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Experiences of healthcare and administrative staff working with asylum seekers in the current polycrisis context: a qualitative study

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Abstract

Background Healthcare and administrative staff working with asylum seekers are at risk of burnout, compassion fatigue and vicarious traumatization. Moreover, they face a series of crises, with the refugee crisis in 2015–2016, the Covid-19 pandemic, the war in Ukraine and climate change, complexifying their daily practice and increasing the number of asylum seekers. Despite this alarming context, scarce research has explored the personal experiences of healthcare and administrative staff working with asylum seekers. In response, this qualitative study aimed to explore their work-related experiences, resources and needs in the current polycrisis context in Switzerland.

Methods Participants ($N=24$) were part of the front-line care team working with asylum seekers in the Canton of Vaud (Switzerland). The sample included nurses, administrative staff, physicians and psychologists. They participated in semi-structured interviews exploring the personal experiences of their work, difficulties and challenges encountered and their resources and needs. Inductive content analysis was used to organize data and identify themes.

Results Main findings highlighted a significant emotional burden for staff related to their patients' migratory journey and experiences in the asylum system. Next, participants expressed various challenges associated with their work, such as heavy workload, lack of partners in the healthcare network, communication barriers and the polycrisis context. Further, findings documented that participants' strong intrinsic motivation and personal and institutional resources support them in overcoming these difficulties. Finally, participants made some suggestions for the improvement of their working environment, including promotion of exchange between colleagues, collaboration with partners and hiring additional staff.

Conclusions Healthcare and administrative staff working with asylum seekers are exposed to multiple challenges and emotional difficulties linked to their patients' experiences. Findings suggest the need to address the well-being of

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this population by developing measures to enhance support for them at individual and structural levels, particularly within the current polycrisis context.

Keywords Healthcare staff, Administrative staff, Asylum seekers, Experiences, Polycrisis, Qualitative study

Introduction

Healthcare and administrative staff working with asylum seekers have been facing a series of various crises recently, which may be referred to as a "polycrisis". The term "polycrisis" can be defined as a distinctive feature of our times, representing interconnected crises that go beyond simple cause-and-effect relationships, and highlighting the complexity of an uncertain world undergoing a systemic transition [1]. To establish the polycrisis context in the migration field, it's worth noting that migration movements have always been punctuated by periods of strong upsurge. Notably in 2015, with the Syrian civil war, the "refugee crisis" manifested itself in migratory flows of historic scale towards Europe [2]. More recently, the worrying impact of climate change on migration, and the invasion of Ukraine by Russian armed forces in February 2022 added new challenges to this already unprecedented situation [3]; more than 6.6 million Ukrainians fled the country three months later [4]. By November 2022, Switzerland had registered almost 70,000 people from the Ukraine, over 5,000 of whom were received by the canton of Vaud [5, 6]. In addition to these migratory crises, the Covid- 19 pandemic put a strain on the social and healthcare system, which considerably accentuated the challenges already present in these sectors [7]. Climate change is also an alarming factor to consider within the migration field. Over the past three years, record temperatures were reached on all continents, the impact on health being increasingly severe [8]. Notably, this makes certain communities vulnerable, causing populations displacement [9]. This crisis is affecting the health of forced migrants, be it in their countries of origin through the deterioration of their living conditions, or during the migration journey through their exposure to more harsh environmental conditions. Moreover, since the legal status of "climate refugees" does not exist, their care is even more complex [10].

The term "migrant" refers to any person who leaves his or her place of habitual residence to settle temporarily or permanently and for various reasons, either in another region within the same country, or in another country [11]. An asylum seeker is a person who has applied to a country for asylum, meaning protection from persecution, but whose procedure has not yet been completed [12]. The main condition for obtaining asylum is the risk of persecution in the event of return to the country of origin. The person is persecuted due to a specific individual characteristic, such as race, religion, nationality, membership of a particular social group or political opinion [12]. In 2022, more than 24,500 asylum applications were submitted in Switzerland. Notably, there are considerable variations from one year to the next, due to complex geopolitical events [13]. People who apply for asylum in Switzerland are granted a different legal status depending on the outcome of their asylum procedure. The rights they receive vary according to the legal status granted. The different permits are the following: asylum seekers (N permit), residence permit (B permit, among others for recognized refugees), settlement permit (C permit, only possible after 5–10 years of B permit), provisional admission (F permit, re-evaluated each year), rejected asylum seekers (emergency aid) and persons in need of protection (S permit) [12]. The S permit was introduced to respond rapidly to situations of mass exodus and offers many advantages (notably for access to healthcare, housing, education and employment) to those who benefit from it. The Swiss Federal Council activated it for the first time in March 2022 for refugees from Ukraine. However, this permit is a source of juridic inequalities and social and health inequities. The Swiss organization for refugees (OSAR) claimed that the S permit should be replaced with a single humanitarian protection status in order to reduce these inequalities [12].

A person whose asylum application has been rejected, but who cannot immediately return to his or her country of origin, receives emergency aid to guarantee a minimum standard of living. This emergency aid, often in the form of a voucher, is very precarious [12]. There is another special situation known as the "Dublin case", which arises when the asylum seeker has already applied for asylum in another country having signed the *Dublin Regulation* (e.g. European members, Switzerland, Norway, Iceland and Liechtenstein). In such cases, Switzerland is unable to carry out the asylum procedure and must, with some exceptions, transfer the person to the state responsible [12].

In the Canton of Vaud, migrant care is ensured by RESAMI "Health network and migration", composed of EVAM, SSM and partner primary care physicians. EVAM "Vaud establishment for migrants", is responsible of social aspects and SSM "Migrant care sector" and primary care physicians ensure the medical aspect. Many of RESAMI's consultations are conducted with interpreters. There are partner associations and interpreter companies [14].

EVAM is a public-sector institution entrusted by the Canton of Vaud with the task of assisting and supporting people who have come to Switzerland seeking protection and have been assigned to the canton. EVAM's

main roles are to provide accommodation, support, integration, assistance, help in finding a job and promotion of autonomy [14]. The SSM, a part of the Center for primary care and public health in Lausanne, is composed of ten branches distributed throughout the canton of Vaud. Their main missions are health assessment and follow-up, transition follow-up, prevention and health promotion, and vaccination; this is first-line care. The SSM is made up of three units-administrative, nursing and medical-which work interprofessionally. Most administrative staff are in direct contact with patients and play an active role in their care. The medical unit includes physicians and psychologists. The SSM works with many partners, as network coordination is essential [15, 16]. This sector has been enormously strained and has undergone many structural changes in recent years, particularly since the start of the war in Ukraine [17]. A "Ukraine team" was set up, with the recruitment of new nurses and administrative staff to deal exclusively with asylum seekers from Ukraine. This team has now merged with the original team. The SSM'S team cares for asylum seekers and Ukrainian war refugees under the aegis of EVAM. These refugees are followed by this team until they obtain a permit (B or C), at which point they are under the care of the usual care network.

Despite important efforts aimed at improving quality of health care in French-speaking Switzerland for asylum seekers [18], significant barriers to access care remain, such as language or discrimination [19]. Consequently, there is an over-use of emergency services linked to an under-use of primary care services, as well as unmet health needs among asylum seekers [19]. In addition, the migration process tends to negatively affect health, particularly mental and dental health [19]. For instance, a meta-analysis has shown a pooled prevalence of 30% for post-traumatic stress disorder in this population [20]. In addition, post-migration social conditions are associated with high rates of anxiety and depression [21]. Due to this context of health and social inequities, the asylum-seeker population is very complex to care for by healthcare providers.

Staff working with asylum seekers are exposed to individual, institutional and systemic difficulties, which can negatively impact their physical and psychological well-being. They often suffer from compassion fatigue (i.e., physical and emotional fatigue leading to a reduction in empathy or compassion), burnout and secondary traumatic stress (i.e., the combination of physical and emotional symptoms that arises from empathetically engaging with individuals who are experiencing trauma) [22, 23]. A study conducted in Greece with staff working with migrants and refugees reported that 25.6% were at high risk for compassion fatigue [24], while a systematic review and meta-analysis of professionals and volunteers working with forcibly displaced people revealed a pooled prevalence of 29.7% for burnout and 45.7% for secondary traumatic stress [25]. More encouragingly, previous research also highlighted certain positive effects brought on by the strength and development that this work can bring to staff, namely compassionate satisfaction and vicarious resilience [26]. In view of the high risks of psychological problems among these professionals, it is important to explore their experiences in order to understand how to improve their work environment. In response, this study aimed to explore the experiences of administrative and healthcare staff working on the front line with asylum seekers in the canton of Vaud in Switzerland. The canton of Vaud is a large county in Switzerland (826,380 residents, approx. 9.4% of the Swiss population), receiving around 10% of Switzerland's asylum population [6].

As illustrated in a recent systematic review and thematic synthesis of qualitative research, there exists little literature on the experiences of staff working with asylum seekers [27]. Existing literature typically focuses on their perception of asylum seekers' health and healthcare, not on their personal experiences while working with this population and their effect on personal life. Focusing on personal experiences, the UNHCR made a rapport in 2016 on the well-being and mental health among its employees, revealing a high percentage of employees at risk for different mental health and behavioral outcomes [28]. However, these employees were humanitarian workers, not staff working in specialized in refugee health. To our knowledge, only two studies qualitatively explored the personal experiences of staff providing first line care to asylum seekers in workplaces specialized in refugee health. The first was conducted in England in 2011 [29] and the second in Australia in 2015 [26]. Participants included nurses, physicians, counselors, and psychologists. Main findings highlighted the emergence of various emotions, depicted as an "emotional rollercoaster", including frustration, anger, discouragement, feelings of powerlessness and anxiety; but also, enthusiasm, satisfaction, and gratitude. The difficulties and challenges encountered consisted mainly of a heavy workload, a strong sense of responsibility, moral and legal dilemmas, and a lack of resources and support from institutions. All of this was described as leading to exhaustion and impacting work-life balance. Findings highlighted the importance of training, support, and supervision [26, 29].

Furthermore, there is a lack of research exploring healthcare and administrative staff`s experiences in working with asylum seekers in the current polycrisis context. The current context is unique in that staff, just out of a pandemic, have found themselves working with war refugees. In 2022 alone, the war in Ukraine

multiplied the number of asylum seekers arriving in Switzerland in challenging situations by 1.6 [30]. The work overload already experienced by healthcare and administrative staff, and their exposure to their patients' suffering and trauma, is likely to increase sharply, with a simultaneous rise in the incidence of burnout, compassion fatigue and secondary traumatic stress. In addition, daily exposure to climate emergencies and war could confront staff with their own uncertainties and fears about the future. It is therefore essential to explore the personal experiences of the healthcare and administrative staff who work with this population. Given the considerable quantity and intensity of the work they dedicate to the health of patients with a migrant background, it is crucial to ensure their well-being so that they can continue their work in a high-quality manner. Thus, the aim of this qualitative study was to explore the experiences of health and administrative staff working with asylum seekers in the current context of polycrisis.

Methods

Study design

We conducted a qualitative descriptive study to explore the experiences, resources and needs of healthcare and administrative staff working with asylum seekers in the current context of polycrisis. Specifically, we conducted individual semi-structured interviews in a subsample of the SSM healthcare and administrative staff. We based our descriptive approach on Sandelowski's work [31]. For this study, we followed the official guidelines for qualitative research, SRQR, a 21-item questionnaire [32]. Table S1 (Appendix 1) describes how we followed each recommendation.

Participants and setting

Participants ($N = 24$) were administrative and healthcare staff of the SSM working with asylum seekers in the Canton of Vaud. Inclusion criteria were: (1) working at the SSM administrative, medical, or nursing unit; (2) working at the SSM for at least six months. Exclusion criteria were: (1) Working at the SSM for less than six months, (2) refusal of participation. Considering that about 48 professionals (28 nurses, 14 administrative staff members, 4 physicians and 2 psychologists) were currently working at the SSM at the time of the study and met the inclusion criteria, we aimed to include around 25 participants to be as representative as possible of the population. We used a quota sampling according to the profession (administrative staff, nurses, physicians, psychologists), numbers of years (6 months to 3 years, > 3 years) and the region of practice. We also ensured that gender proportions were representative of the ones in the whole team.

Procedures

Recruitment took place from November 2023 to December 2023. First, we contacted the SSM management team who helped us in organizing recruitment. An email describing the study was sent by the sector and units' managers to the entire staff of SSM and the principal investigator (a female Swiss born MD student) attended an interal meeting to present the study to staff. Then, a part of the staff was randomly selected following the quota sampling protocol and contacted by email or telephone by the principal investigator. Once contact had been established, if the staff member was interested to participate, the date and place of the interview were arranged by e-mail or telephone, according to their preference. The principal investigator conducted information sessions with selected and interested participants.

The qualitative interviews were conducted face to face within the SSM units and lasted between 28 min and 1 h 56 min, with an average of 1 h 13 min. The interviews were conducted by the principal investigator who had experience in qualitative research under supervision of one of the last authors (PhD female Swiss born senior scientist). Qualitative interviews were conducted until data saturation was reached, i.e. when no new ideas were expressed in the interviews. Compensation was not provided for participation in this study.

Measures

Demographic variables

Single items were used to assess sociodemographic information. These items were used to describe the sample.

Qualitative assessment

Semi-structured interviews were conducted using an interview guide to explore experiences, difficulties and challenges encountered, resources and needs of this population in the context of a polycrisis (see Appendix 2 for the grid). Consistent with semi-structured qualitative inquiry, we constructed the grid with open-ended questions, allowing free speech and exploring main themes (experiences, difficulties, challenges, resources, needs) and the crises (Syrian refugee crisis, Covid, Ukraine, climate). We explained how we defined the term polycrisis before each interview.

Data analysis

Interviews were audio-recorded and transcribed *verbatim* by two professional transcriptionists. The data were analyzed using content analysis with constant comparative process [33, 34]. To develop the codebook, the principal investigator and another researcher (a male Swiss born medical student) with experience in qualitative research completed initial coding independently. Researchers pooled their codes to reduce redundant,

idiosyncratic, or common codes to generate a comprehensive codebook. Then, the codebook was confronted by a senior scientist (PhD female Swiss born senior scientist) who provided feedback, resulting in codebook adaptations. Finally, the principal investigator conducted focused coding and explored the overarching topic areas using Atlas.ti software version 9. Once all transcripts were coded and analyzed, the three researchers involved in the qualitative analysis met to identify and discuss the overarching topic areas. After the analysis, findings were presented and discussed with the study's participants during a colloquium, which led to no adaptations. After the colloquium, we made us available to any of the participants who would be willing to provide with additional feedback privately. We also included a participant among the co-authors for greater reliability.

Methodological rigor

The official guidelines for qualitative research SRQR were followed in this study [32] (see Appendix 1). The study problematic and aims were based on a review of the literature. The qualitative descriptive approach, the settings and contextual factors, the sampling strategy, the ethical considerations and the data collection and analysis are all described in the methods. Finally, the limitations are presented in the discussion.

Ethical considerations

This research project was deemed exempt by the Human Research Ethics Committee of Lausanne University Hospital because it did not involve clinical data measurement. All procedures followed the ethical guidelines outlined in the Declaration of Helsinki. All participants provided written informed consent.

Results

Participants

Of the 57 people regularly employed at the SSM, 9 did not meet the inclusion criteria as they had been working there for less than 6 months. Of the remaining 48 eligible people and following our purposing sampling, 26 were invited to participate, 2 of which declined for personal reasons, resulting in a total of 24 participants.

The sample consisted mainly of females (79.1%), which is congruent with the demographics of the collective. The average age of participants was 36.6 years (SD = 11.7). Regarding nationality, half of the sample had Swiss nationality (50%), while 25% were French, 8.33% Spanish, one was from Italy (4.1%), one from Belgium, one from the United States and one from Germany. Most participants held a higher education diploma (79.2%), whereas the others had either a general or vocational training diploma (20.8%). Concerning occupations, half of the participants were nurses (50%), followed by administrative staff (receptionists and file managers; 25%), physicians (16.5%), and psychologists (8.3%). Participants had worked at the SSM for an average of 4.72 years (SD = 4.4). All ten regional branches were represented and 62.5% of participants worked in several regions simultaneously.

Qualitative results

Three main themes emerged from the qualitative analysis. The first describes the affects lived by participants in connection with their patients' experiences in the asylum system and migratory journey and the resulting consequences on their well-being and personal lives. The second theme focuses on the main difficulties and challenges encountered by participants in their daily practice. Finally, the third theme describes the resources staff benefit from to cope with experienced emotions, challenges, and difficulties. Furthermore, it highlights the needs raised by staff and their suggestions of improvements to meet these needs.

Staffs' affects linked to patients' journey and their situation in the asylum system

Participants reported being touched by their patients' stories, including their experiences in their country of origin, their migratory journey and their current situation as an asylum seeker. The following sections describe staff reactions to their patients' histories and migratory journey, their perceptions and emotional reactions to their patients' current situation in the asylum system, and the impact of these emotions on the participants.

Feeling sad, angry, disgusted and stunned when being confronted to the patients' history and migratory journey

Patients' history and migratory journey When asked about the difficulties encountered in their work, most participants reported their patients' traumatic history and migratory journey. For instance, participant 9 (physician) disclosed: "The other day there was a guy who told me he had to have his feet amputated because when he tried to cross Serbia through the mountains, he froze, he was almost eaten by wolves." Participants commonly shared the deep and wide range of losses experienced by their patients: "They've lost their homes, they've lost everything, they're left with nothing" (Id 6 administrative staff).

The violence experienced during the migratory journey was also mentioned by most participants. It involved physical and sexual violence as well as torture in certain countries: "And then, well, she undressed and she really had marks of torture, electric wires, on her genitals and everything, something horrible" (Id 2 administrative staff). According to the participants, the violence experienced along the migratory journey results in a high

prevalence of mental health problems, particularly post-traumatic stress disorder.

Staff reactions: a large range of emotions Participants commonly shared how touched they were when hearing of these life trajectories, disclosing anger, sadness and disgust: "I think sometimes there's this guilt, then there's empathy, then sometimes sadness, then anger. I think you can go through all kinds of emotions" (Id 10 nurse). A sense of injustice was also often evoked. One physician even expressed feeling stunned: "It's a bit horrifying, to see what human beings can do to other human beings. A feeling of almost stupefaction." (Id 9 physician).

Views, affect and impact of the asylum and social systems: feelings of powerlessness, anger and injustice

Staff perceptions of the Swiss asylum social system The stressful conditions of asylum seekers within the asylum system were mentioned by most participants. Dublin cases, emergency aid, threats of deportation and asylum refusals were described as highly deleterious, with patients in great distress and constantly on hold (e.g., "They're useless, and it's not me saying it, it's them: « I get up, look out the window and wait »" Id 10 nurse), potentially leading to suicide attempts. Some participants depicted their journey through the asylum system as "administrative torture" or compared it to a prison. In fact, most participants shared their negative opinion of the asylum system in Switzerland. "It's horrible. It's not welcoming. It's control" (Id 19 nurse). While explaining being aware of the complexity of the system, many claimed having negative views on emergency aid, Dublin cases, forced expulsions and F permits: "I think that this status of emergency aid is completely deleterious, aberrant and inhuman" (Id 23 nurse).

Emotions and feelings towards the asylum system Participants expressed a range of emotions linked to the current situation of asylum seekers. Some expressed sadness and anger (e.g., "There are some pretty complicated situations where asylum applications are refused, and the applicants are sent back to their country or somewhere else. And that's sad. It makes me angry, at least" Id 1 nurse), while others expressed frustration and injustice.

Many participants reported feeling helpless in the face of their patients' situation. They explained being aware of the negative impact of the asylum system on their patients while having no power over it. When asked about how she felt a nurse (Id 10) said:

> *It was really this feeling of powerlessness that was difficult at first. To find yourself in situations where there's absolutely nothing you can do, where you have no power except to be there and listen. (…) I think we'll always be powerless. (…) I think in our line of work it's a feeling we'll always have.*

One participant related the story of one patient with suicidal ideations, for whom she tried to provide psychological support and hospitalization, but who was eventually expulsed: "It affects me and makes me feel powerless, like I couldn't do anything about the situation" (Id 18 psychologist).

This sense of helplessness is associated with the feeling of not being able to fulfill one's role: "We find ourselves in a situation where our mission is to care for people. In other words, to make them feel better. And then, (…), there's a system that's on the other side, going in the opposite direction" (Id 15 nurse). Relatedly, according to some participants, patients are too preoccupied with their asylum procedure to worry about their health problems, which creates a mismatch in staff and patients' priorities.

Complexities of social aspects As with the asylum system, most participants explained that their patients' social and housing situation influence their consultations. "When people arrive, what do they need? They need housing. You know the housing problems: we're immersed in that" (Id 15 nurse). They described precarious conditions in EVAM hostels and spoke of the critical importance of collaboration with EVAM staff: "They're the ones in the living environment and they give us information that we don't have" (Id 23 nurse). Although some participants reported a fair collaboration, others described it as complicated, notably due to a lack of clarification of the different roles and communication concerns.

War in Ukraine and S permit With the beginning of the war in Ukraine, the notion of injustice linked to the system was highlighted by the application of the S permit, the specific status of Ukrainian refugees. This permit was perceived as unfair by nearly all participants, as this member of the staff illustrated: "I think it's really unfair that they should have an S permit and not the others. (…) I've got a big problem with that" (Id 17 administrative staff).

Whereas this permit was not considered as bad, most participants considered that it should be granted to all applicants and not to a selected population: "It is a good permit, the S permit, I just wish it would be for everyone" (Id 19 nurse). Some mentioned a form of racism: "And perhaps also a phenomenon of identification, Ukrainians are closer to us, we can't leave people like that. It's as if Eritrean or Afghan lives were less precious, less important" (Id 15 nurse).

Emotional Burden, "a sort of moral exhaustion": feeling deeply marked by the patients' stories with personal and professional consequences

Ultimately, the experience of sadness, anger, injustice, and helplessness while facing a patients' stories and situation in the asylum system resulted in significant work-related emotional burden in participants. This was described by all the participants: "Because there are situations that touch us and move us, and then we must learn to live with them" (Id 16 nurse).

The ways it impacts Several participants mentioned that managing the mental and affective burden was particularly difficult at the start of their job in this unit: "At first it was difficult, I could see that it was affecting me, I'd come home in the evening and think about it" (Id 6 administrative staff). Another topic frequently noted is the cumulative effect of emotional charge. They explained that it is harder to deal with emotions when several heavy consultations follow one another: "I say to myself: some days if you have too many stories like that, you can damage yourself. You must be careful" (Id 9 physician). Also described by many participants, is that they are often the first or the only people patients confide in. One expressed feeling as "the depository of the misfortune that befalls people" (Id 10 nurse).

Impact on the consultation According to several participants, this emotional charge and related fatigue impact their ability to conduct the consultations: "And the difficulties are sometimes not being able to do the consultation the way I'd like to, because I'm actually tired; I'm talking about emotional fatigue" (Id 10 nurse). They went on explaining that this burden and fatigue can sometimes challenge their empathy: "I think that's the challenge. It's staying very human without feeling too bad afterwards" (Id 19 nurse).

Impact on the staff member This affective burden was expressed by the majority as affecting them (e.g., "I feel it's still there, it's a situation that really upset me and still does," Id 14 nurse) and touching them deeply: "Maybe it goes beyond the limits of the professional, it affects the person behind the professional" (Id 18 psychologist). One participant described this impact as "a sort of moral exhaustion" (Id 7 nurse), another one as a "deep mark" (Id 15 nurse). The idea of changing profession crossed the minds of some participants: "At a certain point I said to myself 'this isn't for me, I'm not strong enough' " (Id 10 nurse).

Going a step further, virtually all participants shared that it is difficult to put the limit between professional and personal life. Some explained, for example, that certain situations "accompany them home" (Id 9 physician), and that they sometimes think about them in the evenings and at weekends, even affecting their sleep with nightmares or insomnia. Some also recalled crying a few times at home to vent certain emotions. "They're leaving with us, so I don't think we can close the door on work, and that's fine" (Id 5 psychologist).

An impact on their social or family life was also highlighted. Several participants described themselves as "irritable" with their loved ones, or "not being available" (Id 16 nurse) to them. A certain discrepancy was also highlighted, with some participants explaining that the problems of those around them could seem insignificant compared to those of their patients: "Sometimes I find it harder to listen to other people's problems in my private life. (…) Sometimes I'm less empathetic with my loved ones when I've had big, heavy days like that" (Id 19 nurse).

Difficulties and challenges

In addition to the affective burden associated with their patients' experiences, participants expressed numerous difficulties and challenges inherent to their work, whether relational, logistical, or systemic.

Saturated healthcare network: where to refer patients?

The interviewed staff members work in first-line care, meaning they follow patients for a short period with the aim of quickly orienting them within the Swiss healthcare system. However, according to the participants, they face a barrier at this level. One of the most expressed difficulties, voiced by virtually all participants, is the lack of partners to whom they can refer their patients, leading to extra work for them and accentuating their sense of responsibility. According to most participants, this lack of partners is explained by the saturation of the network, referred to as "the crisis of the cantonal healthcare network" by one participant (Id 23 nurse). They specifically highlighted the lack of general practitioners, psychiatrists and psychologists.

In addition, a certain stigmatization of migrant patients was described by several participants, further complicating collaboration with the network: "In the end, you get the impression that they're never the first on the list" (Id 20 physician). According to the participants, the main reasons for physicians' reluctance are the language barrier, working with interpreters, a perception of increased missed appointments in this population and cultural differences.

Consequently, most participants explained resorting to continuing the follow-up themselves, resulting in increased workload. One participant expressed his discomfort at having to do psychiatric follow-ups when he's not trained to: "So, we take care of it, but I don't have the

knowledge or the means to take care of it properly. And that's very frustrating" (Id 20 physician).

In response to these difficulties, the need to improve communication and collaboration with the network was recalled by many. They suggested informing the network about their role and how their unit operates. The need for help from the hierarchy to achieve this was underlined.

Workload, understaffing and lack of time: feeling constantly overwhelmed

Most participants reported the heavy workload they deal with, resulting in delays and longer waits for consultations, with staff expressing a severe lack of time. This workload seems to be explained by the increased number of migrant patients, especially in the context of the polycrisis, but also by understaffing within the unit and the lack of network partners. This was described as having an impact on the participants, particularly in terms of overtime and fatigue.

According to the staff, their workload is enormous. An accumulation of various tasks makes up this load, including for instance: "the increasingly full agenda" (Id 14 nurse), "emails" (Id 14 nurse), "letters" (Id 22 nurse), "liaison sheets", "coordinating with other partners", "sorting requests", "reading files" (Id 12 nurse), "transcribing everything to Soarian [computer software for patients]" (Id 16 nurse), etc. Hence, the administrative part of the workload was the most cited by participants. Just as for the emotional aspect, the notion of accumulation was particularly highlighted. All of this was reported to cause delays and long wait-times to schedule consultations, which was noted as particularly frustrating and annoying for the staff: "Now I'm at the point where I can't schedule someone for a follow-up appointment. So that's another thing that limits me a lot in my work" (Id 22 nurse).

With all these consultations and administrative work, the participants said that they don't have enough time for the rest either, such as sharing information and emotions with colleagues, team sessions, meeting psychologists, training, etc. For example, a nurse gave her opinion on what had been set up for the staff by the institution: "What's missing is the time to access all this" (Id 7 nurse).

According to most participants, the daily overload and shortage of time is accentuated by understaffing. The main perceived causes of this were the work's unattractiveness, its arduous nature, and the fact that contracts are for a maximum duration. Although this was seen as insufficient, the team has nearly doubled since the measures taken in response to the war in Ukraine, which was generally appreciated.

The accumulation of workload coupled with perceived understaffing resulted in many participants working overtime: "I think I did thirty hours of overtime in the space of a few weeks" (Id 12 nurse) and related negative consequences: "This is where we start to suffer psychologically. To see this accumulation of work to which we can't respond" (Id 2 administrative staff). As illustrated here, several repercussions of this work overload were described, such as "fatigue" (Id 12 nurse), "stress" (Id 16 nurse), "suffering" (Id 20 physician), "burnout" (Id 11 nurse), feeling "in over one's head" (Id 16 nurse). As with the emotional burden, this feeling of administrative overload was described by several participants as having an impact on their private lives.

Communicational barriers: taking language and culture into account for the care

A major challenge evoked by many participants is the language barrier leading to communication issues. To overcome this difficulty, the healthcare staff works with community interpreters, which is globally appreciated: "It's an immense privilege to be able to really communicate. It's still great, they're there, they move around, it's a luxury really" (Id 15 nurse). Contrary to healthcare staff, the administrative staff reported that they don't work with community interpreters at all. They recalled using other means, such as translating on their phone, but not finding this optimal. Regarding collaboration with community interpreters, most participants rated it as good, although they explained that it can sometimes be tricky (e.g., "Some take the liberty of going beyond interpreting, to give them advice," Id 14 nurse) and time-consuming.

Other communicational obstacles due to the cultural aspect and the different ways in which people perceive health and care were mentioned by the majority of the participants. To illustrate these cultural differences and beliefs, one participant recounted the story of a patient who was seeing a "demon", which could have been mistaken for psychosis, when in fact it was a cultural expression. According to many participants, these difficulties impact the therapeutic relationship, resulting for instance in missed appointments, potentially compromising care.

The war in Ukraine brought these communicational challenges to the forefront. Three-quarters of participants shared some difficulties related to the healthcare's perceptions among Ukrainian patients: "It was a bit complicated at first because it's not at all the same type of population, with the same needs, the same feelings and the same experiences" (Id 16 nurse). The healthcare system in Ukraine was described as very different from the Swiss one. Participants explained that in Ukraine there is more self-medication, diagnosis and specialist appointments: "A lot of them come in and want to see specialists straight away" (Id 19 nurse), with a level of healthcare consumption that seemed excessive by participants when compared to the Swiss healthcare system. As a result, this population could sometimes be considered as demanding.

Series of crises: the sword of Damocles hanging over the future

Most participants explained that the nature of their work is facing one crisis after another. This was reported as having several consequences. Firstly, participants shared the fact that in working with migrants from the various global crises, they feel closely connected to current events, to which they have direct access through their patients. A physician (Id 9) recalled:

> *It's as if there are moments when I'm immersed in the world's difficulties, because in the end that's what's both very interesting and very intense: it's like having a window on the world's crises that come to us. It's much more real than watching the news. It's people telling us their stories.*

Furthermore, participants explained that they are constantly working amid regional or global crises, whether economic, social, geopolitical, health or structural. These crises were described as following one another without any break in between. A participant noted: "I feel a bit like a spectator sometimes, it's like I can't really keep up with the pace. (…) I think you really have your head in the handlebars" (Id 5 psychologist).

Most participants reported showing resilience while facing this situation of successive crises, which they see as an integral part of their work: "When you come to work here, you know you're going to experience geopolitical crises, and after the war in Ukraine, there's bound to be another one. And there always will be. Because that's part of our mandate" (Id 19 nurse). However, participants mentioned the increased workload following this series of crises and the related consequences on quality of care: "How can we guarantee the same quality of care when we have even more patients to see?", asked participant Id 9, physician.

In addition to these crises, there's also global warming. For most participants though, climate migration is not yet part of their daily routine: "So, for the time being, we haven't been too impacted" (Id 2 administrative staff). Yet, despite the current low number of climate migrants at the consultation, most participants expressed anxieties for the future, because of the great importance and emergency of this crisis (e.g., It hasn't started yet, but it's about to, and it's going to be violent," Id 23 nurse), and the fact that they feel personally concerned by this crisis: "the climate, well, it can affect us more. It has a personal connection that's a little more powerful, a little more present for me" (Id 10 nurse). Between the series of crises and global warming, the questions of "Where are we heading?" and "What lies ahead?" were frequently raised, both on a personal level and in terms of workload.

Resources and needs

As described above, participants mentioned various emotional, relational, logistical, or organizational difficulties. To cope with these challenges, many resources, both personal and institutional, were evoked, besides intrinsic motivation to carry out this work. They also cited needs to complement the resources and put forward suggestions for improving the system of care for asylum seekers and their units, which would ultimately promote their well-being.

Personal resources and institutional support to cope with difficulties

Participants cited various personal and private resources that help them deal with the affective burden generated by their work. First, many explained the need to establish a clear boundary between professional and private life, and several mentioned the importance of not damaging one's mental health with patients' stories and problems related to their care. One of the ways noted by participants to ensure this boundary is the return journey home, "I often manage to switch off at the end of the day, take the train and do my own thing on the train. I read my book, listen to music and it's all over" (Id 12 nurse).

Participants evoked several elements of private life helping them to maintain this separation and supporting them in their work, such as loved ones (e, g, "I think I draw a lot of my resources and energy from my family," Id 2 administrative staff) and sports (e.g., running, boxing, yoga, etc.). Other hobbies were mentioned, such as music, pottery, baking, reading, hiking, and traveling. A participant summed up the benefits of these extra-professional activities: "I think the advantage of sport, music, that sort of thing, is that you're caught up in it, you're in the moment and then it allows you to disconnect and have moments where you take care of yourself" (Id 9 physician).

Other personal resources highlighted by participants included their previous professional experience with populations in vulnerable situations, their acquisition of experience and skills over the years at the SSM and their personality traits (e.g., "Maybe that's my resource too, it's knowing my limits very well and not going beyond them," Id 15 nurse), particularly their great adaptability. In addition, several shared their techniques or rituals used following emotionally heavy consultations. A nurse explained how she applied the advice given by the psychologists: "They advised us to open the window and take a deep breath, which is very good. Or, for example, to wash our hands under cold water. I didn't know about these techniques at all, and in the end, they work" (Id 1 nurse).

Numerous institutional resources were also mentioned, including group sessions, staff meetings, training courses

and mindfulness meditation courses. Among all cited resources, whether personal or institutional, the most frequently cited was collaborating with their colleagues, perceived as essential. When asked about the positive aspects of her job, one nurse answered: "To work in a fabulous team, it's the team that gives hope, it's really motivated people, and it's a team that works together" (Id 3 nurse). The vast majority indicated that being able to debrief with a colleague enabled them to share and process the emotions brought up by consultations, facilitating the transition from work to private life and maintaining a personal balance: "I think that it's the solidarity that exists in this team that's going to make it easier when you get home in the evening, it's easier to have some perspective" (Id 2 administrative staff). Helping each other make care decisions was also cited as relieving them, notably in terms of their sense of responsibility. This was described between members of the same profession but also with others. For example, a strong collaboration with the administrative staff was highlighted: "That's the whole team, that's particularly between the nurses and the admins, we really work together. It isn't possible to work without an admin and it isn't possible for the admins to work without nurses" (Id 3 nurse).

Given that colleagues were perceived as such a marked source of support, moments dedicated to exchanges, such as staff meetings and group sessions were also seen as resources. Staff meetings were mentioned as a resource by participants: "It allows us to have an outlet when we're feeling a bit stuck, in the care of certain patients; and we can benefit from the experience of different colleagues" (Id 4 physician). Group meetings, as described by participants, take the form of a group session accompanied by a psychologist, organized once a month and for which most find benefits. They explained that it's a space where they can talk freely about their working conditions, receive strategies for managing emotions and develop their practice. It was noted that administrative staff do not benefit from these group sessions: "Unfortunately, they haven't set up the same for the admins but I think it's really necessary" (Id 3 nurse). Also mentioned was the availability of the two psychologists whenever they need a debriefing, which was much appreciated: "We can talk, and they're completely available" (Id 1 nurse). Targeting the emotional side of working at the UMSI, mindfulness meditation courses were recently offered to the whole team, which was generally well received: "I think it's great that we've put something in place, for us to try. I think these are tools that can help us better manage the stress in our work and in our lives too" (Id 12 nurse). Most particularly appreciated was the fact that something had been set up for them and their emotional experiences.

Ongoing training, raised by the majority, perceived as a time for sharing knowledge and experiences, was also highlighted as a resource. It was described as enabling professional development and improving one's practice, which is necessary in such a specific job encompassing so many issues. For example, this nurse presented her views on training and how they benefit her:

> *It gives me guidance for my consultations. We've had training courses on low back pain, for example, and I've had several patients that I'm going to see again, and now I know what I need to investigate better. We've had training sessions in psycho-traumatology with our psychologists, on how to approach trauma in the form of metaphor with our patients. Just this week, it was useful because I had a patient who dissociated a bit during the consultation. It's always well-targeted I think, the training courses. They very often correspond to my needs (Id 19 nurse).*

The work schedules were also reported as a positive aspect by the participants. They appreciated the lack of overnights or weekends, and the freedom and autonomy to organize their work, ultimately perceived as improving quality of life. Relatedly, many of them also appreciated being able to work part-time.

Intrinsic motivation: meaning and benefits of this work

Participants expressed a profound motivation for their profession. They shared the deep meaning of their work. The notions most frequently mentioned were: "working with the most vulnerable" (Id 3 nurse), "being able to participate in health equity" (Id 4 physician) and "fulfilling a somewhat humanitarian role" (Id 9 physician). Many explained that this job was a continuation of their professional career with populations in vulnerable situations. Others, themselves from an immigrant background, shared personal reasons and motivations.

In the same vein, feeling useful and being able to help people in real need was perceived as contributing to this intrinsic motivation: "I feel like I'm doing something concrete. When people arrive who have lost everything, and we're the little rock they cling to, I feel like I'm being useful" (Id 7 nurse). For many, this feeling of usefulness resulted in increased valuation, happiness and satisfaction. They explained that although they can't help their patients as much as they would like, the little they can offer them, sometimes just a listening ear, or guidance through the care system, motivates them. What's more, seeing positive developments in their patients was perceived as reinforcing this feeling. For example, a nurse was delighted to see the extraordinary evolution and integration of one of these patients: "He really blossomed like a beautiful flower. And it feels good" (Id 15 nurse).

Another aspect frequently mentioned and considered an important motivator is the degree of diversity in their

activity. They explained that there is "no routine" (Id 2 administrative staff) and that "every day is different" (Id 6 administrative staff). This variety was described in their encounters with patients, due to their cultures and histories (e.g., "Because we're with people from all over the world, who have experienced extraordinary things"; Id 12 nurse), but also in the variety of tasks they must perform, including for instance the multidisciplinary work and the collaboration with different partners.

Relatedly, most participants shared some personal benefits of their work, including personal and open-mindedness skills: "So it allows me to question a lot of things. Both professionally and personally" (Id 1 nurse). In addition, more than half of participants explained that their patients' stories enabled them to step back from their life, realize their privileges and be more grateful for them: "I'm more grateful for my life. When I see the quality of life I have and everything, I realize how privileged I am, and that's something I wasn't very aware of before" (Id 18 nurse). Consequently, many explained that they were growing personally through their professional activity: "We've got a crazy job: it's absolutely brilliant, a real enrichment" (Id 2 administrative staff).

As a result of all these positive elements and intrinsic motivation, despite all the encountered challenges and difficulties, most participants shared feeling good about their work and enjoying what they do: "I come to work every day with a smile on my face. Really because I'm passionate about this job" (Id 16 nurse).

Needs and suggestions: what could be improved

The above results already revealed some needs expressed by the participants, such as fostering collaboration with the network, increasing staffing levels within the team, as well as time, particularly dedicated to administrative tasks and sharing between colleagues. The following paragraph describes the specific or cross-functional needs that participants mentioned, and their suggestions for improvement.

Although institutional resources (i.e., group sessions, staff meetings, and training) were appreciated by participants, they suggested ways for optimization, such as more interdisciplinary staff meetings, and increasing exchanges' depth between staff and hierarchy (i.e., beyond information exchange). Others suggested individual psychological therapy sessions in addition to those provided in groups.

Participants shared their desire for more training on various topics, including clinical examination, the asylum procedures, motivational interviewing, Eye Movement Desensitization Reprocessing (EMDR) and transculturality. Several also mentioned that it would be beneficial to facilitate access to the Certificate of Advanced Studies (CAS) in clinical assessment and advanced practice nurse training.

Next, although mindfulness meditation courses offered to the team was generally appreciated and perceived as beneficial to cope with stress, several participants underlined the importance to act on the underlying working conditions that lead to this mental state (e.g., "If the person needs a mindfulness course, what can be done upstream to prevent that?" Id 18 psychologist). Relatedly, a need mentioned by participants is to have more time to share with colleagues, whether from the same or another profession. They also mentioned the need to not be isolated in a peripheral site. A nurse suggested: "I think having two people consulting on the same day and having colleagues available by phone is already a great thing." (Id 12 nurse) In addition, getting to know each other outside work, through team building activities for example, was expressed by many participants:

> *We need to meet outside with colleagues, to create a certain bond, because in the end, we're all faced with the same situation: people's sadness, the ordeal of many, many migrants. So, yes, we're united at a difficult time, but it would also be good to be united elsewhere, in an activity, to get to know each other even better (Id 1 nurse).*

Regarding the support from the hierarchy, the majority appreciated the availability when needed. A few difficulties were nevertheless highlighted, such as insufficient communication, listening, support and appreciation. According to some participants, communication issues were related to the fact that the hierarchy isn't sufficiently aware of what's going on in the field and to the important managers turnover in recent years, leading to instability for staff. Overall, staff would like more contact with hierarchy to promote communication: "Bosses should listen more and come and see what's happening in the field so they can better understand our needs" (Id 11 nurse). Although participants acknowledged the difficulty for the hierarchy to meet all staff needs, some expressed the need to feel more recognized in their work. According to them, this valorization could be in the form of support, positive feedback, thanks or salary.

Finally, all participants made proposals for improving the care and well-being of their patients, targeting the three parameters of bio-psycho-social care, which would, in turn, have a beneficial effect on their own well-being at work. On the somatic side, all the physicians we met expressed the same need: materials and equipment normally available in a general practice or emergency centers, i.e. ECG and lab tests, minor surgery, etc. They also put forward some ideas for the mental healthcare of patients, such as having psychiatrists on the team or

Table 1 Thematic framework highlighting the major themes and subthemes summarizing healthcare and administrative staff personal experiences

Theme 1: Staff's affects linked to the patients' journey and their situation in the asylum system
Subthemes
• Feeling sad, angry, disgusted and stunned when being confronted to the patients' history and migratory journey (being touched by their patients' traumatic stories)
• Views, affect and impact of the asylum sand social systems: feelings of powerlessness, anger and injustice (the hard conditions of the asylum and social systems)
• Emotional burden, "a sort of moral exhaustion": feeling deeply marked by the patients' stories with personal and professional consequences (accumulation of burden, difficulties to conduct consultations and to find work-life balance)
Theme 2: Difficulties and challenges
Subthemes
• Sutured healthcare network: where to refer patients? (lack of general practitioners, psychologists and psychiatrists in the network)
• Workload, understaffing and lack of time (feeling constantly overwhelmed: accumulation of various tasks, administrative burden)
• Communication barriers: taking language and culture into account in care (work with interpreters and transcultural aspects)
• Series of crises: the sword of Damocles hanging over the future (immersion in the world's difficulties, feeling that there is no break in between, wondering what lies ahead)
Theme 3: Resources and needs
Subthemes
• Personal resources and institutional support to cope with difficulties (clear boundaries, loved ones, sports, hobbies and colleagues)
• Intrinsic motivation: meaning and benefits of this work (working with populations in great need, feeling useful, diversity)
• Needs and suggestions: what could be improved (increase exchanges between colleagues, more training, promote collaboration with the network)

referent psychiatrists, and setting up a psychological unit dedicated to migrants:

> *The ideal for me would be to expand the psychiatric healthcare system, to really create consultations with waiting times adapted to the crisis, waiting times of one to two weeks with each translator present one day for example (Id 1 nurse).*

The impact of the social aspect in the consultations and the consequences for the staff has already been mentioned in the section discussing the asylum system and the one concerning housing and EVAM. When asked about what they would change in the asylum system, some suggested that people who don't have a permit should be turned away directly, rather than being left to wait and hope, whereas others suggested to increase the acceptance rate for asylum applications and consider integration as a factor. Moreover, some participants suggested the idea of having social workers on the team and promoting collaboration and communication with EVAM. Also cited was the idea of allocating more funds to social work, for example to improve living conditions in community centers. Table 1 summarizes the main themes and subthemes extracted from the analysis.

Discussion

This study aimed to qualitatively explore the experiences, difficulties, resources and needs of healthcare and administrative staff working with asylum seekers in Switzerland in the current polycrisis context. Main findings highlighted the emotional burden for the staff relative to their patients' migratory journey and experiences in the asylum system. Next, participants expressed various challenges relative to their work, such as the heavy workload, the lack of partners in the healthcare system, communication barriers and finding themselves always working in times of crisis. Furthermore, findings revealed that their strong intrinsic motivation and their personal and institutional resources support them in overcoming these emotional and structural difficulties. Finally, participants made some suggestions for the improvement of their experience, including psychological support, training, and enhancing collaboration with the network.

Difficulties and challenges: working within multiple systems

Our results revealed various difficulties and challenges encountered by participants pertaining from individual to societal levels. These difficulties and challenges can be divided into three categories: individual, institutional (the SSM) and systemic (cantonal healthcare system, social and asylum systems). Taken together, these difficulties are likely to increase the risk of exhaustion and burnout.

Individual

Main findings revealed various work-related affects, such as powerlessness, sadness, injustice and anger closely linked to the relation with the patients and their past and current situation. Indeed, all participants expressed

being touched and impacted by their patients' stories. Past research on this topic, conducted in England and Australia in 2011 [29] and 2015 [26], revealed the same affects linked to the patient's situation. In our study, the administrative staff, not cited in the literature, expressed the same emotional difficulties as healthcare staff.

Institutional

At the SSM institutional level, findings indicated that staff must deal with an increasing workload, linked to a large number of patients and understaffing within the team. These findings echo those of another study, revealing high workload due to a large caseload of patients, with a feeling of pressure and lack of time and the sense that the quality of care and support decreases [29]. This also reflects the Demand Control Support Work Stress model, which is used in occupational medicine to assess stress at work and its impact on health. It includes the three aspects of workload, freedom and autonomy in tasks, and support from colleagues and superiors [35]. Furthermore, our results demonstrated the challenge of communication barriers, including culture and language barriers, complicating consultations. These findings align with those of a study on the same topic, which indicated that language barriers could be particularly problematic when patients confide in staff about their traumatic experiences [29]. Similar to our results, another study highlighted the help of community interpreters but points out the fact that it still remains an indirect access to the patient [26].

Systemic

Concerning the cantonal healthcare system, staff reported a saturated network, mainly for general practitioners and psychologists, resulting in a lack of partners to whom they can address their patients. The Swiss doctors' bulletin of 2023 confirmed this shortage of general practitioners across Switzerland [36]. Moreover, studies have shown that the stigmatization of migrants can adversely affect their access to and quality of healthcare [37, 38], exacerbating the lack of resources in the network. Another point frequently raised by participants was the difficulty that their work is intrinsically linked to the asylum system and the social and housing system (EVAM), which influences their daily practice. Consistent with past literature, we found that staff perceived the asylum system as the main cause of the patients difficulties and as limiting their ability to support them, which generated additional effort on their part [29]. Congruent with past research [39], our results highlighted that patients' needs linked to asylum status and housing often predominated over those of health, or closely influenced their state of health.

Risk of exhaustion and burnout

The difficulties and challenges outlined above generate an overload of work for staff, as well as numerous negative affects, such as sadness, anger and powerlessness; this results in a significant risk of exhaustion and burnout. Consistent with past research conducted in England and Australia, in 2011 and 2015 [29, 26], we found that the affective reactions to patients' stories had repercussions on staff's well-being, including fatigue and work-life imbalance. These elements are reflected in the definitions of compassion fatigue and secondary traumatic stress [7, 24]. Our findings suggest that both healthcare and administrative staff working with asylum seekers experience affective feelings similar to those associated with compassion fatigue and secondary traumatic stress. Given this worrying context, these findings underline the importance of assessing and addressing staff well-being [40] among those working with asylum seekers, in order to protect them from exhaustion, burnout and associated syndromes.

This focus is crucial in the current polycrisis context. To the best of the authors' knowledge, this study is the first to focus on the polycrisis context in the care of asylum seekers, especially with the crisis of the pandemic Covid- 19, the war in Ukraine and climate change. According to participants, the main challenges specific to this context are the lack of a break in between events, increasing workload and pessimistic views on current events and the future, particularly with the coming climate migration. All of this is detrimental to staff experience. It is therefore particularly important to consider the experiences of staff in the accumulation of these crises, as burdens and experiences intensify, especially today with the situation in Europe, the Middle East and with climate change. For all these reasons, it is essential to take actions to reduce the difficulties and challenges faced by staff, to guarantee their well-being and health and consequently ensure the quality of patients' care.

Suggestions for meeting these difficulties and challenges

Individual

Despite the negative affects experienced by the participants and consistent with past literature from the United Kingdom and in Australia [29, 26], staff also shared positive feelings and disclosed liking their job. We suppose that these positive affects are linked to the numerous resources they use (e.g., hobbies, loved ones, colleagues, group sessions) and the deep sense of intrinsic motivation they claimed, explaining that this job is based on human relation, promotes equity and fosters personal growth. This notion of meaning is found as a key element in Antonovsky's definition of sense of coherence, which is a facilitator of resilience and in the definition of resilience itself, according to Ungar [41, 42]. Furthermore,

findings revealed how important it is to strike the right balance between negative and positive affects in the work environment to avoid imbalance and burnout. The vulnerable position of this work, illustrated by the unattractiveness mentioned earlier, can be seen as an obstacle to the development of resilience, should be addressed. The positive affects and the intrinsic motivation should be promoted in order to foster resilience. Individual and structural interventions must be put in place to build this resilience and reduce the risk of suffering. One idea is that staff should be encouraged to find and use their personal resources. Other suggestions will be cited in the sections below. To present possible interventions, a study identifying leaders' strategies to cultivate nurse resilience highlighted some ideas such as: facilitate social connections, promote positivity, foster mindfulness practice and encourage self-care [43].

Institutional

Important points to focus on and address at the institutional level are heavy workloads, the lack of staff and the time needed to execute the job properly, as well as the time needed to manage and share emotional experiences. Suggestions for improvement would be to hire more staff and promote exchanges between colleagues. Moreover, as administrative staff share the same emotional difficulties as the healthcare staff, group sessions with psychologists should be extended to them. With regard to communication barriers, an article discussed the challenges of working with different cultures, and revealed the importance of cultural flexibility and transcultural training [26]. Indeed, as demonstrated in a review, the transcultural relationship between staff and migrant patients, based on reciprocity, is essential [44]. Regular participation in training courses on communication, transcultural competency, the asylum system and building expertise, skills and knowledge within the field of migration and health is essential for staff working with asylum seekers, and access to interpreters should be facilitated.

Systemic

To overcome the difficulty of the overwhelmed cantonal healthcare system, participants suggested enhancing collaboration with the network and meeting partners, in order to clarify their role and reduce some stigmatization around migrant care. Collaboration with general practitioners, psychologists and psychiatrists is essential for the adequate care and well-being of migrants and their carers, and should be facilitated as much as possible. One suggestion for future studies would be to use the participatory and community paradigm to develop and implement awareness training to reduce stigmatization and promote the care of asylum seekers [45]. Concerning the housing and asylum systems, the results underline the crucial importance of taking the social determinants of health of the asylum seeker patient into account in care, and of improving collaboration between the healthcare team, the asylum system and the social and housing systems. It is necessary to develop interventions to improve the well-being of professionals, but ideally, for the good of patients and the staff who look after them, we need a more equitable social system [39].

Limitations

The results of this study must be interpreted in light of the following limitations. Given that the current team included 34 nurses, 14 administrative staff, 4 physicians and 2 psychologists, the sample was comprised of parts of the nurses and administrative staff, while all physicians and psychologists of the team were included. Furthermore, as this study is qualitative and concerns the system implemented in the canton of Vaud, the results are specific and cannot be generalized, even if they are in line with the few existing results in international literature.

Conclusion and future directions

This study is the first to document the experiences of primary care staff (administrative staff, nurses, psychologists and physicians) working with asylum seekers in the polycrisis context, in particular with the Covid- 19 pandemic, immediately followed by the war in Ukraine. Participants' voiced experiences, difficulties, challenges, resources and needs, revealing a mix of affects linked to their patients' situations and the hindrance to help them. These barriers are inherent to the various systems the staff must work with and within.

Findings underline the importance to consider staff's well-being and to develop individual and structural resources for all professions. Main suggestions to improve the well-being of the staff and therefore indirectly that of their patients are to promote exchanges between colleagues, enhance training and collaboration within their networks and take actions to promote a more equitable social system.

Abbreviations

UNHCR	United Nations High Commissioner for Refugees
RESAMI	Health and migration network
EVAM	Vaud establishment for migrants
SSM	Migrant care sector

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions
L.G., V.G. and P.B. designed the study. L.G. coordinated the study, conducted the semi-structured interviews, analyzed data, drafted the manuscript. Y.S. and V.G. participated in the analysis process. A.F. participated to the recruitment process. R.C. was a participant who reviewed with a critical eye to field experiences. Writing, review and editing, all authors. All authors read and approved the final manuscript.

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

Declarations

Ethics approval and consent to participate
This research project was deemed exempt by the Human Research Ethics Committee of Lausanne University Hospital because it did not involve clinical data measurement. All procedures followed the ethical guidelines outlined in the Declaration of Helsinki. All participants provided written informed consent.

Consent for publication
NA.

Competing interests
The authors declare no competing interests.

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