good, and poor health status, respectively.

- ## Physical health:

Physical health status was assessed using three questions. The first question was "*for at least half a year, to what extent have you been limited because of a health problem in activities people usually do*?". Answer options being: "*severely limited*," "*limited, but not severely*," "*not limited at all*," "*don't know*," and "*refusal*." Almost half of the participants reported limitation in activities attributed to a health problem (47.2 of the sample); 8.3% expressed that the limitation was severe. However, 33.3% did not express having any health-related restrictions. The second question aimed to assess on a scale of ten the grade to which participants feel fit to work, where "*not fit to work at all*" coded as 1, while "*altogether fit to*

work" coded as 10. The options "*don't know*" and "*refusal*" were included as well. Answers ranged from 1 (19.4%) to 10 (36.1%); the median value is 9. The third question was "*overall during the past four weeks, how often did you have physical pain*?". Possible answers being "*not at all*," "*several days*," "*more than half of the days*," "*nearly every day*," "*don't know*," and "*refusal*." A remarkable number of participants revealed having physical pain (72.2%): 52.8% had physical pain on several days, 8.3% on more than half of the days, while 11.1% expressed having daily physical pain. Those who had pain during the month prior to the survey were asked about the pain's severity "*very mild*," "*mild*," "*moderate*," "*severe*," "*extreme*"; 19.2% described the pain to be extreme.

- ## Wellbeing and mood:

Wellbeing and mood were assessed using the wording *"over the past two weeks, how often did you feel restricted in your life due to the following symptoms?"*. Symptoms addressed: pleasure in doing things; depression, sadness, or hopelessness; sleeping problems; tiredness or low energy; poor appetite or overeating; problems in concentration; bad feelings related to oneself; anxiety and nervousness; difficulties in relaxing; restlessness; fear; having nightmares; and irritability. Answer options being "*not at all*," "*several days*," "*more than half of the days*," "*nearly every day*," "*don't know*," and "*refusal*." The results indicate that 69.5% of participants had little interest in doing things, of whom; 13.9% reported having this symptom daily. Refugees who reported having bad feelings (depression, sadness, or hopelessness) made up 63.9% of the sample, while 77.7% expressed tiredness or having low energy. Also, 69.4% had sleeping problems, and 50% were overeating or had a poor appetite. More than half of surveyed Syrian refugees (58.3%) expressed having bad feelings towards themselves as if they failed or disappointed their families. It was challenging to concentrate on some days for 58.4% of participants, and 69.5% felt nervous, anxious, or on edge; of whom, 5.6% had these feelings daily. Worrying was widespread among a remarkable number of surveyed refugees, where 50.1% could not stop or control worrying, 66.8% expressed worrying too much about different things. For 58.3% of respondents, it was challenging to relax. Furthermore, 27.8% of participants feel restless that it is hard to sit still on several days. The vast majority of respondents reported becoming easily annoyed or irritable on several days (47.2%), more than half of the days (13.9%), or nearly every day (8.3%). Approximately half of the participants (47.2%) had a fear of something awful might happen, and 36.2% reported having nightmares.

- Utilization of healthcare services:

Participants' experience with the Portuguese National Health System (SNS) was assessed. Utilization of healthcare services during the year before the survey was measured using two items with the possibility of multiple answering. The first question assessed the utilization of doctors or therapists: "*did you visit a doctor or therapist during the past 12 months?*". If yes: "*which of the following doctors or therapists did you visit*?". 69.4% of the sample reported consultation of a doctor or therapist. General practitioners were the most consulted (72% of total consultations). Dentists and specialists were equally consulted by refugees (each constitutes 16% of total consultations). Psychologists, psychotherapists, and psychiatrists were the least utilized (8%). Consultations of physical therapists also counted 8%. The second question addressed the utilization of hospital treatment. Possible answers being: "*yes, as an inpatient*," "*yes, as a day patient*," "*no*," "*don't know*," and "*refusal*." Of the sample, 66.7% did not mention utilization of hospital treatment; 13.9% reported use of hospital treatment as inpatients, and 19.4% as day patients.

- Unmet health needs and the most frequent barriers to healthcare service utilization:

The question *"Would you have needed one of the following doctors or therapists during the year before the survey but did not consult them?"* was used to address the unmet health needs of Syrian refugees. Of the sample, 55.6% reported unmet health needs. Dental care ranked the top needed healthcare that has not been met (70% of responses), followed by general practitioners (50%) and specialists (35 %).

Respondents who expressed unmet health needs were asked about the most important reasons not to seek a consultation or treatment. Possible answers being "*Could not afford to (too expensive),*" "*I had to wait too long to get an appointment, or: I am on a waiting list,*" "*The treatment/consultation is not possible for me because of my schedule,*" "*It was not possible for me to physically reach the facility,*" "*I am afraid of the treatment or the doctor,*" "*I don't understand the language, or: I cannot explain what my problem is,*" "*I don't know if my problem can be solved,*" "*I don't trust the doctors here in Portugal,*" "*I'm waiting to see whether the problem will become better on its own,*" "*Don't know a good doctor/therapist*," "*Don't know,*" and "*Refusal.*" Multiple answers were allowed. The most frequent healthcare barriers perceived by Syrian refugees were the high costs (75% of responses) and long waiting lists (55%). Language difficulties were significantly perceived as a barrier to access health services

as well (50%). Other reasons for leaving health problems untreated are the lack of knowledge about and trust in healthcare providers in Portugal, inability to physically reach the health facility, waiting for the condition to improve without treatment, and schedule conflict.

- Satisfaction with healthcare provided by the SNS:

Refugees' satisfaction with healthcare provided by the Portuguese National Health Service (SNS) was assessed using the question: "*In a scale of ten, how well do you currently feel provided for in terms of healthcare in Portugal*?", where "*Very bad*" coded as 1 and "*Very good*" coded as 10. Answers ranged from 1 (22.2%) to 10 (11.1%), with seven refugees answering with 5 (22.2%). The median value for refugees' perception of health care provision quality is 5.

5. Discussion:

Syrian refugees are a new and rapidly growing population in Portugal. According to the United Nations, the Syrian conflict resulted in the worst humanitarian crisis since the Second World War, where more than half of the population were forcibly displaced (Al-Rousan, Schwabkey, Jirmanus, & Nelson, 2018). Previous research indicates a higher vulnerability to physical and mental health problems within this population (Georgiadou, Zbidat, Schmitt, & Erim, 2018; Kiselev, et al., 2020). Besides, many barriers challenge Syrian refugees' access to healthcare services in host countries, even in resource-rich ones like Germany and Canada (Green, 2017; Oda, et al., 2017). There is a gap in the research related to refugees' health, access, and barriers to the Portuguese National Health System, particularly Syrian refugees who, to our knowledge, have not yet been assessed.

Syrians have experienced a bloody and tragic conflict for years. Based on previous research in this area, we assume that Syrian refugees have unique healthcare problems and needs different from these of the local population; this should be considered while providing them with healthcare. We also suggest that barriers to healthcare may exist; this could be attributed to linguistic and cultural differences, financial difficulties, lack of knowledge on entitlements and how to use healthcare services, or other reasons.

Health problems and unmet health needs among refugees place a greater burden on host countries (Oda, et al., 2019). Timely access to quality healthcare is essential for good health and successful integration (Oda, et al., 2019). The major goals of health systems are: improving health, providing services according to needs, and establishing systems of fair financing (Vidal, Pontes, Barreira, Oliveira, & Maia, 2018). Adequate access to healthcare for everyone is among the SNS's implementation pillars (Vidal, Pontes, Barreira, Oliveira, & Maia, 2018). Answering the questions "how the health of Syrian refugees is?" and "how Syrian refugees are provided in terms of healthcare in Portugal?" is a step towards addressing the gap in this area of research, and thus developing an appropriate service response to this population's needs.

This research provides a snapshot of the state of health among Syrian refugees. Also, it investigates the quality of healthcare services provided to them by the SNS. The sampled refugees constitute a heterogeneous group. There was a wide variety in terms of marital status and educational level within the surveyed group. Females were over-represented within the sample than males (52.8% versus 47.2%). A high proportion of the group only acquired high school (41.7). The percentage of refugees who achieved tertiary

education was remarkably high (38.9%) compared to data available on the educational attainment among refugees and natives in Portugal, which indicate that only 5% of refugees and 22% of Portuguese natives achieved some tertiary education (Damas de Matos, 2019).

Compared to available data on self-rated health among the Portuguese population (INE, 2020), Syrian refugees are more likely to rate their health as very good or good (50% versus 66.7%, respectively). A slightly higher percentage of our sample rated their health as not very good or poor (16.7% compared to 15.1% of the local population). Findings corroborate the general tendency of refugees to self-rate their health better than natives.

Findings from physical and mental assessment revealed high prevalence rates of physical problems and psychosocial stress among the surveyed sample. The results are in line with previous studies that assessed Syrian refugees (Tinghög, et al., 2017; Abou-Saleh & Hughes, 2015). High rates of psychosocial stress likely result from trauma experienced during the conflict and travel, as well as the many various challenges related to migration, including separation from family members, obstacles to properly use healthcare services as a result of stigma, linguistic and cultural differences, lack of financial means, and lack of knowledge about the Health System in Portugal. Poor physical health can be explained by diseases and injuries acquired before and during migration and have not been addressed. Also, it can be attributed to health needs that emerged during resettlement and have not been met.

Results from self-rated health reveal a good state of health among refugees; this conflicts with their actual health. This conflict can be attributed to unawareness among refugees about their symptoms and the possibility that these symptoms are associated with health problems (the illness itself can prevent them from understanding what is happening). Cultural factors may be involved in the high self-rated health among participants but require further research.

Utilization of healthcare services was measured during the year preceding the survey. Of the participants, 69.4% consulted a doctor or a therapist during that period; this is remarkably low compared to wealthier European countries like Austria, where previous research indicates that almost all the refugees based there have consulted a healthcare provider within a similar period (Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019). General practitioners were the most used (72% of consultations). Specialists and dentists consultations were remarkably low (each constitutes 16% of consultations). Despite the high prevalence of psychosocial stress among participants, psychologists, psychiatrists, and psychotherapists were the least consulted. Our results are in line with previous research, where available data reveal that almost one-quarter of the refugee population in Portugal is not receiving the mental healthcare it needs (Neto, et al., 2019).

More than half of the sample reported unmet health needs (55.6%) against some 3% of the Portuguese population (OECD, 2019). Dentists were the most needed healthcare that could not have been met (70%), followed by general practitioners (50%) and specialists (35%). Costs of healthcare pose the top perceived barrier for not seeking healthcare. These costs are likely associated with co-payments for ophthalmic treatment or dental care, as the latter is mainly provided by the private sector through direct payment or through voluntary health insurance. Like in many European countries, long waiting times and language difficulties are salient barriers for refugees to accessing healthcare services (Mangrio, Carlson, & Zdravkovic, 2018; Kohlenberger, Buber-Ennser, Rengs, Leitner, & Landesmannd, 2019; Daynes, 2016). Inability to physically reach the health facility was also indicated as a barrier. Geographical barriers are likely attributed to the imbalance in services distribution, where the hospitals located outside metropolitan areas -Lisbon, Porto, and Coimbra- do not provide all medical specialties (OECD, 2019). Other barriers to healthcare for Syrian refugees are schedule conflict, lack of knowledge about doctors, and lack of trust in healthcare providers as they have been perceived unfriendly.

However, the registration process in the SNS and information flow about healthcare providers and services access differ between hosting entities. Further research should be done to address how health and access to healthcare for refugees vary depending on the hosting entity.

6. Recommendations:

Although many initiatives have been taken in Portugal to overcome the barriers facing refugees while seeking healthcare, more efforts should be made towards improving the health and quality of healthcare provided for this vulnerable group. Based on the findings, we recommend that:

1) A medical assessment to Syrian refugees upon their arrival in Portugal should be conducted. Results from this assessment should be shared with healthcare providers and considered in healthcare provision.
2) Meeting with a psychologist should be a part of the reception routine for Syrian refugees; this would help address their mental health needs and provide adequate health responses.
3) Campaigns that target the public and healthcare providers to increase awareness about refugees' suffering should be conducted; this would help reduce the stigma and unfriendly behaviours towards this population.
4) Healthcare providers should be given a priority line with Telephone Translation Services provided by the ACM to overcome language difficulties.
5) Fostering translation services by providing Web-based translation services in order to address the barriers related to language.
6) Walk-in clinics that provide healthcare for refugees (including mental care) should be established. These clinics should include an Arabic translator and a cultural mediator. Such clinics help overcome language difficulties, provide culturally appropriate health services, and establish a sense of familiarity and trust among Syrian refugees.
7) Subsidized dental treatment for Syrian refugees should be provided in line with available resources.
8) The social needs of Syrian refugees should be addressed during resettlement. Addressing social needs can be associated with better health outcomes, especially on the mental health level (Neto, et al., 2019).

7. Limitations:

Findings from this study may have limited generalizability because many refugees have been surveyed while residing in reception centres. This research is based on self-reported data. The participants were sampled using a snowball sampling method, which may have introduced bias. The results may reflect social desirability bias.

It is important to illuminate that the study was conducted during the COVID-19 period. The results may reflect bias as the confinement period was associated with further stressors. It would have been considered beneficial if a greater number of refugees could have been recruited for the study. Due to the current extraordinary circumstances around the world, we were unable to increase the sample size. However, our approach and findings are helpful in offering a lens through which the health status, needs, and barriers to services for this new population can be considered.

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