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Determinants of Health Among Refugees and Asylum Seekers in Spain: A Scoping Review

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Abstract

Refugees and asylum seekers may experience health risks before departure, during travel and transit, and after arrival in the host country. This scoping review mapped health determinants among refugees and asylum seekers in Spain and described the main physical, mental, and social health concerns reported in the literature. The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR). We searched PubMed, Scopus, and Web of Science for English-, Spanish-, or Catalan-language sources published from January 2014 through December 2020, supplemented by Google Scholar, reference-list screening, selected journals, and relevant organizational websites. Peer-reviewed studies and eligible grey literature were charted and narratively synthesized using a migration-trajectory framework. Twenty-seven studies were included. Health was shaped by interacting determinants across the migration trajectory, including premigration violence and deprivation, hazardous travel, legal status, reception and accommodation conditions, language and communication barriers, socioeconomic insecurity, discrimination, and access to healthcare. Infectious diseases and mental health conditions were frequently reported, alongside nutritional, oral health, chronic disease, reproductive health, and psychosocial needs. Refugee and asylum seeker health in Spain is determined by cumulative social, legal, material, and healthcare-related conditions rather than migration alone. Effective responses require equitable healthcare access, person-centered reception systems, professional interpretation and cultural mediation, continuity of care, and sustained mental health and social support.

Categories: Health Policy, Public Health, Epidemiology/Public Health
Keywords: emigration and immigration, health services accessibility, refugees, social determinants of health, spain

Introduction And Background

People seeking international protection may encounter health risks before departure, during travel, and after arrival in Spain. Conditions associated with displacement, including violence, trauma, food and water insecurity, detention, poverty, racism, and social exclusion, can affect health at each stage [1-3]. The Spain-specific asylum figures and migration routes below provide the geographical context for this review.

The health needs of refugees and asylum seekers are diverse and may include communicable and non-communicable diseases, injuries, nutritional problems, and mental health conditions [3,4]. Psychological disturbances, such as depression, anxiety, and post-traumatic stress disorder, may be linked to war, persecution, the loss of loved ones, displacement, violence, and uncertainty regarding legal status. After arrival, unemployment, poor housing conditions, discrimination, social isolation, and language or cultural barriers can contribute to these problems [4]. Accessing and using healthcare services can pose considerable challenges for refugees and asylum seekers. Legal and administrative restrictions, limited knowledge of the health system, language barriers, inadequate interpretation services, and discontinuity of care may delay or prevent appropriate treatment [4]. The nature and extent of these barriers vary according to the stage of migration and the relevant national and regional frameworks. Healthcare access must therefore be understood within the wider social, economic, political, and legal context.

By 2018, Spain had become an important European destination and entry point for people seeking international protection. Spain received the fourth-highest number of asylum applications in the European Union, with a total of 54,065 applications lodged that year. Applicants were predominantly from Venezuela, followed by Colombia, Syria, Honduras, and El Salvador [5]. This increasingly diverse population created additional demands for reception services, social protection, and healthcare provision.

Spain can be accessed via the Western Mediterranean route, which involves maritime crossings from North Africa to mainland Spain, as well as land and maritime crossings through Ceuta and Melilla. Armed conflict, political instability, and border-control policies have all contributed to changes in migration routes over time. These routes may expose displaced populations to overcrowding, violence, exploitation, food and water insecurity, interrupted healthcare, and other risks that can adversely affect their health before arrival in Spain.

The social determinants of health are the conditions in which individuals are born, grow, live, work, and age, together with the wider socioeconomic, cultural, political, and environmental systems that shape them [6]. For refugees and asylum seekers, determinants operate across the full migration trajectory: premigration experiences, conditions during travel, legal and reception status, accommodation, employment, social support, discrimination, and access to healthcare after arrival [6,7].

Previous work has examined individual clinical conditions, healthcare access, reception policy, or migrant health in Spain, but evidence relevant to refugees and asylum seekers is dispersed across scientific studies, institutional reports, policy documents, and disciplines. This review maps determinants along premigration, transit, and destination stages in one synthesis while distinguishing refugee-specific evidence from findings in mixed migrant populations where the source permits. Its objectives were to identify health determinants, describe the populations studied, and summarize reported physical, mental, and social health concerns.

Review

Materials and methods

Review Design

A scoping review was conducted to identify and synthesize evidence on the determinants of health, sociodemographic characteristics, and commonly reported health problems among refugees and asylum seekers in Spain. The review was prepared in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) [8]. The PRISMA-ScR reporting checklist is presented in Appendix A.

Information Sources and Search Strategy

We limited eligibility to sources published from January 2014 through December 2020 to map the evidence available during a period that included a substantial rise in asylum applications in Spain. The window captures literature published before and during that rise. Eligibility was based on publication date, so some included sources reported data collected before 2014.

A structured literature search was conducted in PubMed, Scopus, and Web of Science through the University of Barcelona Library. Searches were restricted to documents published between January 2014 and December 2020. The following core search expression was adapted to the syntax and search fields of each database: (refugee OR "asylum seeker") AND (Spain OR Spanish) AND (health OR healthcare OR "health care" OR "health status" OR "mental health" OR "social determinants of health"). The database searches were supplemented by searches in Google Scholar, screening of reference lists, hand-searching of relevant journals, and targeted searches of the websites of key organizations, including the United Nations High Commissioner for Refugees, the International Organization for Migration, and the Migration Data Portal. Both peer-reviewed publications and relevant grey literature were considered. Grey literature included institutional reports, policy documents, working papers, brief reports, and policy recommendations. The search sources and reported database yields are summarized in Table *1*. The reported electronic database search expressions and restrictions are provided in Appendix B.

Information source	Search expression or identification approach	Search yield
PubMed	Common core search expression: (refugee OR "asylum seeker") AND (Spain OR Spanish) AND (health OR healthcare OR "health care" OR "health status" OR "mental health" OR "social determinants of health")	154 database records
Scopus	Common core expression adapted to Scopus search fields; the exact database-specific string was not preserved	74 database records
Web of Science	Common core expression adapted to Web of Science search fields; the exact database-specific string was not preserved	86 database records
Google Scholar	Supplementary searching of relevant published and grey literature; exact individual search strings were not documented	Separate count not recorded
Reference lists	Screening reference lists of relevant publications for additional sources	Separate count not recorded
Selected journals	Hand-searching relevant journals	Journal list and count not recorded
Organizational websites	Targeted searches of the UNHCR, IOM, and Migration Data Portal websites for reports, policies, and related grey literature	Separate count not recorded

TABLE 1: Search strategy and information sources

UNHCR: United Nations High Commissioner for Refugees; IOM: International Organization for Migration

Eligibility Criteria

The review focused on refugees and asylum seekers in Spain. Sources involving broader migrant populations or multiple countries were retained when they provided context relevant to Spain, including evidence on healthcare entitlements, access barriers, or health needs. For example, a Spanish study of immigrant children provided context on parasitic infections, and European studies that included Spain provided comparative evidence on healthcare access. Findings from mixed populations or pooled countries were interpreted at the level reported by the source. Refugee-specific or Spain-specific findings were identified only when reported separately.

Documents were included if they focused on refugees, asylum seekers, applicants for international protection, unaccompanied asylum-seeking minors, or related forcibly displaced populations in Spain. Studies conducted in Spanish regions, cities, border areas, reception centers, or healthcare settings were eligible.

Documents were required to report information on sociodemographic characteristics, determinants of health, migration or reception conditions, healthcare access or utilization, relevant policies, or physical, mental, or social health problems. Eligible evidence included quantitative, qualitative, and mixed-methods studies, as well as reviews, institutional reports, policy documents, working papers, and brief reports. Only full-text documents published between January 2014 and December 2020 in English, Spanish, or Catalan were included.

Documents were excluded if they did not address a relevant refugee, asylum-seeking, or forcibly displaced population in Spain; did not report health-related determinants, healthcare issues, or health outcomes; were published outside the predefined period; were unavailable in full text; were written in an ineligible language; were duplicate records; or lacked findings relevant to the review objectives. The inclusion and exclusion criteria are summarized in Table *2*.

Decision	Criterion	Eligibility rule
Inclusion	Population	Refugees, asylum seekers, applicants for international protection, unaccompanied asylum-seeking minors, or related forcibly displaced populations
	Contextual evidence	Broader migrant or multicountry sources with findings relevant to Spain, interpreted at the population and geographic level reported
	Geographic setting	Spain, including its regions, cities, border areas, reception centers, and healthcare settings
	Sociodemographic/contextual data	Reports on sociodemographic characteristics, migration or reception conditions, or other determinants of health
	Healthcare and policy	Reports on healthcare access or use, healthcare provision, or relevant health policies
	Health outcomes	Reports on physical, mental, or social health problems
	Evidence type	Quantitative, qualitative, or mixed-methods studies; reviews; institutional reports; policy documents; working papers; or brief reports
	Publication period	Published from January 2014 through December 2020
	Language	English, Spanish, or Catalan
	Full text	Full-text document available
Exclusion	Population/geographic relevance	Neither addresses a relevant forcibly displaced population in Spain nor provides contextual evidence relevant to Spain
	Health relevance	Does not report a health-related determinant, healthcare issue, or health outcome
	Publication period	Published before January 2014 or after December 2020
	Language	Published in a language other than English, Spanish, or Catalan
	Full-text availability	Full text unavailable for assessment
	Duplicate records	Duplicate publication record
	Review objectives	No findings relevant to the review objectives

TABLE 2: Inclusion and exclusion criteria

Study Selection

Study selection was conducted by one reviewer in two stages. Titles and abstracts were screened against the predefined eligibility criteria, followed by full-text assessment of potentially relevant records. The available report records 27 full-text exclusions but does not provide counts for individual exclusion reasons. No independent duplicate screening or verification sample was documented. These omissions limit the reproducibility of study selection. The process is summarized in the PRISMA flow diagram.

Data Extraction and Coding

Twenty-seven studies were included in the final review. The charted information comprised author and publication year, design, setting, population, and main findings. Sources were organized into cross-cutting, premigration, transit, and destination-country determinants. Health problems were described separately as infectious diseases, mental health conditions, non-communicable diseases, nutritional problems, oral health conditions, and other physical or psychosocial concerns. When a finding related to more than one domain, it was discussed with the determinant most directly linked to the reported mechanism and cross-referenced in the health-problems synthesis where relevant. The source populations were identified by the terminology used in each study; findings from mixed refugee, asylum-seeking, and other migrant samples were not attributed specifically to refugees when disaggregated data were unavailable.

Quantitative findings were summarized using the frequencies, proportions, and prevalence estimates reported by the source studies. Qualitative, institutional, and policy evidence was synthesized narratively and thematically. No meta-analysis or formal comparison across origin, route, or legal-status groups was undertaken. Differences in study design, population definitions, sampling, and setting mean that reported proportions should be read as study-specific descriptions rather than pooled estimates or representative national rates. No formal methodological quality or risk-of-bias appraisal was conducted because the review

was designed to map the available evidence; the strength of individual prevalence estimates therefore remains uncertain.

Results

Study Selection and Characteristics of the Evidence

The database searches identified 314 records: 154 from PubMed, 74 from Scopus, and 86 from Web of Science. After removing 87 duplicate records, 227 unique records underwent title and abstract screening. A total of 173 records were excluded at this stage, leaving 54 full-text reports for eligibility assessment. Of these, 27 full-text reports were excluded, and 27 studies were included in the final scoping review. The study selection process is presented in Figure *1*.

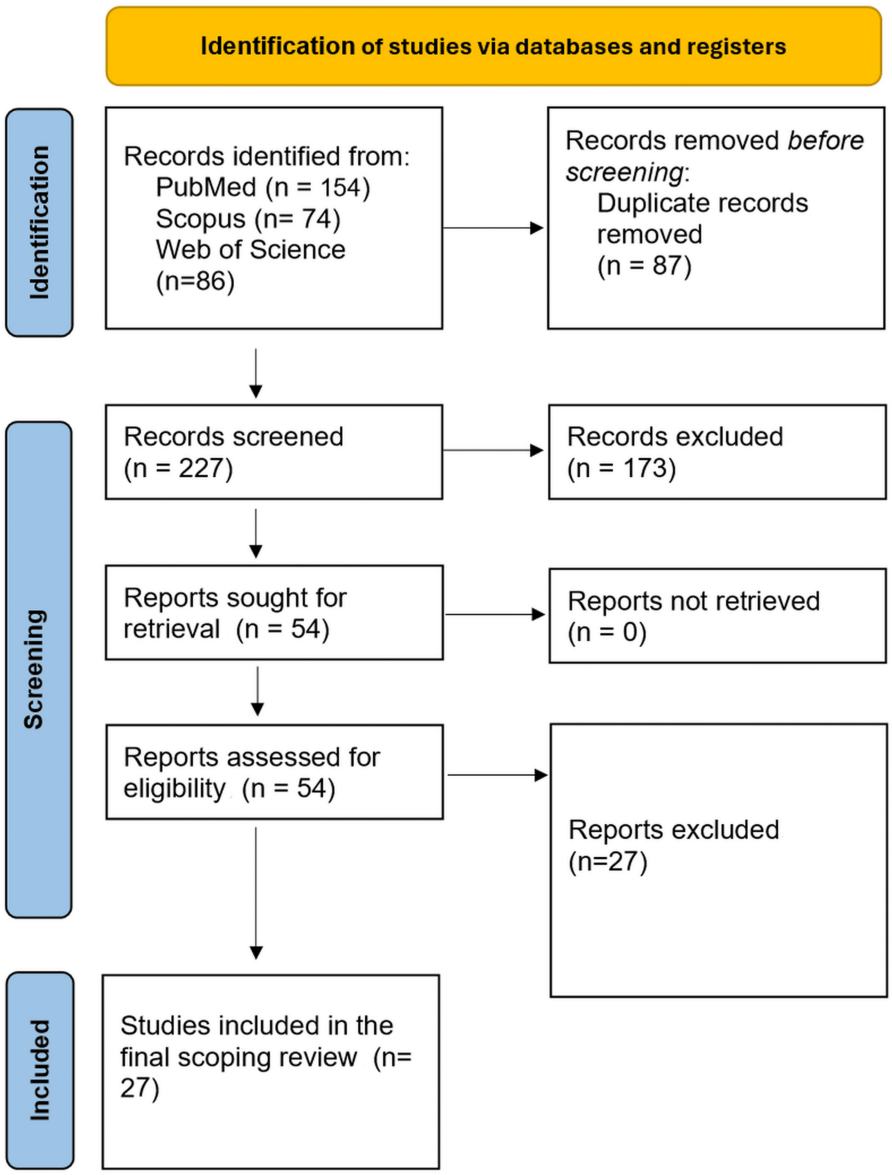


FIGURE 1: PRISMA flow diagram

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Figure *1* depicts the database-based screening counts reported in the review. Records obtained through supplementary searching were not quantified separately in the source manuscript.

The included evidence comprised peer-reviewed research articles, institutional reports, policy recommendations, brief reports, and working papers. Additional sources were used to provide contextual

information but were not included in the formal synthesis. The findings were organized according to the International Organization for Migration framework for the social determinants of migrant health. The principal themes were cross-cutting determinants, country of origin and reasons for migration, travel and transit conditions, destination-country determinants, and commonly reported health problems. The characteristics and main findings of the included sources are presented in Table 3.

Study ID	Title	Country/setting	Study design	Population	Main findings	Evidence scope
Gozalbo et al. 2020 [9]	Assessment of the nutritional status, diet and intestinal parasites in hosted Saharawi children	Spain; Valencia holiday host program	Cross-sectional clinical, nutritional, and parasitological study	Sahrawi refugee children aged 10-13 years hosted from the Tindouf refugee camps	Children showed chronic malnutrition or stunting, hematological abnormalities, lactose malabsorption, and almost universal intestinal parasitosis linked to inadequate nutrition, water scarcity, sanitation, and hygiene	Refugee or asylum seeker evidence in Spain
León-Pinilla et al. 2020 [10]	Support and emotional well-being of asylum seekers and refugees in Spain	Spain; Andalusia, Catalonia, Madrid, Valencia, and the Basque Country	Cross-sectional questionnaire study	Asylum seekers, recognized refugees, and people whose asylum applications had been rejected	Healthcare and legal assistance were the easiest forms of support to access, whereas employment, income, and housing were the most difficult needs to meet. Emotional well-being was positive overall but remained below the maximum possible level	Refugee or asylum seeker evidence in Spain
Paloma et al. 2020 [11]	Promoting posttraumatic growth among the refugee population in Spain: a community-based pilot intervention	Spain; Seville, Andalusia	Mixed-methods, one-group pretest-posttest pilot intervention	Adult refugees recently settled in Seville	The intervention improved overall post-traumatic growth and the domains of appreciation of life, personal strength, relationships with others, and new possibilities. It was considered acceptable and feasible	Refugee or asylum seeker evidence in Spain
Riza et al. 2020 [12]	Determinants of refugee and migrant health status in 10 European countries: the Mig-HealthCare project	Ten European countries, including Spain	Multicountry cross-sectional survey	Adult refugees and migrants who had lived in the country of interview for 6 months to 5 years	Mental health disorders and chronic diseases were associated with poorer general health. Permission to remain and residence in the intended destination country were associated with better health, while linguistic, cultural, and administrative barriers fragmented healthcare access	Multicountry evidence including Spain
Lebano et al. 2020 [13]	Migrants' and refugees' health status and healthcare in Europe: a scoping literature review	Nine European countries, including Spain	Scoping literature review	Migrants and refugees and their access to and use of healthcare in Europe	Persistent inequalities were identified in healthcare access, with unmet mental and dental health needs, legal and communication barriers, discrimination, greater emergency-service use, and lower primary-care use	Multicountry evidence including Spain
Granero-Molina et al. 2019 [14]	Cultural issues in the provision of emergency care to irregular migrants who arrive in Spain by small boats	Spain; southern maritime border	Qualitative phenomenological study	Irregular migrants arriving in Spain by small boats	Three themes were identified: migration as a strategy for improving living conditions, serious risks during the journey, and the need for culturally adapted emergency care	Broader migrant evidence in Spain
Vivas 2019 [15]	Analysis of food provision strategies in the reception of refugees in Catalonia (Spain)	Spain; Catalonia	Narrative and bioethical analysis informed by field experience and organizational interviews	Refugees participating in reception programs in Catalonia	Refugees had limited autonomy over food choices during initial reception. Nutritional needs differed by country of origin, with more urgent concerns among refugees from parts of Africa	Refugee or asylum seeker evidence in Spain
La Spina 2019 [16]	Categories of exclusion in migrants' access to healthcare in Canada: a comparative perspective	Canada and Spain	Comparative legal and policy analysis	Migrants, asylum seekers, and refugees affected by healthcare-entitlement policies	Legislative reforms in Canada and Spain created or reinforced categories of exclusion that restricted migrants' and refugees' access to healthcare	Multicountry evidence including Spain
Chiarenza	Supporting access to healthcare for refugees	European countries under	Mixed-methods study using	Healthcare providers and governmental, non-governmental,	Healthcare access was hindered by legislative, financial, and administrative	Multicountry

et al. 2019 [17]	and migrants in European countries under particular migratory pressure	migratory pressure, including Spain	interviews, focus groups, and a systematic literature review	international, and civil-society organizations serving refugees and migrants	barriers; inadequate interpretation and cultural mediation; limited information; and poor service coordination	evidence including Spain
Marcu 2018 [18]	Refugee students in Spain: the role of universities as sustainable actors in institutional integration	Spain; Madrid universities	Qualitative study using in-depth semi-structured interviews and thematic analysis	Refugee university students and institutional experts	Recognition of previous qualifications, language barriers, and fragmented institutional coordination limited educational integration. University access, scholarships, and credential recognition supported inclusion	Refugee or asylum seeker evidence in Spain
Riatto et al. 2018 [19]	Oral health status of Syrian children in the refugee center of Melilla, Spain	Spain; Temporary Stay Centre for Immigrants, Melilla	Cross-sectional clinical study	Syrian refugee children aged 5-13 years	Dental caries affected 75% of six-year-olds and 50% of 12-year-olds. Restorative treatment levels were low, although most periodontal sextants were considered healthy	Refugee or asylum seeker evidence in Spain
Jiménez-Ivars et al. 2018 [20]	Interpreting in refugee contexts. A descriptive and qualitative study	Spain	Small-scale qualitative study using interviews and focus groups	Interpreters working with refugees and refugee service users	Interpreters reported dissatisfaction with their employment and working conditions. Refugees frequently perceived interpretation services as inadequate, negative, or frustrating	Refugee or asylum seeker evidence in Spain
Serre-Delcor et al. 2018 [21]	Health status of asylum seekers, Spain	Spain; Barcelona	Retrospective observational clinical study	Asylum seekers assessed at an international health center	Although 94.7% were asymptomatic, 23.1% were diagnosed with at least one infection. Infection was more frequent among participants from sub-Saharan Africa and those travelling by combined land and maritime routes	Refugee or asylum seeker evidence in Spain
Ledoux et al. 2018 [22]	Migrants' access to healthcare services within the European Union: a content analysis of policy documents in Ireland, Portugal and Spain	Ireland, Portugal, and Spain	Content analysis of official policy documents	National policy frameworks addressing migrants' access to healthcare	Policies emphasized equity and service adaptation, including cultural mediation and professional training. However, inclusive commitments did not always translate into implementation and were vulnerable to political and economic pressures	Multicountry evidence including Spain
Bravo and Santos-González 2017 [23]	Asylum-seeking children in Spain: needs and intervention models	Spain; nine autonomous territories	Mixed-methods descriptive study and document review	Unaccompanied foreign minors and professionals involved in their care	Employment and improved living conditions were major migration motivations. Needs differed across reception systems and included education, health, housing, emotional support, and preparation for adulthood	Broader migrant evidence in Spain
Belhassen-García et al. 2017 [24]	Nutritional status of children from low-income countries arriving in Spain	Spain; Salamanca	Observational clinical study	Children and adolescents arriving from sub-Saharan Africa, North Africa, and Latin America	Nutritional risk for growth problems was identified in 6.8% of participants, while 17.8% were overweight. Body mass index increased with longer residence in Spain	Broader migrant evidence in Spain
Belhassen-García et al. 2017 [25]	Should parasitic disease be investigated in immigrant children with relative eosinophilia from tropical and sub-tropical regions?	Spain; Salamanca	Prospective observational clinical study	Immigrant children from tropical and subtropical regions without absolute eosinophilia	Relative eosinophilia was present in 14.2%. Among children with relative eosinophilia, 60% were diagnosed with a parasitic disease, and coinfection was frequent	Broader migrant evidence in Spain
Mason 2016 [26]	Caring for the unseen: using linking social capital to improve healthcare access to irregular migrants in Spain	Spain; Madrid	Descriptive case study and program analysis	Irregular migrants supported through a faith- and community-based network	Community and church-based social networks helped irregular migrants obtain health information and access services that they previously did not know about or could not navigate	Broader migrant evidence in Spain
Evangelidou	Brief guide to mental health and psychosocial		Practice guidelines and	Syrian refugees in	The document recommended comprehensive mental health and	Refugee or asylum

et al. 2016 [27]	support for Syrian refugees in Spain	Spain	narrative guidance	Spain	psychosocial needs assessments followed by tiered, culturally appropriate interventions based on identified needs	seeker evidence in Spain
Serre Delcor et al. 2016 [28]	Infectious diseases in sub-Saharan immigrants to Spain	Spain; Barcelona	Retrospective clinical record review	Sub-Saharan African immigrants attending an international health center	At least one infectious disease was identified in 72.8% of participants. Latent tuberculosis, intestinal parasites, helminth infections, and hepatitis B were common	Broader migrant evidence in Spain
León Pinilla et al. 2016 [29]	Interpreting in a refugee context: assessment by the agents involved	Spain	Mixed-methods field study using qualitative and quantitative questionnaires	Asylum seekers, refugees, interpreters, service providers, and relevant officials	Interpretation was regarded as essential throughout the asylum process, but limited funding, insufficient training, and inadequate institutional attention reduced service quality	Refugee or asylum seeker evidence in Spain
Cimas et al. 2016 [30]	Healthcare coverage for undocumented migrants in Spain: regional differences after Royal Decree Law 16/2012	Spain; 17 autonomous regions	Comparative health policy and regulatory review	Undocumented migrants affected by Royal Decree-Law 16/2012	Some autonomous regions adopted measures to reduce the effects of the Royal Decree-Law, whereas others implemented it as intended. This produced substantial regional inequalities in healthcare entitlement and access	Broader migrant evidence in Spain
Monge-Maillo et al. 2015 [31]	Screening of imported infectious diseases among asymptomatic sub-Saharan African and Latin American immigrants: a public health challenge	Spain; Madrid	Retrospective observational screening study	Asymptomatic sub-Saharan African and Latin American immigrants attending a tropical-medicine referral center	HIV, hepatitis B and C, and latent tuberculosis were more frequent among sub-Saharan African participants. Malaria and schistosomiasis were also detected, while Chagas disease was prevalent among Latin American participants	Broader migrant evidence in Spain
León Pinilla et al. 2015 [32]	Refugees and well-being: a qualitative study in Spain	Spain; several provinces	Exploratory qualitative study using interviews and a focus group	Eight asylum seekers/refugees and one non-governmental service provider	Participants reported fear, uncertainty, language barriers, unemployment, and limited integration. Nevertheless, they perceived greater safety and some improvement in personal satisfaction after arriving in Spain	Refugee or asylum seeker evidence in Spain
Belhassen-García et al. 2014 [33]	Relevance of eosinophilia and hyper-IgE in immigrant children	Spain; Salamanca	Prospective observational clinical study	Immigrant children from sub-Saharan Africa, North Africa, and Latin America	Absolute eosinophilia and elevated immunoglobulin E were present in 22.9% and 56.8% of children, respectively. Filariasis, strongyloidiasis, and schistosomiasis were the most frequent underlying infections	Broader migrant evidence in Spain
Suess et al. 2014 [34]	The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context	European Union and EFTA countries, with substantial relevance to Spain	Narrative review of comparative studies and reports	Undocumented migrants and European healthcare-entitlement frameworks	Healthcare entitlements varied widely across Europe, and legal and practical barriers frequently restricted effective access. Royal Decree-Law 16/2012 moved Spain from relatively inclusive access toward a restrictive entitlement model	Multicountry evidence including Spain
Suess et al. 2014 [35]	Right of access to healthcare in the context of the Royal Decree-Law 16/2012: the perspective of civil society organizations and professional associations	Spain	Narrative review of documents from civil society organizations and professional associations	Vulnerable populations, including undocumented migrants, affected by Royal Decree-Law 16/2012	Civil society and professional organizations anticipated adverse effects on healthcare access, quality, and health. They proposed alternatives and emphasized citizen participation to preserve universal and sustainable public healthcare	Broader migrant evidence in Spain

TABLE 3: Characteristics and main findings of the included studies

Study ID links each source to its numbered reference. The population and setting columns reproduce the scope of the source; some studies concern refugees or asylum seekers directly, whereas others include irregular migrants, general migrant populations, or several countries. Findings from mixed populations should not be interpreted as refugee-specific estimates when subgroup data are unavailable. Secondary reviews and policy analyses contribute contextual evidence and are not independent clinical prevalence datasets. Sample sizes and population-definition clarity were not consistently available in the source table; this table is descriptive and does not represent a formal quality appraisal.

EFTA: European Free Trade Association

Cross-cutting determinants

The literature addressing cross-cutting determinants focused mainly on age, gender, socioeconomic conditions, and social support.

Age and Life-Course Vulnerability

Children and young adults feature prominently in the cited evidence. Some source statistics describe European Union asylum applicants rather than a Spain-specific population [15,36]. They are used only as broader context; the available charting record does not establish Spain-specific age proportions for these figures.

Age influences protection needs, healthcare requirements, dependency, accommodation, nutrition, education, and access to social services. Children and adolescents experienced vulnerabilities related to interrupted education, inadequate accommodation, safeguarding concerns, and limited access to age-appropriate services. Unaccompanied minors faced additional risks associated with family separation, legal uncertainty, and the transition from child-protection systems to adult services.

Gender

Several included sources described changes in the demographic composition of displaced populations [23,31,36,37]. Earlier flows were often characterized by young and middle-aged men, while later sources also described women, children, pregnant women, older adults, and people with chronic conditions [37]. The cited 2015 proportion of women did not have a clear Spain-specific denominator in the available charting record and is therefore omitted.

The sex distribution varied by geographical origin. One study reported a higher proportion of women among Latin American populations and a higher proportion of men among populations originating from sub-Saharan Africa [31]. Gender influenced exposure to violence and exploitation, sexual and reproductive health needs, caregiving responsibilities, socioeconomic vulnerability, and barriers to obtaining healthcare.

Socioeconomic Conditions and Social Support

Economic insecurity operated both as a reason for migration and as an important post-arrival determinant of health. Among unaccompanied minors, obtaining employment and achieving a safer and more stable life were frequently reported motivations for migration [23].

Following arrival in Spain, unemployment, financial insecurity, unstable accommodation, social isolation, and limited understanding of available services negatively affected health and well-being. Conversely, community networks and social support facilitated access to healthcare and other essential resources. Linking social capital was particularly important for people who did not understand their healthcare entitlements or feared contact with official institutions [26,32].

Overall, age, gender, socioeconomic position, and social support interacted to influence vulnerability rather than operating as isolated determinants.

Country of origin and reasons for migration

Countries of origin differed across study populations and over time. One clinical study reported that the principal countries represented among Mediterranean arrivals included Syria, Afghanistan, Iraq, Eritrea, Pakistan, Iran, Somalia, Morocco, and Sudan [21]. Other sources described arrivals in Spain from Mali, Algeria, Nigeria, Palestine, Guinea, and several North African and sub-Saharan African countries [15,23,28].

The cited 2015 source discusses applicants from Syria, Afghanistan, Iraq, Kosovo, Albania, and Pakistan [36]. The available charting record does not establish a Spain-specific denominator for the previously reported proportion.

Applicants from Latin American countries, particularly Venezuela and Colombia, became increasingly prominent in Spanish asylum statistics in later years.

Reasons for migration were multidimensional and included armed conflict, political persecution, environmental insecurity, poverty, unemployment, discrimination, family separation, and the pursuit of safety or improved living conditions [14,23,28]. Among unaccompanied adolescents, employment and the expectation of a better life in Europe were frequently reported motivations [23].

Country of origin influenced health through more than the geographical distribution of disease.

Premigration exposures included violence, food insecurity, interrupted vaccination and healthcare, inadequate sanitation, loss of family and community networks, and differences in previous access to health services.

Travel and transit

The literature consistently described travel and transit conditions as hazardous. People using irregular routes often lacked reliable information about their departure, their destination, the condition of the vessel, or the people organizing the journey [14]. Limited time, information, and resources prevented adequate preparation.

Reported risks included dehydration, hunger, exposure to extreme environmental conditions, injury, infection, sexual violence, exploitation, anxiety, and depression. Overcrowding in small boats and violence involving passengers, smugglers, security personnel, or authorities further increased physical and psychological risks [14].

The migration route influenced the health needs observed after arrival. Combined land-maritime journeys and prolonged transit through areas with inadequate sanitation and limited healthcare services were associated with a higher probability of detecting infection in some clinical populations [21,28].

The effects of transit were cumulative. Experiences during the journey interacted with premigration trauma and post-arrival insecurity, contributing to continuing physical, psychological, and social vulnerability.

Destination-country determinants in Spain

The principal destination-country determinants identified in the literature were legal status and healthcare entitlement, reception and accommodation conditions, language and communication barriers, cultural mediation, and the needs of unaccompanied minors.

Legal Entitlement and Healthcare Coverage

Legal status and entitlement to publicly funded healthcare were among the most frequently discussed determinants. Several sources examined the effects of Royal Decree-Law 16/2012, which introduced major changes to the Spanish healthcare system [31,36,38].

Before the decree, entitlement to publicly funded healthcare was largely based on residence. Following its implementation, access became more closely linked to insurance and Social Security status, resulting in the exclusion of many undocumented migrants from routine publicly funded care [38]. The legislation retained specified entitlements for emergency care, pregnancy and childbirth, children younger than 18 years, and applicants for international protection. Nevertheless, the included evidence described inconsistent implementation and cases in which these protections were not fully respected [16,38].

One policy analysis reported that approximately 873,000 National Health System cards were removed after the 2012 regulation. This administrative figure should not be equated with a count of undocumented migrants or with the number of people denied all medical care. Separately, an advocacy-monitoring network documented 3,340 cases of healthcare exclusion between January 2014 and March 2017; 55% involved undocumented migrants [38].

These figures should be interpreted as advocacy-monitoring data rather than comprehensive national surveillance statistics.

Regional variation in implementation, uncertainty regarding eligibility, administrative requirements, limited knowledge of entitlements, and fear that personal information might be shared with immigration authorities further discouraged access to healthcare [16,26,32,38,39].

Royal Decree-Law 7/2018 subsequently revised the national framework toward universal healthcare access, including recognition of healthcare rights for foreign nationals without legal residence under the conditions in the law [40]. This 2018 reform must be distinguished from the restrictions introduced in 2012. The included studies nevertheless describe administrative and regional barriers to effective access during the period they examined [16,26,29,38,39].

Reception Centers and Accommodation

Reception facilities represented an important initial point of contact with healthcare and social services. Evidence from Melilla described substantial overcrowding in the Temporary Stay Centre for Immigrants, where approximately 2,000 residents were accommodated in a facility designed for 480 people, including around 300 children [19].

The included reports described overcrowding alongside restricted privacy, economic hardship, language barriers, and limited continuity of care. These observations identify coexisting needs but do not establish that overcrowding caused psychological, nutritional, infectious disease, or oral health outcomes.

In Catalonia, reception was described as a phased process based on individualized integration pathways [15]. During the initial phase, applicants for international protection could remain in refugee reception centers for approximately 6-12 months. Services included accommodation, food, psychological support, occupational activities, language education, and the preparation of an individual integration plan.

Subsequent phases involved supported integration into local communities, including school enrolment, employment assistance, housing support, legal guidance, and assistance from governmental and non-governmental organizations. The Spanish Red Cross, the Catalan Commission for Refugee Aid, Caritas, and other organizations provided substantial support throughout this process [15].

The availability, quality, and continuity of reception services influenced adaptation, social integration, and health after arrival.

Language, Interpretation, and Cultural Mediation

Language barriers affected communication with healthcare professionals, informed consent, continuity of treatment, asylum procedures, and trust. Several non-governmental organizations developed interpretation services to address deficiencies in public provision [20,29,36].

The absence of a unified registry of trained public-service interpreters contributed to inconsistent availability and variation in service quality. Particular shortages were reported for less frequently requested languages, including Bengali, Urdu, Kurdish, Lingala, Bambara, and Burmese [29].

The literature distinguishes linguistic interpretation from cultural mediation. Cultural mediators supported communication by explaining cultural meanings, reducing misunderstandings, strengthening therapeutic relationships, and helping refugees express emotional distress [27].

Language proficiency alone was therefore considered insufficient. Interpreters and cultural mediators required appropriate training, clearly defined professional roles, and knowledge of healthcare, legal, and social service systems.

Unaccompanied Minors and the Transition to Adulthood

Unaccompanied minors experienced heightened developmental, legal, psychological, and safeguarding needs. Travelling without parents or other responsible adults increased exposure to violence, exploitation, inadequate accommodation, and interruptions in education and healthcare [36].

Their arrival placed considerable demands on Spanish child-protection systems, which were required to adapt services and procedures to the specific needs of these adolescents [23]. Under Spanish legislation, an unaccompanied minor entering the country should be placed under the guardianship of the competent regional authority. However, differences were reported between autonomous communities in the availability and quality of support.

The transition from child-protection services to adulthood was identified as a particularly vulnerable period. Catalonia and Biscay were described as examples of regions that developed programs providing housing, employment support, socioeducational and psychological follow-up, legal advice, and financial assistance to young people aged 16-21 years [23].

Commonly reported health problems

The health problems identified in the included evidence reflected experiences before migration, during travel, and after arrival in Spain. The principal areas examined were infectious diseases, mental health, nutrition, oral health, chronic conditions, and reproductive health needs.

Infectious Diseases

Infectious diseases were among the most frequently examined health outcomes, particularly in clinical studies involving newly arrived asylum seekers and people originating from sub-Saharan Africa [21,28].

Reported conditions included latent tuberculosis infection, hepatitis B, HIV, schistosomiasis, strongyloidiasis, filariasis, hookworm infection, giardiasis, and other parasitic diseases. Some infections were asymptomatic at diagnosis.

In one clinical study of 303 asylum seekers, 70 participants (23.1%) were diagnosed with at least one infection. Diagnoses were reported more often among participants from sub-Saharan Africa and those who had travelled by combined land and maritime routes [21]. These are within-study descriptive patterns; the review did not calculate confidence intervals or test differences between origin or route groups.

Another study involving 180 newly arrived patients from sub-Saharan Africa identified 19 cases of schistosomiasis, 16 cases of hookworm infection, 10 cases of giardiasis, and nine cases of strongyloidiasis [28].

The evidence is consistent with individualized screening informed by country of origin, travel history, symptoms, and individual exposure, followed by appropriate treatment. The reviewed studies did not evaluate screening accuracy or resource use, and they do not imply a generalized infectious disease risk among refugees and asylum seekers.

Mental Health and Psychosocial Well-Being

Mental health emerged as a major concern across the migration trajectory. Potentially traumatic experiences included war, torture, sexual and gender-based violence, bereavement, hazardous journeys, violence by smugglers or authorities, and prolonged residence in refugee camps [11,21,27]. Post-arrival stressors included poverty, inadequate housing, exploitation, discrimination, social isolation, family separation, unemployment, and uncertainty regarding legal status and the future. Language barriers, cultural differences, stigma, and difficulty establishing trust further complicated recognition and treatment.

Reported outcomes included post-traumatic stress symptoms, depression, anxiety, psychosomatic complaints, and existential distress [11,21,27,37]. A community-based intervention among adult refugees in Seville showed that culturally informed group support could improve post-traumatic growth. Improvements were reported in appreciation of life, personal strength, relationships with others, and recognition of new possibilities [11].

The evidence indicated that refugee mental health could not be understood exclusively through psychiatric diagnoses. Safety, dignity, social support, cultural identity, and opportunities for integration also influenced psychological recovery.

Nutrition, Oral Health, Chronic Disease, and Other Health Needs

Nutrition and oral health received less attention than infectious disease and mental health, although the available evidence indicated substantial unmet needs.

Among Syrian children living in the Melilla reception center, dental caries affected approximately 75% of children younger than 10 years. The restoration index was only 5%, indicating limited treatment, although periodontal health was generally satisfactory [19].

Nutritional concerns included anemia, micronutrient deficiencies, undernutrition, overweight, and obesity. These conditions varied according to country of origin, premigration circumstances, duration of displacement, changes in diet and physical activity, and length of residence in Spain [15].

Changes in lifestyle following arrival, including increased sedentary behavior and greater consumption of inexpensive processed foods, were identified as potential contributors to being overweight and obesity, particularly among children and adolescents.

Other reported health concerns included diabetes, chronic diseases, injuries, reproductive health needs, and obstetric and gynecological problems [15,36,37]. Women and girls experienced risks related to pregnancy, inadequate access to food and healthcare, sexual violence, exploitation, and abuse during migration.

Overall, the evidence supported comprehensive health assessments addressing physical, mental, nutritional, oral, reproductive, and social needs rather than focusing exclusively on individual diseases.

Discussion

This scoping review mapped the determinants of health among refugees and asylum seekers in Spain across the migration trajectory. The main finding was that health is not shaped by migration alone, but by the cumulative interaction of premigration experiences, conditions during travel and transit, and circumstances after arrival. Conflict, persecution, deprivation, interrupted healthcare, and loss of social networks may be compounded by hazardous journeys and later intensified by legal insecurity, inadequate accommodation, unemployment, language barriers, discrimination, and difficulties accessing healthcare. Refugee and asylum seeker health should therefore be understood within a broad social, legal, and structural framework rather than through isolated diseases or individual behaviors.

The included evidence was heterogeneous and covered clinical, social, legal, and service-related issues. Infectious diseases were investigated particularly among newly arrived people and those originating from sub-Saharan Africa. Reported conditions included latent tuberculosis, hepatitis B, schistosomiasis, strongyloidiasis, hookworm infection, and giardiasis [21,28]. These clinical findings are consistent with considering individualized screening based on origin, route, symptoms, and exposure. The review did not evaluate the diagnostic accuracy, effectiveness, or resource implications of screening protocols. The findings do not imply that refugees and asylum seekers pose a uniform infectious disease risk; an excessive focus on communicable diseases may reinforce stigma and divert attention from broader health needs.

Mental health also emerged as a major concern. Refugees and asylum seekers may experience war, persecution, violence, bereavement, family separation, exploitation, and life-threatening journeys before reaching Spain. Nevertheless, psychological distress was not explained by premigration trauma alone. Post-arrival conditions, including uncertain legal status, unemployment, poverty, inadequate housing, discrimination, and social isolation, could maintain or worsen depression, anxiety, post-traumatic stress symptoms, and psychosomatic complaints [11,21,27,37]. This indicates that mental health services should not focus exclusively on past trauma. Trauma-informed clinical care should be combined with stable housing, legal support, community participation, and culturally appropriate psychosocial interventions. The community-based intervention conducted in Seville suggests that group support can strengthen personal growth, social relationships, and appreciation of life following displacement [11].

Legal status and healthcare entitlement were among the most important destination-country determinants. Evidence related to Royal Decree-Law 16/2012 demonstrated that formal healthcare rights did not always ensure effective access [16,26,29,38,39]. Regional differences in implementation, administrative complexity, limited understanding of entitlements, and fear that personal information could be shared with immigration authorities discouraged some individuals from seeking care. Equitable healthcare therefore requires more than legal recognition. Clear guidance, simplified registration procedures, staff training, confidentiality safeguards, and consistent implementation across autonomous communities are also necessary.

Reception and accommodation conditions had an important influence on health. Severe overcrowding in the Temporary Stay Centre for Immigrants in Melilla reduced privacy, complicated infection control, and contributed to psychological, nutritional, and oral health problems [19]. In contrast, the phased reception model described in Catalonia combined accommodation with psychological support, language education, employment assistance, and individualized integration planning [15]. These examples show that reception systems can either reduce vulnerability or create additional health risks. Minimum national standards are therefore needed for accommodation capacity, privacy, safeguarding, nutrition, healthcare referral, and continuity of treatment.

Language barriers affected communication, informed consent, understanding of treatment, continuity of care, and trust in institutions. The reviewed evidence also distinguished between interpretation and cultural mediation. Professional interpreters enable accurate linguistic communication, while cultural mediators help explain cultural meanings, expectations, and expressions of distress [20,27,29]. Both services should be regarded as essential components of safe and person-centered healthcare. Adequate training, confidentiality standards, clearly defined roles, and access to interpreters for less frequently spoken languages are required.

Age, gender, and socioeconomic position influenced vulnerability across all stages of migration. Women and girls experienced specific reproductive and obstetric needs, caregiving responsibilities, and increased exposure to sexual and gender-based violence [15,36,37]. Children and unaccompanied minors face nutritional, developmental, educational, legal, and safeguarding concerns. The transition from child-protection services to adulthood was especially vulnerable because housing, financial, educational, and psychological support could end abruptly. Programs developed in Catalonia and Biscay demonstrate the importance of maintaining support during this transition [23].

The review also identified nutritional, oral health, chronic, and reproductive health needs that received less research attention than infectious diseases and mental health. Reported problems included malnutrition, anemia, micronutrient deficiencies, overweight, obesity, untreated dental caries, diabetes, injuries, and obstetric and gynecological concerns [15,19,36,37]. These diverse needs support comprehensive primary-care assessments rather than fragmented, emergency-only, or disease-specific services. Assessment and care should be adapted to age, gender, country of origin, travel history, living conditions, and individual priorities.

Overall, the findings indicate that access to healthcare alone is insufficient to achieve health equity. Housing, employment, education, legal protection, social support, and protection from discrimination directly influence health and the ability to use healthcare services. Effective responses therefore require coordination between healthcare providers, reception centers, social services, child-protection authorities, legal services, and community organizations.

Strengths and Limitations

A major strength of this review was its integration of clinical, social, legal, and policy evidence across premigration, transit, and destination stages. The inclusion of peer-reviewed studies and grey literature in English, Spanish, and Catalan allowed the review to capture issues that are often overlooked, including interpretation, cultural mediation, reception conditions, oral health, nutrition, and the transition of unaccompanied minors to adulthood.

Several limitations should be acknowledged. The search used three principal databases and broad search terms. Exact Scopus and Web of Science search strings and separate yields from Google Scholar, reference lists, journals, and organizational websites were not retained, so those supplementary sources cannot be added reliably to the PRISMA counts. Screening and extraction were performed by one reviewer, with no documented independent verification sample. The available record does not itemize the 27 full-text exclusions by reason. No formal methodological quality appraisal was undertaken. The included studies varied in design, sampling, setting, and population definitions, and several combined refugees or asylum seekers with irregular migrants or other migrants; their results cannot always be assigned to a specific legal-status group. The search ended in December 2020, and no documented update search is available. Consequently, the map does not represent evidence published after that date, and relevant Spanish- or Catalan-language grey literature may have been missed.

Future Directions

Future research should prioritize prospective, longitudinal, and intervention-based studies. Studies are needed to determine how legal status, housing, employment, social support, and continuity of care influence health over time. Greater attention should be given to chronic diseases, reproductive health, disability, nutrition, oral health, aging, and the transition of unaccompanied minors into adulthood.

Research should use clear definitions to distinguish refugees, asylum seekers, applicants for international protection, irregular migrants, and other displaced populations. Findings should be reported separately, where possible, by age, gender, country of origin, legal status, migration route, duration of residence, and autonomous community. Future evaluations should assess the effectiveness, acceptability, equity, and cost of interpretation, cultural mediation, community mental health programs, integrated primary-care pathways, and different reception models. Refugees and asylum seekers should also be involved in identifying research priorities, interpreting findings, and designing services.

Conclusions

This scoping review mapped 27 sources published from 2014 to 2020 on the health of refugees and asylum seekers in Spain and the conditions that shaped it. The literature described health risks before and during migration, as well as barriers after arrival, including insecure housing, uncertainty about healthcare entitlements, and limited access to professional interpretation. Mental health and infectious diseases were frequently reported, alongside unmet oral health and nutritional needs. Evidence from broader migrant populations and multicountry studies provided context, while refugee-specific and Spain-specific conclusions were limited to findings reported separately for those groups. The review provides a historical account of the evidence available through December 2020.

Appendices

Appendix A

Item	PRISMA-ScR domain	Location in the manuscript	Reporting status
1	Title	Title	Reported
2	Structured summary	Abstract	Partially reported
3	Rationale	Introduction and Background	Reported
4	Objectives	Introduction and Background, final paragraph	Reported
5	Protocol and registration	Review design (no prospective registration reported)	Reported
6	Eligibility criteria	Eligibility criteria; Table 2	Reported
7	Information sources	Information sources and search strategy; Table 1	Reported
8	Search	Search strategy; Table 1 (common expression available; exact adapted strings not documented)	Partially reported
9	Selection of sources of evidence	Study selection	Reported
10	Data charting process	Data extraction and coding (single reviewer)	Reported
11	Data items	Data extraction and coding; Table 3	Reported
12	Critical appraisal of individual sources (optional)	Data extraction and coding (no formal appraisal undertaken)	Not conducted
13	Synthesis of results	Data extraction and coding	Reported
14	Selection of sources of evidence	Results: Study selection and characteristics; Figure 1 (counts available; exclusion reasons not itemized)	Partially reported
15	Characteristics of sources of evidence	Table 3	Reported
16	Critical appraisal within sources (optional)	Not applicable; no formal critical appraisal conducted	Not applicable
17	Results of individual sources	Table 3	Reported
18	Synthesis of results	Results: determinant and health-problem thematic sections	Reported
19	Summary of evidence	Discussion	Reported
20	Limitations	Strengths and limitations	Reported
21	Conclusions	Conclusions	Reported
22	Funding	Funding statement	Reported

TABLE 4: PRISMA-ScR reporting checklist

Reporting limitations: Counts for Google Scholar, other supplementary sources, and reason-specific full-text exclusions were not available from the provided manuscript. Exact database-specific search adaptations were likewise not recorded.

PRISMA-ScR: Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews

Appendix B

Database	Search strategy	Search fields and restrictions	Results
PubMed	(refugee OR "asylum seeker") AND (Spain OR Spanish) AND (health OR healthcare OR "health care" OR "health status" OR "mental health" OR "social determinants of health")	All fields; publication date restricted to 2014-2020	154
Scopus	(refugee OR "asylum seeker") AND (Spain OR Spanish) AND (health OR healthcare OR "health care" OR "health status" OR "mental health" OR "social determinants of health")	Article title, abstract, and keywords; limited to articles published from 2014 to 2020	74
Web of Science	(refugee OR "asylum seeker") AND (Spain OR Spanish) AND (health OR healthcare OR "health care" OR "health status" OR "mental health" OR "social determinants of health")	All fields; publication date restricted to 2014-2020	86

TABLE 5: Reported database yields and common search expression

The expression shown for each database is the common conceptual search expression, not a verbatim archived search string. Database fields, publication restrictions, and yields were recorded in the source materials; the exact Scopus and Web of Science syntax, search dates, and any additional filters were not preserved. Therefore, these rows do not constitute reproducible database-specific strategies.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Nada Asad

Acquisition, analysis, or interpretation of data: Nada Asad

Drafting of the manuscript: Nada Asad

Critical review of the manuscript for important intellectual content: Nada Asad

Supervision: Nada Asad

Disclosures

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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