Globalization and Health

REVIEW

Open Access

Barriers and facilitators to primary healthcare utilization among immigrants and refugees of low and middle-income countries: a scoping review

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Abstract

Introduction Primary health care (PHC) is the most common model for providing primary care, and PHC services are the most common points of care that immigrants and refugees attend as a first step. Most immigrants travel to low- and middle-income countries (LMICs), yet only a few studies have examined their health conditions and their access to PHC in these countries. We have attempted to identify the barriers and facilitators that immigrants and refugees encounter when using PHC in these countries.

Methods We searched PubMed, Scopus, Web of Science, Embase, ProQuest, Google Scholar, Microsoft Academic, and OpenGrey in this scoping review from its inception to the end of October 2023. Moreover, we manually searched key journals, reference lists, and citations from included studies to identify any missed studies. We extracted data from each selected study using a predefined form. Finally, a thematic analysis approach was utilized to synthesize the collected data from the included qualitative studies.

Results 17 qualitative studies were included in this review, which were from Iran ($n=3$), Brazil ($n=3$), Kenya ($n=2$), Jordan ($n=2$), Eastern Sudan ($n=1$), Lebanon ($n=1$), Bangladesh ($n=1$), India ($n=1$), Turkey ($n=1$), Thailand ($n=1$), and Malaysia ($n=1$). Among the most common and important reported barriers are language differences, insufficiency of trained carers, unemployment, inability to pay the costs of hospital and medicines, no insurance coverage for immigrants, no clear referral and care system for immigrants, discrimination against women, and improper residence locations. Insurance coverage, awareness programs, and the study of immigrants' needs, along with their social and financial support from family, are among the most essential facilitators.

Conclusion For LMICs, funding is always a limitation, and increasing PHC utilization is the best choice for improving health. Knowing the challenges and facilitators of PHC utilization from the point of view of each stakeholder is a promising way to decide and make policies that can improve the health of both immigrants and refugees, as well as society as a whole.

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Keywords Primary healthcare, Immigrants, Refugees, Healthcare utilization, Low- and middle-income countries, Scoping review

Introduction

Immigration is a world-changing phenomenon in our era, increasing about 3-fold since 2010 with 41 million immigrants to 2024 with more than 117 million immigrants [1, 2]. People flee from their own countries for various reasons, including war, violations, climate change, and the risk of persecution due to their race, ethnicity, gender, or religion [3]. Two main subpopulations of immigrants are "refugees," who cross international borders in search of peace and security, and "asylum seekers," who seek international protection without a defined status of their refuge [4]. The health status of immigrants is a global challenge because they arrive in their destination countries with complex physiological and psychological conditions and needs that require healthcare services. For instance, a 2000 retrospective study in Canada, a country that welcomes immigrants, revealed that the health condition of immigrants significantly deteriorates 10 years after their arrival compared to the day they arrived, highlighting the shortcomings in healthcare provision for immigrants [5, 6]. Afghan immigrants arrive in Iran with unknown health conditions; thalassaemia is common among them due to a lack of premarital medical tests; and pediculosis is prevalent among them, which is difficult to treat because they believe in not giving young girls a haircut. This contributes to the complexity of their health needs, which the Iranian healthcare system often fails to address [7].

To provide primary care, primary health care (PHC) is the most common model in low- and middle-income countries (LMICs), which focusses on the prevention and early detection of diseases (in comparison to primary medical care (PMC), which is usual in high-income countries and focusses on treatment) [8, 9]. PHC is defined by the World Health Organization (WHO) as a "whole-of-society approach to effectively organizing and strengthening national health systems to bring services for health and well-being closer to communities" [10]. PHC services in LMICs can address up to 80% of the population's health needs at a lower cost than PMC, highlighting the significance of access to these services in enhancing overall health [11, 12]. The WHO has set Universal Health Coverage (UHC) as a 2030 goal, with PHC aiming to achieve 90% of it by educating resilient PHC workforces, establishing a people-centered health system, and digitalizing services [13, 14]. One of the main points of UHC is to include all people regardless of their immigration status [15].

PHC services are the most common points of care that immigrants attend in their initial steps [16, 17]. Research demonstrates that providing immigrants with optimal access to PHC can significantly reduce health inequalities [18]. Despite the documented lower use of PHC by immigrants compared to the native population, various factors significantly influence the accessibility of PHC services for immigrants [8]. The attitude of healthcare providers toward immigrants, their acquaintance with immigrants' health needs, the ability to communicate with each other despite language and cultural differences, and the unfamiliarity of immigrants with the health system of the new country are among the previously distinguished challenges in the way of PHC access for immigrants [19, 20]. Some strategies, like the "migrant-friendly hospital project" or the "Amsterdam Declaration," are in response to these challenges and emphasize training healthcare providers in cultural competence and understanding immigrants' needs [1].

Despite the common belief that high-income and developed countries are the primary host of immigrants, the United Nations High Commissioner for Refugees (UNHCR) reports that low- and middle-income countries (LMICs) account for the majority of immigration, accounting for approximately 75% of all immigrants in 2024 [2]. However, only a limited number of studies have examined the health status of immigrants and their access to PHC in these countries [1]. Furthermore, the numerous limitations in these countries pose a challenge to their ability to provide health services to the growing immigrant population. Even for their own population, PHC implementation faces multiple barriers, such as a poor economic situation, insufficient policymaker-implementer interactions, insufficient coordination with the community, a lack of trained health staff, inadequate marketing, inappropriate caregiver remuneration, a lack of insurance coverage, and a suboptimal PHC network arrangement. Besides, some facilitators have been mentioned, such as having a legal policy for implementing healthcare packages, contracting out the delivery of health services, flexibility in the funding mechanisms, availability of female health staff, good carer-patient interaction, and defined benefits packages [12, 21].

In this context, providing PHC services for immigrants requires a precise investigation of challenges and facilitators. To our knowledge, no previous study has comprehensively reviewed the results of qualitative studies about PHC utilization for immigrants in LMICs. Therefore, in this scoping review, we focus on the obstacles and enablers of PHC utilization for immigrants and refugees in LMICs, derived from qualitative studies, to illuminate this path for decision-makers. Using qualitative studies

enables us to understand the perceptions and insights of stakeholders more comprehensively than quantitative studies.

Methods

This scoping review is based on the Preferred Reporting Items for Systematic Reviews and Meta-analyses Extension for Scoping Reviews (PRISMA-ScR) checklist [22]. This methodology is beneficial for gathering a wide range of literature in a specific field. We can investigate key themes and concepts in the field using a review approach. We conducted this systematic scoping review based on Peters et al.'s (2015) guidance [23].

Search strategy

We used the SPIDER (sample, phenomenon of interest, design, evaluation, and research type) search framework to develop search strings. The research team considered "Immigrants, refugees, and asylum seekers" as the sample, "PHC" as the phenomenon of interest, and "qualitative study" as the research type. Based on some evidence, this search framework is more sensitive and reliable than some other frameworks for searching qualitative research, such as PICO (Population, Intervention, Comparison, and Outcome) [24]. We also contacted to relevant experts and used the free text method to explore additional potential terms. We used keywords such as "primary health care," "primary healthcare," "immigrants," "refugees," "asylum seekers," "qualitative study," and other equivalent terms. We developed the initial search strategy for the PubMed database and then modified it for different databases such as Scopus, Web of Science, Embase, ProQuest, Google Scholar, Microsoft Academic, and OpenGrey (Additional file 1). We manually searched key journals like Primary Health Care Research & Development, Australian Journal of Primary Health, Journal of Primary Care & Community Health, Journal of Primary Health Care, Journal of Immigrant & Refugee Studies, and Journal of Immigrant and Minority Health, along with reference lists and citations from included studies, to identify any missed studies. The search strategy identified studies published from April 1973 to the end of October 2023. We conducted the last update for this search in September 2024.

Study selection

We entered all the search results into the Endnote X21 software (Thomson Reuters, New York, NY), removed duplicates, and screened the remaining studies based on their title and abstract to determine if their subject aligned with our aim. We then applied inclusion and exclusion criteria to determine the final sample of studies for the research. We set the following inclusion criteria: (1) scientific studies with a qualitative design; (2) publication in a peer-reviewed journal; (3) writing in English; (4) exploring the experiences of various stakeholders (such as immigrants, PHC providers, policymakers, etc.) regarding primary health care utilization by immigrants; (5) conducting research in low- and middle-income countries, based on World Bank data; and (6) the availability of full text. On the other hand, our exclusion criteria were: (1) quantitative studies; (2) protocol studies, letters to the editor, abstracts, and editorials; (3) non-English language studies; (4) studies without full text; (5) review studies; and (6) qualitative studies that did not focus on knowledge of experiences related to PHC utilization by immigrants and refugees. Two authors (S.M.I.M. AND S.SH) independently performed these steps, and resolved any disagreement through discussion and the participation of the third author (M.E.). Figure 1 displays the PRISMA flowchart of study selection.

Data extraction

Two authors (S.M.I.M. and S.SH.) independently performed the data extraction process. Before starting this process, all team members contributed to the development of a data collection form. This form's items were: (1) first author's name; (2) publication year; (3) host country; (4) sampling approach; (5) country of origin of the immigrants; (6) data collection method; (7) interview format; (8) interviewees; (9) analysis approach; (10) challenges of integration; 11) facilitators of integration; 12) summary of findings; and 13) funding source (Table 1). Other authors checked this process to ensure the accuracy of the extracted data. At this stage, as in previous stages, we resolved any disagreement through discussion and, in some cases, the participation of the expert author (M.B.).

Data synthesis and analysis

We applied the thematic analysis approach to synthesize the collected data from the included qualitative studies [25]. After that, four authors (S.SH, M.E., M.B., and K.B.L.) reviewed and evaluated the similarities and differences among these summaries and identified the main themes, including barriers and facilitators, based on Yang et al.'s proposed framework on the classification of immigrant health service utilization. The behavioural medical model serves as the foundation for this framework, which categorizes the disparities in immigrants' health service utilization into two levels: immigrant-specific and general [26]. This framework gave us a pre-defined and established basis for categorising our findings into groups that demonstrate relevance to the health status of immigrants.

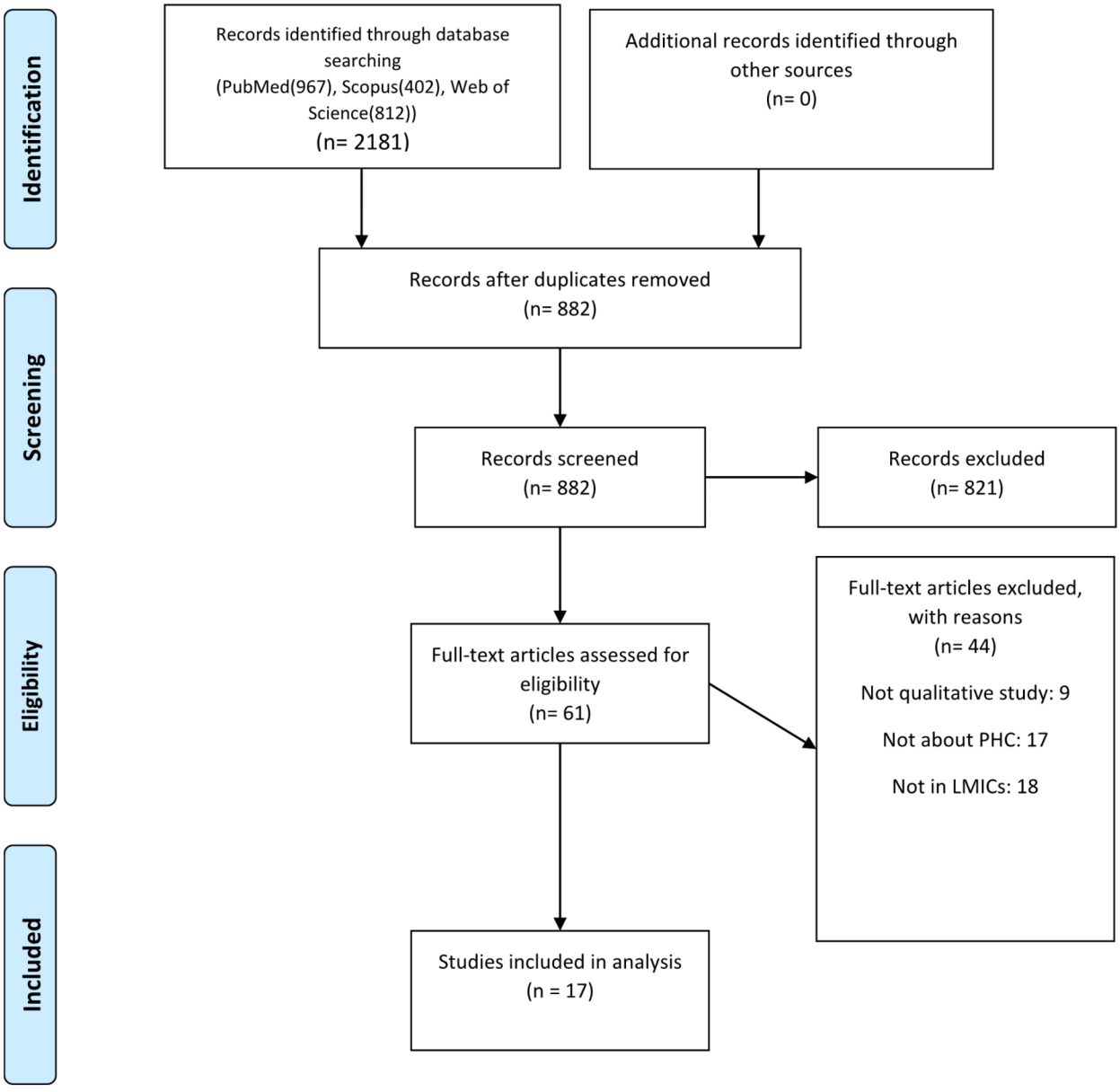

Fig. 1 The PRISMA flowchart of the included studies

Results

This scoping review included 17 qualitative studies from LMIC countries (Fig. 1). The included studies spanned different continents, with 11 (64.7%) originating from Asia, three (17.6%) from Africa, and three (17.6%) from South America. These studies investigated the origins of immigrants from Asia (58.8%, $n=10$), Africa (17.6, $n=3$), and South America (17.6, $n=3$). Additionally, one study ([27], conducted in India) included immigrants from every country. The timeframe of these studies indicates that 5.8% ($n=1$) took place in the 1980s, followed by 5.8% ($n=1$) in the 1990s, 35.3% ($n=6$) in the 2010s, and 52.9% ($n=9$) in the 2020s. Table 1 presents an overview of these studies.

Barriers to PHC utilization

Based on Yang et al.'s proposed classification of health service utilization for immigrants, we categorized the extracted barriers to PHC utilization (Table 2). The majority of the studies identified language differences [7, 28–32], insufficiency of trained caregivers [27, 29, 33, 34], economic problems such as unemployment and inability

Table 1 An overview of included studies

Author (publication year)	Study aim	Participants (*N*)	Sampling	Country of study	Country of origin	Data collection method	Interview format	Interviewees	Analysis approach	Summary of findings	Funding source	Ref.
G. Barnabas (1982)	To assess the nutritional and childcare among Ethiopian refugees in Eastern Sudan	151	Not clarified	Eastern Sudan	Ethiopia	Structured interviews	Face-to-face	Ethihopian refugees	Descriptive statistical analysis	Malnutrition and infection come as top priorities in health work amongst refugees, while cultural practices are important, too.	Not clarified	[65]
R. Talhouk (2020)	To gain an understanding of the potential for technology integration in primary health care provision	17	Purposive sampling	Lebanon	Syria	Semi-structured interviews	Face-to-face	Key informants and health care providers	Thematic analysis	Although many barriers are like other countries, lower health and technology literacy is a significant difference in Syrian refugee.	United Kingdom Engineering and Physical Science Research Council award and The Newcastle University Research Investment Fund	[33]
A. Takbiri (2020)	To explore the challenges of providing primary health care to Afghan immigrants in Tehran	25	Purposive sampling	Iran	Afghanistan	Semi-structured interviews	Face-to-face	PHC providers, including physicians, psychologists, and midwives	Thematic analysis	Communication barriers, lack of insurance coverage and screening system, and the negative attitude against Afghan immigrants are among the most common challenges of providing PHC for them.	Tehran University of Medical Sciences and Health Services	[7]
L. Nikfarid (2020)	To explore the experiences of Afghan mothers living in Iran who had a child with cancer	9	Purposive sampling	Iran	Afghanistan	Semi-structured and in-depth interviews	Face-to-face	Afghan refugee women with children diagnosed with cancer	Content analysis	Cultural barriers in the way of self-empowerment make Afghan mothers need more assistance in coping with children with cancer. Tailored care plans are suggested.	None	[35]

Table 1 (continued)

Author (publication year)	Study aim	Participants (*N*)	Sampling	Country of study	Country of origin	Data collection method	Interview format	Interviewees	Analysis approach	Summary of findings	Funding source	Ref.
V. Mutiso (2018)	To explore the perceived mental-health-care access barriers affecting the resettled refugee population in Eastleigh, Kenya	82	Purposive sampling	Kenya	Somali	Focus group discussion and semi-structured interview	Face-to-face	Refugees, primary health workers, religious leaders, and senior Somali refugee doctors	Content analysis	Cultural and religious beliefs, insufficient health services, culture-insensitive mental health services, poverty, language barriers, stigma, and discrimination are among the most critical barriers accessing mental health care for refugees.	Not clarified	[28]
S. Jannat (2022)	To find out the condition of Rohingya refugee women's sexual and reproductive health in terms of contraception, sanitation, and hygiene	50	Purposive sampling	Bangladesh	Rohingya (Myanmar)	Semi-structured interview	Face-to-face	Refugee women	Thematic analysis	Many factors like gender-based violence and patriarchal society impacts are continuously affecting sexual and reproductive health continuously	Not clarified	[38]
S. Gee (2019)	To understand factors that contribute to poor health outcomes throughout the reproductive life cycle and across the continuum of care in refugee settings	229	Purposive and convenience sampling	Kenya	Somali	Focus group discussion and in-depth interviews	Face-to-face	Community members, relevant UN and non-governmental organization staff, community leaders, health managers, and front-line health care providers	Inductive and deductive techniques (thematic analysis)	The intense desire for large families and the primary social role of the woman as child bearer impacted maternal and neonatal health in the camps through preferences for early marriage, low demand for contraception, and avoidance of caesarean sections.	The Bill and Melinda Gates Foundation	[34]

Table 1 (continued)

Author (publication year)	Study aim	Participants (*N*)	Sampling	Country of study	Country of origin	Data collection method	Interview format	Interviewees	Analysis approach	Summary of findings	Funding source	Ref.
N. Gawde (2016)	To understand access to maternal health care and the factors shaping it amongst poor migrants in Mumbai, India	234	Random sampling	India	All migrants	Structured and in-depth interviews	Face-to-face	Migrant women, health care providers, and health officials	Thematic analysis	Poor maternal healthcare was due to weaker demand for health care, lack of social support and knowledge, inadequate health infrastructure, and lack of specific strategies for improvement of migrants' access to health care.	Indian Council of Medical Research (ICMR), New Delhi	[27]
N. Azizi (2021)	To identify obstacles and facilitators of providing primary health care to Afghan refugees from the perspective of health care providers	21	Purposive sampling	Iran	Afghanistan	Semi-structured interviews	Face-to-face	Healthcare providers	Content analysis	Lack of trained personnel, identification records, communication barriers, and insurance are among main challenges, while free-of-charge PHC, availability for migrant, justice, and insurance variety are among opportunities for migrants.	Iran University of Medical Sciences	[29]
P. Torun (2018)	To assess the health needs of urban refugees living in Istanbul	891	Snowball sampling	Turkey	Syria	Questionnaire	Face-to-face	Syrian women from households, doctors, decision makers, and NGO representatives	Thematic analysis	Cost of living in Istanbul, language barriers, and lack of knowledge about Turkish health system are the main challenges of Syrian refugees.	The Bezmialem Vakif Universit Scientific Research Projects Funding Scheme	[30]
C. Silveira (2017)	To investigate inequalities in living conditions and access to health services among Bolivian immigrants living in the central area of São Paulo, Brazil	183	Random sampling	Brazil	Bolivia	Semi-structured interviews	Face-to-face	Bolivian immigrants	Descriptive statistical analysis	Immigrants are increasingly included in PHC as well as work and access to documentation.	National Council for Scientific and Technological Development	[31]

Table 1 (continued)

Author (publication year)	Study aim	Participants (*N*)	Sampling	Country of study	Country of origin	Data collection method	Interview format	Interviewees	Analysis approach	Summary of findings	Funding source	Ref.
S. Rajaratnam (2022)	To understand the experiences of Rohingya women in Malaysia, particularly in accessing public hospitals	33	Purposive sampling	Malaysia	Myanmar	Focus group discussion and in-depth interviews	Face-to-face	Rohingya women refugees and asylum seekers, medical social workers, medical officers, volunteer workers/activists, refugee organization officers, and a mental health service provider	Thematic analysis	Barriers for Rohingya women are experience of marriage and domestic violence, access to public hospitals, financial challenges, and inability of medical social workers to provide services for them.	Faculty of Social Sciences and Humanities, University Kebangsaan Malaysia	[36]
T. M. Powell (2022)	To examine participants experiences of the healthy community clinic (HCC-MH), a mental health awareness intervention delivered to Jordanians and resettled Syrians in a border community in Jordan	21	Maximum variation sampling	Jordan	Syria	Focus group discussion	Face-to-face	Syrian and Jordanian participants	Thematic analysis	Awareness of their own emotional needs, upbeat life style and behavior changes, and normalized emotional distress are among benefits of this intervention for Syrian refugees.	Americares	[66]
L. Maconick (2020)	To examine the interaction between physical and mental health of patients with NCDs at an MSF clinic in Irbid, Jordan, in the context of social suffering	34	Convenience sampling	Jordan	Syria	Focus group discussion and semi-structured interviews	Skype	Syrian refugee and Jordanian patients, clinical, managerial, and administrative staff of the MSF clinic	Thematic analysis	A 'disconnect' between staff and patients' perceptions of the potential role of the NCD and mental health service in alleviating this suffering.	Médecins sans Frontières	[37]

Table 1 (continued)

Author (publication year)	Study aim	Participants (*N*)	Sampling	Country of study	Country of origin	Data collection method	Interview format	Interviewees	Analysis approach	Summary of findings	Funding source	Ref.
L. N. Losco (2019, 2021)	Integration of the migrant population from the perspective of the Bolivian population residing in São Paulo, Brazil and to understand what the role of the community health agents is, to guarantee the principle of universality of the public health services offering access and	79	Snowball sampling	Brazil	Bolivia	Semi-structured interviews	Face-to-face	Health professionals and Bolivian immigrants	Thematic analysis	Understanding cultural differences, the need for state policy, and cooperation between immigrants and heath staff are among the main concerns and solutions for Bolivian migrants in Brazil	Coordination for the Improvement of Higher Education Personnel (Capes)	[32, 67]
S. Maybin (1992)	To compare the health situation and access to health care in refugee camp with surrounding natives	Not clarified	Not clarified	Thailand	Laos	Not clarified	Not clarified	Refugees	Not clarified	Access to primary health care facilities in the Camp was, moreover, easier and free of charge	Save the Children Fund (UK)	[10]

Table 2 A summary of barriers for utilization of PHC for immigrants

Themes	Subthemes	Barriers	Study (Country)
Need for healthcare (General factors)	Self-reported/evaluated health	Increasing feelings of anxiety when the child needs to be visited	[35] (Iran)
		Not being able to read the prescriptions on drugs	[35] (Iran)
		Need for dental and antenatal care	[30] (Turkey)
Need for healthcare (Immigrant-specific factors)	Immigrant-specific health needs/conditions	Absence and lack of trained and professional personnel	[29] (Iran)
		Leaving in non-notified slums, which makes it challenging to identify pregnant women	[27] (India)
		Being spoken to rudely or being neglected by the midwife	[34] (Kenya)
Resources	Financial resources	Refugees do not believe in the coverage of insurance	[29] (Iran)
		Lack of adequate financial resources for mental healthcare	[28] (Kenya)
		Poor economic circumstances	[35] (Iran)
		Unemployment of the father of the family	[35] (Iran)
		Lack of insurance coverage for all immigrants	[7] (Iran)
		Precarious work relations	[31] (Brazil)
		Inability to pay for hospital bills and medicines	[36] (Malaysia)
		Lack of available employment and working restrictions	[37] (Jordan)
	Social resources	Hard subsequent follow-ups	[29] (Iran)
		Poor acceptability of services	[28] (Kenya)
		Lack of local idioms of mental illnesses	[28] (Kenya)
		Fear of husband becoming addicted to drug	[35] (Iran)
		Not having contact with other mothers of children with cancer	[35] (Iran)
		Illegal residence	[7] (Iran)
		Lack of valid identification documents	[7] (Iran)
		Afghans' mistrust in the healthcare staff	[7] (Iran)
		Shortage in human resources	[33] (Lebanon)
		Distrust of Turkish doctors resulting from language barrier	[30] (Turkey)
	Informational resources	Vague records of identification	[29] (Iran)
		No access to previous health care records	[29] (Iran)
		Lack of understanding and proper verbal communication	[29] (Iran)
		Preference for services with the least possible cost	[27] (India)
		Lack of information about maternal healthcare facilities and their location	[27] (India)
		Language barriers in the communication	[28] (Kenya)
		Not having enough information about the care of the child	[35] (Iran)
		Language differences	[7] (Iran)
		Limitations in benefiting from interpreters	[7] (Iran)
		Not knowing about the right to free access to health care	[30] (Turkey)
		Language barrier and unawareness of how to access services	[30] (Turkey)
		Language barrier	[31, 32] (Brazil)
	Access to healthcare	Discontinuing treatment in long-term conditions	[29] (Iran)
		Living in an uncomfortable house, being far from the basic healthcare facilities	[35] (Iran)
		Not having visits to healthcare	[35] (Iran)
		Not following up on treatment for health problems	[35] (Iran)
		Forgetting to get medicines prescribed by physicians	[35] (Iran)
		Limited equipment available	[33] (Lebanon)
		Difficulties with obtaining medicines	[30] (Turkey)
		Challenging process of registration and admission in hospitals	[36] (Malaysia)
		High charges in hospitals and private clinics	[36] (Malaysia)

Table 2 (continued)

Themes	Subthemes	Barriers	Study (Country)
Predisposing factors (General factors)	Demographic factors	Lack of inter-organizational information exchange	[29] (Iran)
		High number of children and family members	[29] (Iran)
		High prevalence of some diseases	[7] (Iran)
		Life-threatening healthcare issues such as STDs, unwanted pregnancies, menstrual disorders, and psychological trauma	[36] (Malaysia)
		Higher birth rate in the refugee camp	[68] (Thailand)
	Socioeconomic status	Low training in the use of PHC	[29] (Iran)
		Less communication between refugee pregnant women and others	[34] (Kenya)
		Drug-addicted husbands	[38] (Bangladesh)
		Lack of knowledge about sexual health	[38] (Bangladesh)
		Unsuitable accommodation and work conditions	[7] (Iran)
		Low level of education	[7] (Iran)
		Low level of education among refugees limits their ability to use technologies	[33] (Lebanon)
		Not being able to choose female doctors	[30] (Turkey)
		Unhealthy housing	[31] (Brazil)
		Racism, discrimination, and prejudice	[31] (Brazil)
		The normalization of violence within refugee groups	[36] (Malaysia)
		Women and girls' experiences of marriage and domestic violence	[36] (Malaysia)
		Social stigma	[66] (Jordan)
		Poorer nutritional status in the under-fives living in refugee camp	[68] (Thailand)
		Poverty, social exclusion, stigmatization and vulnerability	[67] (Brazil)
		Linguistic and cultural differences	[67] (Brazil)
		Malnutrition and infection among children	[65] (Sudan)
	Health beliefs	Refusal to receive vaccination	[29] (Iran)
		Low consumption of Iron-folic acid tablets in pregnant refugees	[27] (India)
		Insufficient food intake and poor thoughts about oral medications	[34] (Kenya)
		Improper feeding of neonates	[34] (Kenya)
		The use of traditional medicine for newborn's disease	[34] (Kenya)
		Lack of freedom to talk about menstruation problems	[38] (Bangladesh)
		Shame of visiting doctors in the case of STDs	[38] (Bangladesh)
		Acceptability of some unusual behaviors such as hyperactivity	[28] (Kenya)
		Lack of optimism with the available mental health interventions	[28] (Kenya)
		Mental issues do not need medications	[28] (Kenya)
		Interconnectedness of physical and mental health	[37] (Jordan)

Table 2 (continued)

Themes	Subthemes	Barriers	Study (Country)
Predisposing factors (Immigrant-specific factors)	Immigration status	Absence and lack of trained and professional personnel	[27] (India)
		Poor education and illiteracy among refugee women	[27] (India)
		Early marriage and childbearing	[34] (Kenya)
		Gender-based violence, physically and mentally	[38] (Bangladesh)
		Less place to wash and dry their clothes during menstruation	[38] (Bangladesh)
		Perceived stigmatization and discrimination against refugees	[28] (Kenya)
		Being upset by memories, not willing to go back to Afghanistan	[35] (Iran)
		Trying to keep their current state unchanged as it seems safe	[35] (Iran)
		Refugees' unstable political and physical environments	[33] (Lebanon)
		Fear of arrest, detention, and deportation	[36] (Malaysia)
		Anger, sadness, grief, hopelessness, or even a passive death wish	[37] (Jordan)
		Separation and loss of families	[37] (Jordan)
		Not feeling psychologically or economically equipped to follow lifestyle advice	[37] (Jordan)
		Negative impact of war and refugee experience on medical adherence	[37] (Jordan)
		Undocumented in the country, making them vulnerable to precarious work situations, non-supported by Brazilian labor laws	[67] (Brazil)
	Assimilation	Not being familiar with coping methods	[35] (Iran)
		Lack of social support and harmful coping strategies	[37] (Jordan)
	Immigrant ethnic culture	Believe in higher social status for women with many children	[34] (Kenya)
		The use of contraception as interfering with God's will results in fear of contraceptives	[34] (Kenya)
		Breastfeeding as a natural way to delay subsequent pregnancy	[34] (Kenya)
		Fear of being examined or cared for by male staff	[34] (Kenya)
		Fear of caesarean section	[34] (Kenya)
		Religious beliefs about the use of contraception	[38] (Bangladesh)
		Patriarchal society and not being able to decide for themselves	[38] (Bangladesh)
		Traditional healing methods against mental disorders (e.g., drum beating, evil spirits, etc.)	[28] (Kenya)
Macro-structural/contextual factors	Government Policy	No legal permission to work for refugees	[36] (Malaysia)
		No access to free public healthcare and education	[36] (Malaysia)
	Healthcare system	Lack of proper information structure	[29] (Iran)
		No clear referral and feed-back system	[29] (Iran)
		Unavailability of delivery care in primary facilities	[27] (India)
		Delay in the arrival of the ambulance for delivery	[34] (Kenya)
		Negative perception of hospital care	[34] (Kenya)
		Inadequate and lack of culture-sensitive mental health services	[28] (Kenya)
		A mismatch between the work hours of the PHC centers and Afghan immigrants' conditions	[7] (Iran)
		Inadequate organizational support for the staff working in an immigrant populated region	[7] (Iran)
		The complexity of making appointments and long waiting times	[30] (Turkey)
	Social, economic, and political conditions	Lack of a screening system upon arrival from the borders	[7] (Iran)
		Relative irresponsibility of the society towards the Afghan immigrants	[7] (Iran)
		Less importance towards Afghan workers by the employers	[7] (Iran)
		Negative attitudes of some Iranians and PHC providers towards immigrants	[7] (Iran)
		Increased workload for doctors and other health professionals	[30] (Turkey)
		Different habits and cultural customs	[32] (Brazil)

to pay the costs of hospital and medicines [35–37], and unhealthy social conditions such as discrimination against women [27, 35, 36, 38], improper residence locations [31, 38], and their isolation [35, 37] as the main barriers to PHC utilization.

General factors that contribute to immigrants' healthcare needs include increased anxiety during doctor visits for their children [35], difficulties in understanding prescribed drugs [35], the need for dental and antenatal care [30], living in unidentified slums [27], and mistreatment by caregivers [34]. There are also problems in the host countries, like immigrants not having the right to work [36], not being able to get free education and health services [36], not having insurance [7], not having a clear referral and care system for immigrants [27, 29], PHC centres' hours not matching the needs of immigrants [7], staff working in areas with a lot of immigrants not getting enough help [7], doctors and other health professionals having too much work [30], and immigrants having a bad opinion of health staff [7, 34].

Facilitators of PHC utilization

The reviewed studies identified a few suggested or implemented conditions as facilitators of PHC utilization for immigrants (Table 3). These facilitators include insurance coverage [29], awareness programs, studies of immigrants' needs [29, 32], social and financial support from family and friends [36], and the proximity of health centers in refugee camps [38].

Policymakers are primarily concerned with contextual factors, such as ensuring justice and equality [29], providing health services for refugees [29], providing distinct health instructions for immigrants [29], supplying medical social workers [36], and organizing conferences on immigrants' needs that involve all stakeholders, including immigrants themselves [32].

Table 3 A summary of facilitators for utilization of PHC for immigrants

Themes	Subthemes	Facilitators	Study (Country)
Need for healthcare (General factors)	Self-reported/Evaluated health	-	
Need for healthcare (Immigrant-specific factors)	Immigrant-specific health needs/conditions	-	
Resources	Financial resources	Free of charge PHC	[29] (Iran)
		Insurance coverage for refugees	[29] (Iran)
		Provide cash incentives	[27] (India)
	Social resources	Getting awareness programs and training to ensure their better sexual health and the importance of contraception	[38] (Bangladesh)
		Providing "women-friendly spaces" and "adolescent-friendly spaces" for talking about their well-being	[38] (Bangladesh)
		Having trust in the health care providers, not having any complaints	[35] (Iran)
		Seeking help from MHPSS services or other sources of support	[37] (Jordan)
	Informational resources	Comprehensive information system for refugees	[29] (Iran)
	Access to healthcare	Implementation of HIV prevention program	[27] (India)
		Improved number and quality of latrines	[38] (Bangladesh)
		The nearness of healthcare facilities in refugee camps	[38] (Bangladesh)
Predisposing factors (General factors)	Demographic factors	Social support from their extended family and friends	[36] (Malaysia)
	Socioeconomic status	Feeling happy when compared with the care available in Afghanistan	[35] (Iran)
		High education among a large proportion of female refugees	[33] (Lebanon)
	Health beliefs	Mental health awareness intervention	[66] (Jordan)
Predisposing factors (Immigrant-specific factors)	Immigration status	Identifying immigrants needs	[29] (Iran)
	Assimilation	-	
	Immigrant ethnic culture	-	
Macro-structural/contextual factors	Government Policy	Providing justice and equality	[29] (Iran)
	Healthcare system	Availability of health care services for refugees	[29] (Iran)
		Separate health instruction for refugees	[29] (Iran)
		Medical social workers	[36] (Malaysia)
	Social, economic, and political conditions	A conference on the needs of immigrants between immigrants, care-providers, and decision-makers	[32] (Brazil)

Discussion

In this study, we reviewed qualitative studies concerning the barriers and facilitators of PHC utilization in LMICs for immigrants. We reviewed 17 studies, mainly conducted in Asia, and extracted challenges and facilitators in this field from different stakeholders' points of view. In these countries, funding and financial problems are the main barriers to PHC usage for immigrants. Other barriers mentioned include language differences, the insufficiency of trained carers, discrimination against women, and inappropriate residence locations. Insurance coverage, awareness programs, and studying immigrants' needs as well as their social and financial support from their families are among the most important facilitators.

The primary barriers involved gaining access to primary care services for refugees and immigrants, as well as identifying key facilitators to enhance their access within the context of LMICs. These countries host the majority of refugees (86%), who also bear the most significant burden of mortality and morbidity from non-communicable diseases (NCDs) [39]. Despite the increasing prevalence of NCDs, most LMICs' healthcare systems prioritize treatment, allocating only modest funds to primary care [40]. However, migrants often get medical care through the primary care network in their new countries [41].

The vast influx of refugees from nations like Iran, Turkey, Jordan, and Lebanon put a significant strain on the national health care systems of the hosts. On the other hand, waiting a long time to seek the appropriate treatment has resulted from being unable to receive medical attention [42, 43]. In Jordan, 90% of Jordanian patients have faith in their physician; nonetheless, lengthy wait times keep them from consulting one, which dramatically raises the rate of self-medication. Individuals who thought that health center wait times were excessive were twice as likely to self-medicate, with 88% of patients doing so if they thought the wait times were excessive [44]. Financial barriers have impeded refugees' access to primary care services in Jordan [45, 46] and Lebanon [47]. The cost of primary care still includes missed time, travel, and supplies [48]. Some exclusionary policies that restrict and bureaucratize access to PHC have been adopted, such as more stringent document requirements for acquiring housing and food subsidies, the end of gratuities, and the beginning of charging for PHC services [49]. Previous studies have mentioned cost barriers as one of the main obstacles to refugees accessing primary health services, as demonstrated in the current study [50].

Lack of knowledge of 'Who's Doing What, Where, and When' is an impediment to effectively navigating the health system and is fundamental in addressing healthcare access barriers for refugees, particularly in early phases of displacement among new arrivals and those situated in urban settings [51]. Due to unfamiliarity with the health system or inadequate access to healthcare facilities, foreign migrants in Malaysia tend to initiate care at a later stage of pregnancy [52]. The language barrier Syrians faced, as well as the unavailability of patients' medical records in Turkey, had a negative impact on the health staff. Doctors providing primary health care services did not feel they could effectively attend to the needs of migrants [53]. Due to the lack of formal interpretation services, primary care facilities dealing with Somali refugees in Kenya frequently use ad hoc interpreters. There have been reports of informal interpreters, such as friends, family members, or taxi drivers, misrepresenting terminologies and symptoms or even breaching patient confidentiality [28].

The barriers to accessing primary health services are more significant. For example, post-migration living difficulties can significantly increase immigrants' risk of post-traumatic stress disorder [54]. When implementing mental health interventions for refugees and asylum seekers in LMICs, primary care doctors recognize the constrained primary care system and the low recognition rates of common mental disorders as particular challenges [55]. Given the limited resources for mental health in LMICs, most primary care clinics in refugee settings must make difficult choices about which capacities to prioritize [56]. Moreover, a lack of funding for migrant health, particularly for preventive care, leads to low levels of HIV testing among migrants from LMICs [57]. These services have been proven to be challenging to access by refugees and migrants in LMICs that we have reviewed in this study.

In Iran, a previous qualitative study divided the problems that refugees face in getting primary health care into three groups: problems that happen before they are referred to PHC centres include having a lot of children, high service costs, not having medical insurance, getting to health centres, and making appointments for services; problems that happen after they are referred to PHC centres include language barriers, the behaviour of health care providers, and delays in receiving services; and problems that happen after PHC delivery, such as referral patients and high costs of para-clinics [58]. This study backs up what that study said.

The current study illustrates that refugees and migrants encounter various obstacles when attempting to access and utilize primary health services within the context of LMICs they represent. Nevertheless, Amara and Aljunid have stated that most urban refugees in LMICs have adequate access to primary healthcare services [59]. Their study included some, but not all, of the countries we have reviewed in this study.

Healthcare professionals and primary healthcare providers have a significant role in ensuring refugees have

adequate access to primary care services. On the other hand, several primary health care reforms have increased the accessibility of services migrants require. With the goal of both integrating Syrian professionals into the health system and guaranteeing that Syrian refugees can receive health care without running into language or cultural barriers—a significant facilitator not identified by this study—primary health care reform in Turkey permits Syrian health professionals to work in the Turkish health system [53]. On the other hand, Somalian refugees highlight the shortage of trained community health workers in rural areas of their host countries, Kenya and Ethiopia, where their simple messages and primary health care services could significantly impact the situation [60].

People view integrating affected refugees into national health systems by addressing the humanitarian-development nexus as a helpful approach. However, in Thailand, an integrated and evidence-based PHC, adequately funded and implemented by one health agency, is a practical and relevant approach to reduce the infectious disease burden in refugee camps [61]. Also, low-cost eHealth strategies like online scheduling and referrals made it easier for everyone to get the same access to PHC services. This meant that newly diagnosed and identified cases who didn't have a regular provider could still get care in PHC for refugees [62].

Strategies include shifting resources for NCDs and other traditional hospital services to the primary level and creating vital health promotion programs emphasizing prevention and self-care. Additionally, we should prioritize encouraging refugees to use primary care facilities first and, when necessary, provide referral services to hospitals for more complex conditions [63]. Cross-cultural medicine can also improve the relationship between a doctor and a patient and help get past common barriers to care. These barriers can include communication problems caused by language and cultural differences as well as disease explanations that are based on culture [64].

Strengths and limitations

To our knowledge, this is the first study to review all qualitative studies regarding immigrants' access to PHC services in LMICs, gathering stakeholders' opinions about barriers and facilitators of PHC utilization. Drawing attention to the struggles of LMICs to improve the health of immigrants is a valuable goal that we tried to achieve in this study.

This study is not without its limitations. Firstly, our scope limited us to reviewing only qualitative studies, which may have resulted in missing data in this field and potentially contributed to further bias. Secondly, reviewing only English articles might be a source of bias for us, especially since most LMICs' mother tongues are not English. Thirdly, the number of studies in LMICs is much lower than in high-income countries, which might be another source of bias. Therefore, it is crucial to promote more research in the area of immigrant PHC utilization in these countries, in order to generate more data that can serve as a foundation for future decision-making. Future studies must focus on finding solutions to challenges in PHC utilization for immigrants, particularly by identifying current facilitators.

The findings and conclusion of this review should be considered in light of the studies' contexts and representative countries. We cannot generalize the findings to other countries or all LMICs because the 17 reviewed studies only represent 11 LMICs. Since qualitative research by design involves only specific settings, generalizations are not possible beyond the research population. The majority of studies were non-random, which limits generalization at this level. Therefore, it is best to interpret these insights as representative of the specific settings and populations under study, rather than suggesting broader trends across LMICs.

While some LMICs have a strong representation in the literature when it comes to the obstacles and enablers that refugees face in accessing primary care, there is an under-representation of LMICs with high migration rates. For instance, our review excludes countries like Ethiopia, the Philippines, and Somalia, which experience significant refugee movements due to the lack of primary research on this issue. Filling this gap would enable us to gauge the specific problems and opportunities for healthcare services in these contexts. Therefore, this is the foundation for future studies about how well refugees access primary care services within those regions. Filling the gap would provide a more representative picture of access to care for refugees at the global level.

Conclusion

Appropriate PHC access and utilization are effective strategies for increasing society's health at the lowest possible cost. Immigrants are currently a growing population worldwide. Because of their specific circumstances, their health needs require special attention. For LMICs, money is always a limitation, and increasing PHC utilization is the best choice for health improvements. Knowing the challenges and facilitators of PHC utilization from the point of view of each stakeholder is a promising way to make decisions and policies that can improve the health of both immigrants and society as a whole. Among these barriers, the most common ones that need to be addressed are language differences, insufficiency of trained carers, unemployment, inability to pay hospital and medicine costs, mistreatment by carers, lack of access to free education and health services, lack of insurance coverage for immigrants, lack of a clear referral and care system for immigrants, discrimination against

women, and incorrect residence locations. Facilitators such as insurance coverage, awareness programs, studying immigrants' needs, social and financial support from family and friends, and the proximity of health centers in refugee camps could help overcome those barriers.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12992-024-01079-z.

Supplementary Material 1

Acknowledgements
This paper and the research behind it would not have been possible without the exceptional support of all the contributors who agreed to donate their time and ideas and take part in this study.

Author contributions
S.M.I.M, M.E, K.B.L, H.K, and S.SH contributed to the conception and design of the study. S.SH conducted the search, and S.M.I.M was co-moderator. S.M.I.M and H.K conducted screening and selecting the final studies, which K.B.L, S.SH, and M.B discussed regularly. S.M.I.M, M.E, K.B.L, H.K, and S.SH wrote the initial draft, and M.B contributed to manuscript revisions. All authors read and confirmed the final manuscript.

Funding
This research was supported by the Shiraz University of Medical Sciences, Shiraz, Iran (No: 27912).

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
The Research Ethics Committee of the Shiraz University of Medical Sciences provided the ethical approval for this study (IR.SUMS.REC.1402.141) previously. All methods were performed in accordance with the relevant guidelines and regulations such as Declarations of Helsinki. Informed consent for participating in this study was obtained from all the participants before the interview sessions.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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Received: 27 April 2024 / Accepted: 11 October 2024
Published online: 24 October 2024

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