Rev Rene. 2025;26:e94260.
DOI: 10.36517/2175-6783.20252694260
www.periodicos.ufc.br/rene

Original Article

The international population's (mis)knowledge of the Brazilian health system: the experiences of professionals and migrants*

(Des)conhecimento da população internacional sobre o sistema de saúde brasileiro: experiências de profissionais e migrantes

How to cite this article:
Buzzerio LF, Soldera AGS, Cruz ADQ, Luz MS, Sanguino GZ, Marcon SS, et al. The international population's (mis)knowledge of the Brazilian health system: the experiences of professionals and migrants. Rev Rene. 2025;26:e94260. DOI: https://doi.org/10.36517/2175-6783.20252694260

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*Extracted from the dissertation "Experiências de migrantes internacionais e profissionais de saúde com o atendimento de emergência: uma análise temática", Universidade Estadual de Maringá, 2024.

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Conflict of interest: the authors have declared that there is no conflict of interest.

ABSTRACT

Objective: to find out about the experiences of health professionals and international migrants regarding this population's (lack of) knowledge about the Brazilian health system. **Methods**: a qualitative study was carried out in the emergency department of a university hospital. Nine health professionals and six migrants were interviewed. Symbolic Interactionism and Reflective Thematic Analysis were adopted as the theoretical and methodological frameworks, respectively. **Results**: two themes emerged: situations that contribute to lack of knowledge about the health system and the consequences of lack of knowledge about the health system. **Conclusion**: migrants' lack of knowledge about the Brazilian health system stems from language barriers and social and bureaucratic vulnerabilities, hindering access and continuity of care. Health professionals point to the need for more significant preparation to deal with situations, while migrants report difficulties in understanding the health system and using services. **Contributions to practice**: the findings are relevant for managers and professionals to think about strategies and protocols that encourage international migrants to enter health facilities and simultaneously consider their training process on how the system works.

Descriptors: Transients and Migrants; Health Personnel; Health Systems; Knowledge.

RESUMO

Objetivo: conhecer as experiências de profissionais de saúde e migrantes internacionais acerca do (des)conhecimento dessa população sobre o sistema de saúde brasileiro. **Métodos**: estudo qualitativo, realizado no serviço de emergência de um Hospital Universitário. Foram entrevistados nove profissionais de saúde e seis migrantes em atendimento. O Interacionismo Simbólico e a Análise Temática Reflexiva foram adotados como referencial teórico e metodológico, respectivamente. **Resultados**: emergiram dois temas: situações que cooperam para o desconhecimento sobre o sistema de saúde; e consequências/desdobramentos do desconhecimento sobre o sistema de saúde. **Conclusão**: o desconhecimento dos migrantes sobre o sistema de saúde brasileiro decorre de barreiras linguísticas, vulnerabilidades sociais e burocráticas, dificultando o acesso e a continuidade do cuidado. Os profissionais de saúde apontam a necessidade de maior preparo para lidar com as situações, enquanto os migrantes relatam dificuldades na compreensão do sistema de saúde e utilização dos serviços. **Contribuições para a prática**: os achados são relevantes para que gestores e profissionais pensem estratégias e protocolos que estimulem a entrada dos migrantes internacionais nos serviços de saúde e, ao mesmo tempo, considerem seu processo formativo acerca do funcionamento do sistema.

Descritores: Migrantes; Pessoal de Saúde; Sistemas de Saúde; Conhecimento.

Received: Oct. 2th 2024; Accepted: Jan. 28th 2025.

Introduction

The contemporary migratory process has been a central issue in government discussions worldwide. This is because its occurrence is pantopolist and involves a complex set of factors that range from public health actions to economic, cultural, and social impacts[1]. It is estimated that there will be about 281 million international migrants in the world in 2024, equivalent to 3.6% of the global population[2]. The issue has become increasingly relevant in Brazil, especially after the intensification of migratory flows in recent years and the country's entry into the migrant smuggling route[3].

Various factors, such as armed conflicts, economic crises, climate change, and the search for better opportunities, drive the international migration phenomenon. In addition, economically, migration can have both positive and negative effects. If, on the one hand, migrants contribute to the labor force and can help address shortages in specific sectors, on the other hand, the massive influx can put pressure on the public health, education, and housing systems and generate social tensions[2].

Although the occurrence of the "healthy migrant effect" and the different perceptions/definitions of illness linked to culture are well documented in the literature, as a rule, migrant populations present a set of vulnerabilities that make them more susceptible to illness[4]. Poor living conditions, lack of regular access to medical care in their countries of origin, and the challenges faced during the migration process - exposure to unhealthy environments and deprivation of fundamental rights - contribute to the increased demand for health care among international migrants[5].

In Brazil, the Unified Health System (SUS) guarantees the right to care for all people, including international migrants, regardless of their migratory status. This is one of the pillars of the SUS, which is based on the principles of universality and equity[6]. However, despite the fundamental clause guaranteeing the existence of such inclusive rights, there is significantly less use of health services among migrants compared to the native population, even though they need physical and/or mental health care. Therefore, guaranteeing access is not enough to make health care for the migrant population a reality[3,7].

Migrants' knowledge of their health rights is crucial for seeking care. However, many were unaware of how to access the host country's health system pragmatically. This occurred even after several years of residence, reinforcing the need for specific informational and educational actions both on arrival and longitudinally[4,7-8].

Understanding health-seeking behavior among international migrants involves recognizing that this social group's actions and interactions are influenced by previous experiences with health care and their level of knowledge about the host country's health system[9]. Although the available evidence[4,7-8] points to significant difficulties, there is still a gap in analyzing the factors that lead to this lack of knowledge.

In this context, it is essential to understand experiences that show factors that perpetuate the difficulties and barriers encountered. The study of these dynamics must include the perspectives/experiences of the migrants themselves, who experience the challenges of the system, as well as those of health professionals who deal directly with these limitations in their daily lives and the practice of care. This approach allows us to identify how the lack of knowledge about the system not only influences migrants' individual decisions but also affects the efficiency and equity of the care provided. Looking at the phenomenon under study from different perspectives broadens the possibility of a more comprehensive understanding.

Thus, this study aimed to to find out about the experiences of health professionals and international migrants regarding this population's (lack of) knowledge about the Brazilian health system.

Methods

Type of study

This qualitative study used the Consolidated Criteria for Reporting Qualitative Research (COREQ) tool to describe its main methodological aspects. The theoretical framework of Symbolic Interactionism was used to support the research since this sociological theory analyzes lived experiences and the socio-individual construction of subjective meanings based on the interaction between social actors (in this case, health professionals and international migrants)[9].

Study location

The investigation occurred at a medium-sized university hospital in south Brazil. This service acts as a point of entry for spontaneous demand and through referrals. The hospital is located at the headquarters of the 15th Regional Health Department of Paraná, which covers 30 municipalities.

In the emergency department, patients are received and classified according to their level of risk, and they are then treated or referred. The team is staffed by 103 on-call doctors (in general practice, surgery, orthopedics, pediatrics, obstetrics, and gynecology) and 29 nurses. The service has 24 observation beds, eight inpatient beds, four for semi-intensive care, and six for emergencies.

Study participants

Sampling was convenient, characterized by selecting participants based on their accessibility. This sampling was necessary to identify people who met the study's inclusion/exclusion criteria. The leading researcher invited the professionals and migrants in the emergency department to participate on different days and other times (including the morning, afternoon, and evening shifts). She also enlisted the help of professionals working in the sector to inform her when an international migrant was in attendance so that she could invite them to participate.

The inclusion criteria for the professionals were being a doctor or nurse, working in the emergency department, and having treated international migrants there. Professionals on vacation or away from work during the research period were excluded. For migrants, the inclusion criteria were having non-Brazilian nationality, being over 18 years old, living in Brazil, and receiving care at the service where the study was conducted. Migrants who were not clinically and/or emotionally able to participate in the interview and those who did not speak Portuguese, Spanish, or English, languages known to the main researcher, were excluded.

Twenty-four health professionals who met the inclusion criteria were contacted. Of these, 10 refused to participate, citing a lack of familiarity with the subject, even though they work with migrant populations. Five professionals were initially willing to participate but did not keep in touch. Regarding migrants, 15 people who met the inclusion criteria were approached, but nine refused to join without specifying a reason. Finally, the study involved nine health professionals and six international migrants.

Although the researcher was familiar with the sector where the study took place, she had no previous links with the interviewees due to her experience as a resident in urgent and emergency nursing care. It is important to highlight her expertise in collecting and analyzing qualitative data in emergency contexts, and she was also directly and continuously supervised by a senior researcher in the group.

Period and data collection

The interviews took place between August and October 2023, in person and in a single meeting with each participant. All of them took place in a reserved room within the hospital itself, were audio-recorded in full, and later transcribed and translated into Portuguese, when necessary (two interviews were conduc-

ted in Spanish). Each interview lasted an average of 25 minutes and was conducted using a semi-structured instrument composed of two parts. The first part addressed the sociodemographic characterization of the participants, while the second consisted of questions directed at the relevant theme. Among the example questions, the following stand out: "Tell me which health service(s) you seek when you need care and why?" (migrants); "In your work process, how do you perceive the knowledge that international migrants have with the health system in Brazil?" (professionals). After being transcribed, the content was not returned to the participants due to a time limitation. However, at the end of each interview, it was ensured that they could exclude any part of the audio and, consequently, of the future analysis process. All interviewees agreed with the complete analysis of the audio.

Data treatment and analysis

The interviews were analyzed by the leading researcher using Atlas.ti® software to organize data based on the methodological framework of Reflective Thematic Analysis[10] in the light of Symbolic Interactionism[9]. The analysis took place in six phases of a non-linear process: 1) familiarization with the data, based on floating and intensive readings; 2) generation of initial codes, at which point the main propositions of the study were revisited, and significant aspects were identified in the interviewees' statements; 3) search for themes, which was established by separating the initial codes by similarities between them, using different colors; 4) review of the themes; 5) definition and naming of the themes and; 6) production of the final research report[10]. Data analysis revealed two main themes.

The interviews were carried out with all the participants who were contacted and agreed to take part. However, during the analytical process, the thematic saturation of the data was confirmed by identifying the repetition of key information for understanding the phenomenon[11].

Ethical aspects

To ensure anonymity, each professional was coded "Professional," followed by a random number. As for the migrants, they were coded "Migrant" followed by a number, also at random. Everyone signed the Informed Consent Form in two copies of equal content. The Standing Committee on Ethics in Research with Human Beings of the State University of Maringá approved the research under opinion no. 6,014,601/2023, and Certificate of Submission for Ethical Appraisal: 66594523.9.0000.0104.

Results

Fifteen participants, nine health professionals, and six migrants, were interviewed. Of the professionals, eight were nurses, one was a doctor, two men and six women, aged between 25 and 59. The length of time they had been working ranged from two to 35 years, and the length of time they had been working in the area was from two to 10 years. The migrants were three women aged 22, 35, and 54 and three men aged 23, 25, and 34. Two were from Venezuela, one from Haiti, one from Equatorial Guinea, one from Paraguay, and one from the Democratic Republic of Congo.

Two migrants were university students, and two others were regularly employed, one as a machine operator in the food industry and the other as a mechanic. Another worked as a delivery man for apps but was out of work due to health problems. Finally, one migrant has no employment or educational ties in Brazil. The minimum length of residence in the country was two weeks, and the maximum was seven years. Half of the interviewees said they had come to Brazil with their families, and all said they had chosen the country to search for better working and living conditions.

Based on the results, it was possible to establish two complementary perspectives on the knowledge of international migrants about the Brazilian health system, one coming from the subject themselves and the

other considering health professionals' perceptions. This latter social actor, despite not experiencing the reasons and consequences of the lack of knowledge when interacting with migrants in their daily *practice*, can also recognize nuances that need to be considered to serve this segment of the population better. Two thematic axes were identified: Situations contributing to lack of knowledge about the health system and Consequences/developments of lack of knowledge about the health system.

Situations that contribute to lack of knowledge about the health system

From the analysis of the data, it was found that health professionals sometimes interacted with migrants surrounded by a symbolism marked by stigmas and prejudices. This type of service was generally seen as inadequate and uninformative, which meant that migrants' lack of knowledge about the health system remained: *They didn't know anything. Some come to get a certificate, so sometimes the service is generalized because of this issue, and those who need it end up being put in situations like "it's nothing; you just came to get a certificate." So, I think this issue of them thinking they can come to get a certificate is also tricky for us* (Professional 4). *I'm not prejudiced against immigrants, but we know that some doctors in the service don't like to see people. They don't explain adequately. Without explanation, they remain unaware of the health system. Before long, they'll be back in the emergency room for reasons sensitive to primary care* (Professional 1).

It was identified that, according to the health professionals, the experience of different vulnerabilities, the lack of knowledge about the host society and the language, as well as the fact that employers did not offer the necessary support, in a synergistic way, cooperated to maintain the migrants' lack of knowledge regarding health services: *I see this a lot, that they stay in the market with little baskets asking for help. These situations leave them more vulnerable; the focus is on survival, and they do not know about health services, promoting health, or anything else* (Professional 4). *I've seen a pregnant woman, and she usually comes with her husband; he's the one who can talk to us a bit more because we couldn't identify* [the language spoken]. *So, if you don't know the language or society, will you know health? You won't!"* (Professional 6). *"I don't know if it's because of the workforce, the companies and industries in the neighboring towns, I think they manage to keep the immigrants there a bit longer as a workforce, and sometimes they don't give them the correct information, clarification, so they don't have a sense of the whole picture, including the health services available to them and how to use them* (Professional 3).

At times, the professionals realized that many of these vulnerabilities led the migrants to find it difficult to assimilate the information passed on during consultations and how the health system worked. The migrants' speeches were convergent when they referred to difficulties in understanding appointments at the health service, especially during the first interactions with the place because when they compared it to their society of origin, the health services were quite different: *You have to validate the information because it can be very confusing, he may not understand us talking and explaining and it ends up that he won't be able to leave the emergency room and go to the health unit, simply because he didn't understand your command* (Professional 5). *I won't talk about my case because I've been here for a year, and I already understand very well. I find it very complicated that you have so many health units here in Brazil, and each one is for a different type of thing. It complicates things for us. It's not like that in my country* (Migrant 6).

Sometimes, professionals and migrants observed social conditions linked to the migratory process, which symbolically represented the concept of fear, as barriers to be faced by migrants when they need health care, making it difficult for them to access the system and, consequently, get to know how it works: *Often they don't have a visa or authorization to be outside their country, so I don't know if this is a factor that keeps them from getting treatment, afraid that something will happen, worried that they will have to return to their country* (Professional 3). *At first, I was scared to use the SUS because it took me a while to get my documents in order, so I stopped going* (Migrant 1).

Consequences/consequences of lack of knowledge about the health system

The health professionals realized that the lack of knowledge about the Brazilian health system meant

that international migrants didn't use the services or put off seeking them, even if they were going through situations that required health care, such as an acute illness or pregnancy: *The lack of knowledge makes the immigrant have an unattended pregnancy, we advise that in the subsequent pregnancy they seek medical assistance from the beginning, do all the exams, worrying about the routine part of the exams that have to be collected, the routines that are recommended and guide them* (Professional 7). *A serious problem is that they* [the migrants] *keep going from service to service; sometimes, they take a long time to come because they don't know them. Once we realized that the problem wasn't constipation; the problem was that the child hadn't eaten for 15 days, it took a long time* (Professional 8).

Delays in seeking health services or not seeking care led to new consequences, such as self-medication. What's more, when they did seek care, the continuity of treatment in primary care did not materialize: *Because I didn't know anything about Brazil, I didn't know how to seek help. My son needed a doctor; I bought some medicine and gave him some tea to help him get better. After a while, I discovered where the health unit was* (Migrant 5). *I've already discharged some patients, referred them to the BHU* [Basic Health Unit]*, gave them the referral, explained how it worked, where we gave the medication, and I had to re-arrange this patient a few days later. He returned to the emergency room without using the medication and didn't go to the BHU, because he improved with the initial treatment at the ER* [Emergency Room] (Professional 3).

Some migrants reported that the consequences of their lack of knowledge were difficulties in getting health care, given the bureaucracy involved in getting care via the SUS. For internationals, bureaucratic issues are more challenging to understand because symbolically, they can sound like mistrust for being a migrant: *I had an accident with spring, and I went to the doctor. They treated me, but I went to get the medicine, and they told me I needed a card; I couldn't get it, and that's when I realized I didn't know how healthcare worked here* (Migrant 3). *I had to go to the health unit to see the doctor because I had a pain in my stomach. I was seen there, but then a woman came to confirm my address so I could get medication and make other appointments. I got suspicious because they didn't seem to believe that I lived near the unit, then they explained that it was expected, and I didn't understand anything* (Migrant 4).

Discussion

Based on the results, it was possible to identify some of the reasons behind migrants' lack of knowledge of the Brazilian health system and the consequences of this. The aspects that permeate this lack of knowledge are interconnected and were pointed out by both professionals and migrants. Difficulties related to social vulnerabilities, such as language barriers, lack of knowledge and understanding of Brazilian society, and financial limitations, were highlighted. Structural factors also emerged, such as challenges related to the complexity and bureaucracy of the system. The lack of culturally sensitive services, socio-cultural and religious aspects, and prejudice were also present in the speeches and are in line with the findings in the literature[1,8].

Xenophobia, racial prejudice, and discrimination are social barriers that increase migrants' vulnerability[1]. In the study, the professionals and the migrants themselves revealed stigmas and generalizations during social interaction in the services, which are often internalized and present in the healthcare work environment. These stigmas reflect structural social thinking and directly influence how people are welcomed, the quality of care, and their understanding of how the health system works[12].

Social vulnerability was identified as a critical factor in access to health care for migrant populations. Professionals reported that irregular migratory status and precarious employment reinforce barriers that hinder health care. In addition, insecurity about their legal situation can prevent them from seeking care, even when necessary. A study carried out in Spain with 14 Iranian migrants and 11 health professionals showed that undocumented immigrants faced structural and individual barriers based on their social vulnerability. Among other things, being undocumented led to restricted rights of access and fear of rejection in health services[13].

The lack of knowledge about the health system and the rights of migrants creates a vicious cycle in which people don't access services because they

don't know about them, and because they don't access them, they continue not knowing about them. In this sense, they remain on the margins of society and the supply of health services. This cycle is reflected in a delayed search for services, self-medication, and lack of continuity of treatment. Furthermore, without understanding how the system works, they make inappropriate use of emergency services, overloading tertiary care and failing to address their health needs adequately[14].

Health practices can influence patterns of use of health services in the host country in the country of origin since beliefs, experiences, and forms of care vary according to previous interactions and the culture of each migrant. Self-medication, often a common practice, coupled with the difficulty of accessing the health system, contributes to its prevalence among migrants. In countries with weakened health systems, the pharmacy is often the first option sought to treat health problems. Still, this practice can be harmful by masking symptoms in the early stages of the disease and compromising adherence to medical and health guidelines[3,15-16].

Migrants themselves recognize that they often only seek medical attention when there are urgent needs, neglecting prevention and ongoing care. How they are treated during care can directly impact their health and illness process and their perception of the quality of care on offer, meaning that, as a rule, they only seek services in acute situations[17]. Especially when they feel more vulnerable due to their documentation or regularization in the host country[13,16,18].

Also, concerning vulnerability, the language and cultural barrier was repeatedly mentioned. Communication difficulties showed that language is one of the most significant obstacles to migrants' understanding of the guidelines. Language also limits the ability of professionals to understand their needs, directly interfering with treatment and integration into the service. There is evidence that using health services was twice as prevalent among those who spoke and understood Portuguese as those with language difficulties[19-20].

Knowing the host country's language is essential for the migrant's integration and empowerment process. There are still no language policies in Brazil aimed at interpretation and translation in public health services, as in Canada, for example[21]. Therefore, it is necessary to invest in training professionals to deal with groups of different ethnicities, cultures, and languages, meeting their needs[12,21]. Although this process is gradual, services must adopt communication strategies beyond verbal language to better serve this population.

Therefore, more time must be spent on translation services for migrants and health professionals as a strategy for overcoming linguistic and cultural barriers to accessing health care. In countries such as Spain and the European Union, there is growing recognition of the need for health policies that integrate translation services and training in cultural competence for health professionals, which is crucial to promoting health equity and ensuring that migrants can access and understand the health services available[22].

Developing communication skills that transcend the language barrier and consider customs, habits, intonation, and body language strengthens dialogue. It is important to avoid quick, stereotyped, and prejudiced judgments and seek to understand situations from the other person's point of view. Attentive and qualified listening to non-verbal communication and respecting the rhythms and communication styles of everyone and culture are essential during social interaction in health services[23].

The inclusion of migrants in the Brazilian health system highlights the complexity of migratory processes. In addition to cultural, moral, and political vulnerabilities, previous experiences that generate fear or apprehension about health services and access problems can constitute barriers to seeking and using them[24-25]. Therefore, health practices aimed at migrants need to consider the diversity of experiences of this population.

Health professionals need to be aware of the emergence of specific and chronic illnesses, whether

related to the working conditions of these individuals, the health problems prevalent in their countries of origin, or the illnesses developed in the host country. These diseases can be aggravated by lifestyle habits and environmental factors acquired during the acculturation process, which can lead to physical limitations and, consequently, increase the demand for health services in Brazil[13,24-26].

Consequently, the health of international migrants is directly influenced by various public policies beyond the health system. The development of public policies that go beyond fundamental legal rights, based on interventions that promote integration, can improve the health and integration of migrants[27].

This reinforces the importance of integrative strategies that not only provide guidance on how the service works but also develop a culture of prevention and health promotion, especially in Primary Care, with a view to greater continuity and adherence to treatment, improving quality of life, and including the entire family nucleus in care. For this reason, it is also essential to involve migrant communities in developing and implementing health actions to ensure that their needs and preferences are considered[18].

To tackle the existing care challenges, it is necessary to understand that migratory flows around the world highlight the need for health professionals to develop skills in offering culturally sensitive and effective care to this population. Health teams must be trained to listen and understand the sociocultural and historical context of migrants, welcoming them and establishing an empathetic dialog[1].

Developing strategies that consider the various barriers migrants face in accessing health services is essential. Implementing public policies to facilitate the integration of migrants, with a focus on education and effective communication, is also essential. These actions will contribute not only to increasing migrants' knowledge of the Unified Health System but also to ensuring that they can access and use health services appropriately and efficiently.

Study limitations

One of the limitations relates to the fact that the interviews with migrants took place while they were being attended to. This certainly influenced the low level of participation in the study and may also have altered the content of the statements made by those who agreed to take part due to the fear of suffering any penalties/sanctions in their care after being interviewed, even though the confidentiality of the information was guaranteed. Another possible limitation relates to the fact that the professional interviews were carried out during working hours, leading to more objective participation, as at different times, they showed concerns about returning to their jobs. However, to increase the number of participants, it was decided to collect data in the emergency department.

Contributions to practice

Understanding the situations that contribute to unfamiliarity with the workings of the health system can help managers and health professionals develop strategies that are adapted to the realities and needs of migrants. These initiatives can include developing educational materials in multiple languages, specific training for health teams on reception and intercultural communication and creating protocols that integrate clear and accessible information into the processes of receiving and orienting migrants.

In addition, partnerships with non-governmental organizations, social entities, and religious groups that serve migrants can be key to broadening the dissemination of this information and taking advantage of already established spaces of trust and welcome. By recognizing and acting on the specific barriers faced, these actions contribute to reducing inequalities in access and promoting a more effective and humanized integration of migrants into the Brazilian health system.

Conclusion

International migrants' unfamiliarity with the Brazilian health system is multifactorial, influenced by social vulnerabilities, language barriers, structural prejudices, and difficulties related to the system's complexity and bureaucracy. These barriers negatively impact both access and continuity of care, perpetuating situations of underuse of services, self-medication, and inappropriate use of emergency rooms.

Health professionals' perceptions highlighted the need for more significant preparation to deal with migrants' cultural and communication specificities. In contrast, migrants' reports showed difficulties understanding the guidelines and using the services available. Issues related to migratory status and precarious insertion in the labor market emerged as additional factors that aggravate ignorance.

Authors' contribution

Conception and design or analysis and interpretation of data: Buzzerio LF, Sanguino GZ, Marcon SS, Barreto MS. Writing of the manuscript or relevant critical review of the intellectual content. Final approval of the version to be published and agreement to be responsible for all aspects of the manuscript relating to accuracy or completeness being adequately investigated and resolved: Buzzerio LF, Soldera AGS, Cruz ADQ, Luz MS, Sanguino GZ, Marcon SS, Barreto MS.

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