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Medical xenophobia and healthcare exclusion of refugees and migrants in Africa: A scoping review

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ABSTRACT

Background: Medical xenophobia, manifesting as discrimination and exclusion from healthcare based on nationality or documentation, threatens migrants' and refugees' rights and public health. This study maps evidence of what is known about medical xenophobia and healthcare exclusion of refugees and migrants in Africa.
Methodology: The framework established by Levac et al. offered a structured method for executing this scoping review. This research implemented a comprehensive search strategy to identify academic papers and grey literature. Databases such as CINAHL, Emcare, Medline Ovid, Scopus and Web of Science were utilised, focusing on the period from 2014 to 2024. A total of 20 articles were selected for data extraction and thematic synthesis.
Results: The scoping review identified pervasive medical xenophobia and exclusion of refugees and migrants in African healthcare systems. This phenomenon included discriminatory attitudes from healthcare personnel, cultural insensitivity, verbal abuse, poor or denial of care due to documentation status of refugees and migrants, financial exploitation, and linguistic discrimination in healthcare settings. Refugees and migrants often avoided healthcare services due to fear of harassment or deportation, worsening their physical, mental and maternal health outcomes. Interventions highlighted in the literature encompassed policy reforms, cultural sensitivity training for providers, community engagement, enhanced service accessibility, and ongoing monitoring to address systemic inequalities.
Conclusion: Addressing healthcare access inequities for refugees and migrants necessitates structural reforms to ensure accountability for inadequate treatment, uphold human rights and promote equity and culturally and linguistically inclusive practices.

1. Background

Medical xenophobia refers to the negative attitudes and practices of healthcare professionals towards refugees and migrants based on their identity as non-nationals (Crush and Tawodzera, 2014; Mvundura, 2024; Vanyoro, 2019; Zihindula et al., 2017). This phenomenon is characterised by discriminatory behaviours that manifest in various forms, such as differential treatment, verbal and physical abuse, exclusion and denial of healthcare services based on nationality, language or lack of documentation (Basaran and Sayligil, 2022; Crush and Tawodzera, 2014; Mvundura, 2024; Temin et al., 2021). These practices contribute significantly to healthcare exclusion and disparities faced by non-national populations in many settings. While medical xenophobia is a global phenomenon, its manifestations in Africa are uniquely shaped by historical, socio-political, and systemic dynamics within health systems (Crush and Tawodzera, 2014; Mvundura, 2024; Zihindula et al., 2017). Evidence from Africa highlights deeply entrenched discriminatory practices and medical xenophobia, which affect migrant and refugee populations significantly (Arnold et al., 2014; Chekero and Ross, 2018; Munyaneza and Mhlongo, 2019; White and Rispel, 2021). Focusing on Africa provides a critical lens for understanding the forms of medical xenophobia and healthcare exclusion and how these intersecting forms of exclusion operate in under-resourced settings and how context-specific interventions have been implemented or neglected (David et al., 2024; Msabah, 2022; Vanyoro, 2019).

In this context, understanding the definitions of refugees and migrants is essential, as their legal statuses, rights, and health needs differ significantly and shape their experiences of medical xenophobia and healthcare exclusion. In the literature, refugees and migrants are frequently regarded as a unified population and addressed collectively

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(Shahin et al., 2020). However, refugees and migrants are distinct categories of people who move across borders, with refugees fleeing persecution or conflict and migrants often moving voluntarily (Costello, 2018; McBrien, 2017). Migrants are defined as "persons who move or have moved across an international border or within a State away from their habitual place of residence, regardless of their legal status, whether the movement is voluntary or involuntary, the causes for the movement, or the length of the stay"(IOM, 2019). In contrast, the 1951 Refugee Convention defines a refugee as a person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable or, owing to such fear, is unwilling to avail [themself] of the protection of that country"(UNHCR, 2025). These distinctions are crucial, as they influence both the vulnerabilities that refugees and migrants face in accessing healthcare and the ways in which medical xenophobia and healthcare exclusion manifest against them.

A xenophobic healthcare provider assesses and treats individuals based on their language, looks and nationality—contrary to the ethical standards and codes of conduct [professional deontology] that ought to guide their professional actions and obligations to their patients (Basaran and Sayligil, 2022). The World Health Organisation, WHO (2023) reported that through Universal Coverage (UHC) "all people have access to the full range of quality health services they need, when and where they need them." Healthcare providers have no justification for mistreating patients and medical xenophobia is a recognised and detrimental issue (Basaran and Sayligil, 2022). Mason (2024) reported that medical discrimination occurs when patients experience varying degrees of treatment influenced by attributes such as race or ethnicity, resulting in negative health consequences and sustaining inequalities among disadvantaged populations. Within the healthcare system, the degree of intercultural sensitivity exhibited by professionals, including nurses, plays a crucial role in shaping xenophobic attitudes, with elevated sensitivity being associated with a decrease in xenophobic tendencies (Yıldız et al., 2024).

In Africa, particularly South Africa, medical xenophobia is profoundly embedded within the public health system, where refugees and migrants frequently encounter hostility and, at times, are either denied care or subjected to substandard services due to their non-native status (Crush and Tawodzera, 2014; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Vanyoro, 2019). This form of discrimination constitutes not only a violation of ethical principles and human rights but also mirrors broader societal xenophobic attitudes that are reflected within the healthcare domain (Crush and Tawodzera, 2014; Mvundura, 2024). The literature indicates that these perspectives are shaped by anti-migrant narratives prominent in media and political arenas, which healthcare practitioners may assimilate and manifest in their professional behaviour (Mvundura, 2024). Nevertheless, the systemic obstacles within the healthcare framework, such as staffing shortages and resource limitations that impact all patients, and the explicit targeting of migrants for sub-standard treatment underlines the xenophobic foundations of these practices (Vanyoro, 2019). The bias towards refugees and migrants is further complicated by the absence of definitive policies and guidelines for the treatment of migrants, resulting in discretionary practices among healthcare providers that may either alleviate or exacerbate xenophobic inclinations (Vanyoro, 2019). According to the International Organisation for Migration, IOM (2022, p. 2), "the majority of the SADC member States offer limited access to healthcare for migrants as stipulated in the national constitution, legislations and policies…the rights of migrants to access healthcare services remain limited when compared to the lights of citizens." Furthermore, IOM (2022, p. 1) argued that "health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity."

The exclusion of refugees and migrants constitutes not only a breach of their fundamental rights but also presents a public health hazard, as untreated medical conditions may worsen and infectious diseases could proliferate, impacting both citizens and non-citizens alike (Mipatrini et al., 2017; Moezzi et al., 2024; Tesfai et al., 2023; Zihindula et al., 2017). The exclusion from primary care services has the potential to intensify health inequalities and result in poorer health outcomes, consequently escalating the long-term costs for healthcare systems (Moezzi et al., 2024). The denial of healthcare services grounded on documentation status or nationality, regardless of protective policies, results in delayed or disrupted treatment, further burdening an already overextended health system (Zihindula et al., 2017). This exclusion is exacerbated by linguistic obstacles and negative perceptions from healthcare professionals, which deter refugees from pursuing essential medical care until their conditions reach critical levels (Tesfai et al., 2023). The psychological ramifications of such exclusion are considerable, leading to heightened trauma and stress among refugees, who frequently perceive themselves as unwelcome and marginalised within healthcare environments (Temin et al., 2021; Tesfai et al., 2023).

Furthermore, the exclusion from healthcare services can result in self-exclusion, wherein refugees skip seeking care entirely, opting for alternative treatments or traditional remedies, which may lack efficacy (Mattes and Lang, 2021; Tesfai et al., 2023). This predicament is further complicated by the structural vulnerabilities that refugees encounter, such as political and moral exclusion, which strip them of their right to belonging and access to appropriate healthcare (Mattes and Lang, 2021). The absence of healthcare access not only undermines the physical health of refugees but also their sense of belonging and psychological fortitude, as they are frequently perceived as unworthy of care (Mattes and Lang, 2021). To combat medical xenophobia and healthcare exclusion, healthcare systems must adopt multifaceted strategies focused on policy reform, education and accountability. Governments need to enforce non-discriminatory healthcare policies and enhance cultural competence among healthcare providers while fostering community engagement and investing in equitable resource allocation. In line with the issues around medical xenophobia and medical exclusion of refugees and migrants, this study aims to map evidence of what is known about medical xenophobia and healthcare exclusion of refugees and migrants in Africa.

2. Methodology

The Levac et al. (2010) framework was used to guide the scoping review on medical xenophobia and the exclusion of healthcare services for refugees and migrants in Africa. This framework enabled a systematic and thorough approach to synthesising existing empirical evidence. The methodology consisted of five key stages: (1) identifying the research questions, (2) identifying relevant studies, (3) selecting studies, (4) charting the data and (5) collating, summarising and reporting the findings.

2.1. Identifying the research question

The first stage required the development of a broad and investigative research question (Levac et al., 2010). For this review, the primary question was: "What is known regarding medical xenophobia and healthcare exclusion of refugees and migrants in Africa?" This research question allowed for a comprehensive exploration of various aspects, including the manifestations of xenophobia in healthcare settings, the negative impacts of medical xenophobia and healthcare exclusion and potential interventions to improve the situation. Sub-questions were formulated to guide the review process further.

1. What are the manifestations of medical xenophobia and healthcare exclusion experienced by refugees and migrants in Africa?
2. What are the consequences of medical xenophobia and healthcare exclusion for refugees and migrants in Africa?

3. What interventions should be implemented to mitigate medical xenophobia and healthcare exclusion, and improve the healthcare experiences of refugees and migrants in Africa?

2.2. Identifying relevant studies

The second stage involved conducting a thorough search to identify all relevant studies addressing the research question (Levac et al., 2010). Searches were carried out across multiple databases, including CINAHL, Emcare, Medline Ovid, Scopus and Web of Science, ensuring a wide range of healthcare and social science literature was covered. Manual searches for grey literature supplemented these database searches to provide a comprehensive methodology. A timeframe of 10 years was considered, ranging from 2014 to 2024. The search strategy created using the following key terms: medical xenophobia, healthcare exclusion, prejudice, social discrimination, racism, attitude of health personnel, healthcare, medical care, health services accessibility, healthcare disparities, refugees, migrants, Africa. Based on these terms, customised search strings were developed for each database to meet its specific requirements, as per the following example:

- **S1**: exp Refugees/ OR exp Transients and Migrants/
- **S2**: healthcare.mp OR medical care.mp OR "health services accessibility" OR "attitude of health personnel"
- **S3**: exp Racism/ OR exp Xenophobia OR discrimination.mp. OR prejudice OR "medical xenophobia" OR "healthcare exclusion" OR "healthcare disparities"
- **S4**: exp Africa/
- **S5**: S1 AND S2 AND S3 AND S4

2.3. Selecting studies

The third stage involved selecting studies and ensuring that only relevant and high-quality evidence was included (Levac et al., 2010). Predefined inclusion and exclusion criteria were applied to filter the findings. The inclusion criteria focused on empirical studies related to

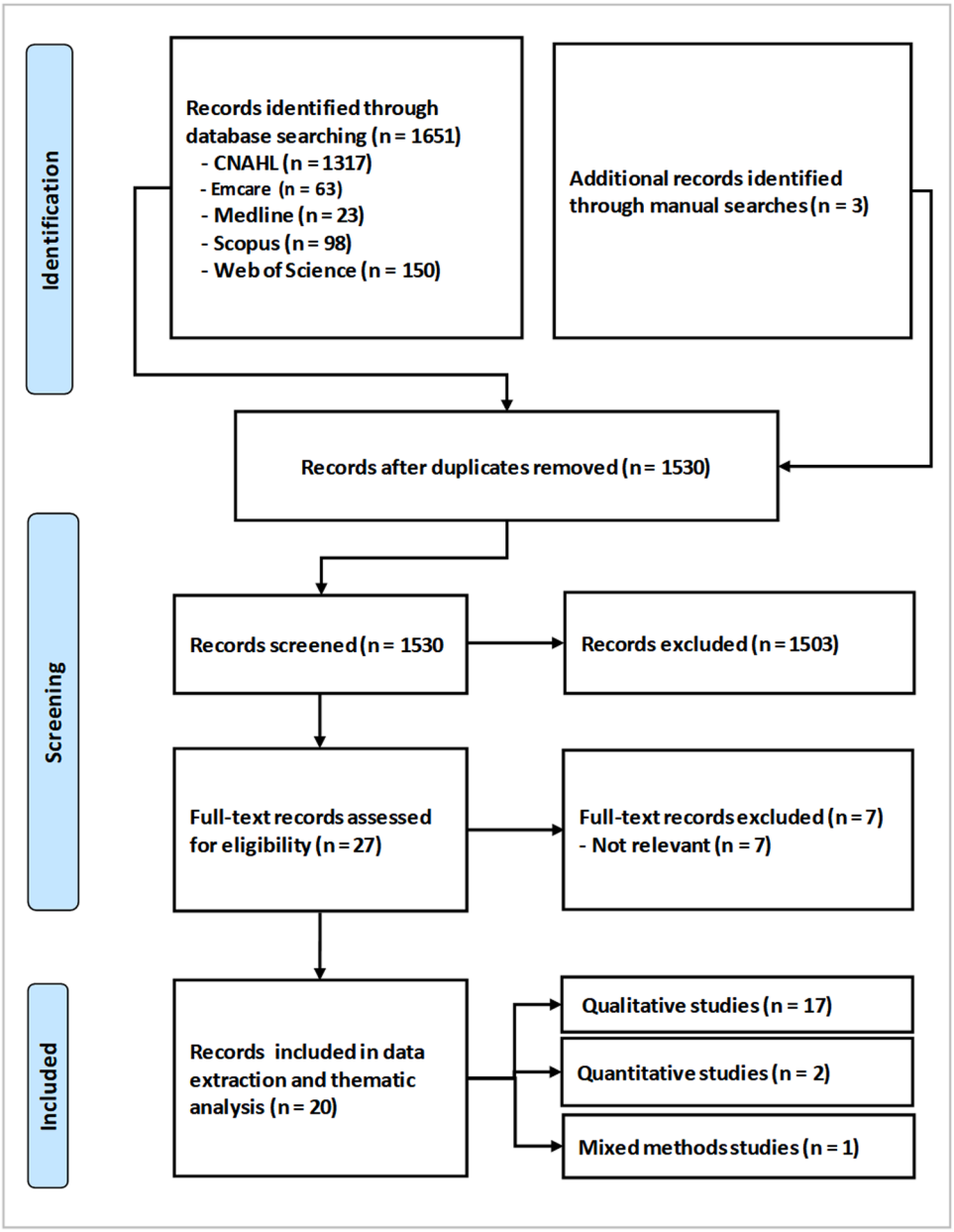

Fig. 1. PRISMA flowchart.

medical xenophobia, healthcare exclusion, or barriers to access for refugees and migrants in African countries. Those studies were published in English. The exclusion criteria ruled out unrelated studies, non-empirical studies, those focusing on other geographical regions and research not involving refugee or migrant populations. The researcher and an expert in scoping reviews, screened the titles and abstracts. This was followed by full-text assessments of potentially eligible articles. Any disagreements were resolved through consensus (Levac et al., 2010). Reasons for excluding studies were documented to ensure transparency.

The research questions, along with the Mixed Methods Appraisal Tool (MMAT), guided the selection and appraisal of relevant studies. MMAT version 2018 was employed for its suitability in assessing diverse study designs, including qualitative research, randomised controlled trials, quantitative non-randomised studies, quantitative descriptive studies, and mixed-methods research (Hong et al., 2018). Each study was first categorised into one of the MMAT's five study design groups, then evaluated against the tool's five methodological criteria, with responses recorded as "Yes," "No," or "Can't tell" (Hong et al., 2018). While no studies were excluded based on quality, the MMAT findings were used to highlight the methodological strengths and limitations of the existing evidence on medical xenophobia and healthcare exclusion in Africa. EndNote Version 20 was utilised for organising and managing the retrieved sources.

As presented in Fig. 1, a total of 1651 records were identified through database searches, including CINAHL (n = 1317), Emcare (n = 63), Medline (n = 23), Scopus (n = 98), and Web of Science (n = 150). An additional three records were identified through manual searches, yielding a combined total of 1654 records. After removing duplicates, 1530 records remained for screening. Of these, 1503 records were excluded based on title and abstract screening, leaving 27 full-text articles assessed for eligibility. Following full-text review, seven articles were excluded as not relevant, resulting in 20 studies included in data extraction and thematic analysis. Among these included studies, 17 were qualitative, two were quantitative, and one was a mixed-methods study. The PRISMA flow diagram outlines the selection process (Fig. 1).

2.4. Charting the data

The fourth stage involved charting the data, essential for organising and synthesising information from the included studies (Levac et al., 2010). An iterative data extraction chart was developed and piloted in several studies to ensure consistency and comprehensiveness of the data extraction process. Extracted information included author(s), publication year, study location, aim of the study, population and sample, methods, and key findings. Charting was conducted systematically and regularly reviewed by team members for accuracy. Table 1 summarises the key findings. Table 2 provides a synthesis of the manifestations of medical xenophobia and healthcare exclusion. Table 3 presents a synthesis of the consequences, and Table 4 presents a synthesis of the interventions.

2.5. Collating, summarising and reporting results

Step 5 involved collating and synthesising findings, summarising evidence into key themes and presenting them to highlight their significance (Levac et al., 2010). Following data charting, data analysis was conducted using Braun and Clarke's six-phase thematic framework, which offers a structured and systematic approach to ensure consistency and reliability throughout the analysis process (Braun and Clarke, 2006). Dividing the process into distinct phases allowed researchers to attend carefully to each step, reducing the risk of overlooking significant insights. The first phase involved repeated, immersive reading of the data for familiarisation. In the second phase, initial codes were developed through systematic identification of salient features within the dataset. During the third phase, related codes were grouped into preliminary themes. The fourth phase focused on reviewing and refining these themes to ensure they accurately reflected both the coded extracts and the broader dataset. In the fifth phase, themes were clearly defined and labelled to capture their core meaning and scope. The sixth and final phase comprised synthesising the analysis into a coherent narrative that addressed the research questions. Through thematic analysis, researchers identified the forms or manifestations of medical xenophobia and healthcare exclusion, the adverse effects or consequences of medical xenophobia and healthcare exclusion and interventions to mitigate the discriminatory practices against refugees and migrants in Africa. Findings were interpreted in line with the research question. The scoping review outcomes were reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines, as outlined by Tricco et al. (2018), to maintain transparency and ensure comprehensive reporting.

3. Results

3.1. Study characteristics

Of the 20 studies, the majority (n = 17, 85 %) employed qualitative methods, while two studies (10 %) utilised quantitative methods and one study (5 %) adopted a mixed method (Table 1). The prevalence of qualitative methods underscores a strong focus on exploring the in-depth perspectives, experiences, and contextual factors related to medical xenophobia and healthcare exclusion, rather than quantifying the scope of the issue or statistically examining causal relationships. The scarcity of quantitative and mixed-method research limits the broader generalisability and empirical measurement of these issues to larger African migrant and refugee populations.

Country distribution analysis indicated that South Africa accounted for a significant proportion of the studies, with 15 (75 %). Ghana, Kenya, the Lake Chad Basin (including Cameroon, Chad, Niger and Nigeria) and Senegal each contributed one study (5 %) (Table 1). The higher number of studies conducted in South Africa reflects the significant research focus on this context, largely driven by the well-documented prevalence of medical xenophobia and healthcare exclusion in the country. Consequently, the findings may not be entirely generalisable to other African nations, which often have different socioeconomic conditions, migration patterns, and healthcare systems.

Furthermore, of 20 studies, eight studies (40 %) were conducted between 2014 and 2019—before the COVID-19 pandemic—while 12 (60 %) were conducted from 2020 to 2024. The rise in studies on medical xenophobia and healthcare exclusion after 2020 shows increased academic focus on these issues during and after the COVID-19 pandemic. This trend probably arises from greater awareness of how public health crises can worsen discrimination and exclusion faced by refugees and migrants in healthcare systems. However, the focus on research during the pandemic might limit understanding of how medical xenophobia and healthcare exclusion occur under normal, non-crisis conditions.

3.2. Manifestations of medical xenophobia and exclusion

The issue of medical xenophobia and healthcare exclusion was manifested in the prejudiced and intolerant actions displayed by healthcare practitioners, alongside the unjust denial of care based on an individual's documentation and immigration status. Moreover, economic obstacles and entrenched discrimination, combined with the hurdles created by language barriers, significantly intensify this exclusionary environment (Table 2).

3.2.1. Discriminatory and xenophobic attitudes of healthcare providers

All 20 studies included in this review highlighted how discriminatory practices and xenophobic attitudes—exhibited by healthcare providers—have profoundly influenced refugees' and migrants' accessibility

Table 1
Summary of the study.

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
Afari-Asiedu et al. (2024)	Ghana.	"To explore the factors influencing vaccination uptake among pastoralist nomads in four regions of Ghana."	- Pastoralist nomads and key informants in four regions of Ghana ($n = 182$).	Qualitative	- Healthcare providers' fear of being attacked by pastoralist nomads contributes to their hesitance in visiting nomadic settlements for vaccination, reflecting a form of medical exclusion. - There is a perceived use of derogatory words and discrimination against pastoralist nomads by healthcare providers, which negatively influences vaccination uptake among this population. - Language barriers between health workers and pastoralist nomads hinder effective service delivery, further exacerbating the challenges these nomadic communities face in accessing healthcare. - The findings suggest that strengthening collaboration between the Ghana Health Service and community leaders could help build trust and overcome barriers related to discrimination and exclusion in healthcare access. - Tailor vaccination efforts with language support, familiar settings, and collaborative outreach to enhance accessibility and participation.
Akokuwebe et al. (2023)	South Africa.	"To document health services satisfaction and medical exclusion among migrant youths in Gauteng Province, South Africa."	- Migrant youths aged 18 to 29 years in Gauteng Province, South Africa ($n = 2162$).	Quantitative	- In-migrants reported a higher prevalence of medical exclusion (5.8 %) and lower health services satisfaction (37.8 %) compared to immigrants in Gauteng Province, South Africa. - -Medical exclusion among migrant youths in Gauteng Province is a significant issue, with a prevalence of 5.5 % for in-migrants and 4.2 % for immigrants, indicating barriers to accessing healthcare services. - Medical xenophobia, characterised by negative attitudes and discriminatory practices from healthcare providers towards migrants, contributes to the exclusion experienced by these populations. - Factors such as having no medical aid, being female, and expressing dissatisfaction with health services were identified as significant predictors of medical exclusion among migrant youths. - The study highlights that migrants with a household member suffering from mental health conditions reported higher rates of medical exclusion, suggesting that stigma and discrimination may exacerbate their healthcare challenges. The study suggested that: - Implementing awareness programs, revising existing laws, and developing inclusive health policies that address barriers such as nationality and social status. - A coordinated national approach involving multiple stakeholders should tackle socio-economic determinants of health and enhance insurance coverage and healthcare utilisation for migrants.
Alfaro-Velcamp (2017)	South Africa.	"To investigate the varying access to healthcare for asylum seekers, refugees, and immigrants in South Africa, particularly in Cape Town, due to unclear legal status."	- Asylum seekers, refugees, and immigrants in South Africa ($n = 3000$).	Mixed methods	- The research highlights a significant divergence between the South African Constitution, which guarantees access to healthcare for everyone, and the actual practices of healthcare providers, particularly asylum seekers, refugees,

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Table 1 (*continued*)

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					and undocumented migrants. This divergence contributes to medical xenophobia and exclusion. - Hospital administrators often require documentation from patients before providing care, which disproportionately affects undocumented immigrants and leads to their exclusion from necessary healthcare services. - Many healthcare providers feel compelled to engage with civil society organisations for guidance on how to treat patients with uncertain legal status, indicating a lack of clarity and support within the healthcare system. This situation fosters an environment of discrimination against vulnerable groups. - Surveys indicate that a significant portion of South Africans believe access to health services should depend on citizenship and legal status, reflecting societal attitudes that contribute to the medical exclusion of migrants and refugees. - The legal authority placed on hospital administrators to determine patients' legal standing has resulted in violations of human dignity for asylum seekers and refugees, further entrenching discrimination in healthcare access. - The research underscores that the inconsistent application of immigration laws and healthcare regulations leads to confusion and discrimination, preventing many immigrants from receiving the healthcare they are entitled to under the Constitution. The study suggested that: - Healthcare policies at provincial and municipal levels in South Africa must be reframed to align with constitutional rights, ensuring accessible and non-discriminatory care for all, including immigrants and refugees. - Clear guidelines, legal education for healthcare providers, and collaboration with civil society organisations are essential to mitigate medical xenophobia, uphold human dignity, and promote equitable treatment for vulnerable populations.
Arnold et al. (2014)	Kenya.	"To explore the barriers to accessing healthcare experienced by urban migrants and Kenyans living in vulnerable areas of Nairobi, Kenya."	- Urban migrants and Kenyans living in areas considered to be spaces of vulnerability in Nairobi. - The sample size consisted of participants from four specific locations: Mathare, Kayole, Majengo, and South B, with a total of 14 government program representatives, 14 service providers, 4–6 migrants and 4–6 Kenyans from each location.	Qualitative	- Urban migrants in Nairobi face unique barriers to accessing healthcare, including real or perceived discrimination, which contributes to medical xenophobia and exclusion. - Cost discrepancies between migrant and Kenyan clients were identified, indicating that migrants may be charged higher healthcare service fees, exacerbating financial accessibility issues. - Language barriers were noted as a limitation for migrants, potentially leading to misunderstandings and further exclusion from healthcare services. - The threat of harassment by authorities while travelling to healthcare facilities was reported by migrants, creating an environment of fear that deters them from seeking necessary medical care. - Despite the constitutional right to health for all individuals in Kenya,

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Table 1 (*continued*)

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					migrants continue to experience barriers that reflect systemic discrimination and exclusion from mainstream health programming. Results emphasised that: - Promoting equitable healthcare for migrants involves establishing inclusive policies, fostering partnerships to integrate vulnerable groups into health services, and improving migrant-sensitive care by addressing language barriers and service disparities. - Cultural competence training for healthcare providers, public awareness campaigns to combat xenophobia, and ongoing research to evaluate and enhance healthcare access are essential to ensuring comprehensive and non-discriminatory health services for migrants.
Chawhanda et al. (2024)	South Africa.	"To explore the experiences of migrant women in accessing and utilising sexual and reproductive health and rights (SRHR) services, as well as the experiences of healthcare workers in providing these services in Ekurhuleni, South Africa."	- Migrant women and healthcare workers in Ekurhuleni, South Africa. - The sample size consists of **five** internal migrants, **eight** international migrant women aged 18–49 years, and **four** healthcare workers ($n = 17$).	Qualitative	- Migrant women experience multiple forms of discrimination, including medical xenophobia, which significantly hinders their access to sexual and reproductive health services (SRHR) and HIV services. This discrimination is based on factors such as age, language, HIV status, and migration status. - Language barriers exacerbate the challenges faced by migrant women, as they often struggle to communicate their needs effectively, leading to misunderstandings with healthcare workers. - Healthcare workers also report facing difficulties due to language challenges, which complicates their ability to provide appropriate care to migrant women. - The lack of interpretation services in public healthcare facilities further contributes to the barriers faced by migrants, making it difficult for them to access necessary services. - Cultural and religious beliefs play a crucial role in determining migrant women's access to SRHR services, with some women finding it unacceptable to receive care from male healthcare workers. - The study highlights that both internal and international migrant women face similar challenges in accessing healthcare, indicating a widespread issue of discrimination and exclusion within the healthcare system. - Healthcare workers often exhibit negative attitudes towards migrants, which can lead to stigmatisation and judgmental sentiments, further discouraging migrants from seeking care. It is suggested that: - Empowering migrants through education on their rights, promoting a diverse and multilingual health workforce, and addressing discrimination like medical xenophobia are key to ensuring equitable healthcare access. - Strategies such as cultural sensitivity training, migrant-friendly policies, and monitoring discrimination through national surveys can enhance healthcare

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Table 1 (*continued*)

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					experiences for both migrants and providers.
Chekero and Ross (2018)	South Africa.	"To explore the experiences of Zimbabwean migrant women in accessing healthcare in Giyani, Limpopo province, South Africa."	- Zimbabwean migrant women accessing healthcare in Giyani	Qualitative	- Medical xenophobia is prevalent in South Africa, where migrants often experience neglect and hostility from healthcare staff due to their lack of documentation. This results in significant barriers to accessing healthcare services. - Migrant women report feeling excluded from health services and believe they are treated differently from South African citizens, which compromises their access to necessary healthcare. - The perception among migrants is that state officials perform unnecessary surgical interventions, such as C-sections, on non-citizens, reflecting a broader issue of obstetric violence against migrants. - Healthcare providers may refuse access to state institutions based on the lack of proper documentation, leading migrants to seek care through private healthcare or personal networks despite the associated costs. - The South African health policy, while progressive on paper regarding migrant rights, often fails in practice, as migrants face discrimination and exclusion from services they are legally entitled to. - The invisibility of migrants in healthcare statistics further exacerbates their exclusion, as they are often not recorded in health databases, leading to a lack of resources allocated to meet their needs. It is suggested that: - Migrant women can navigate healthcare challenges more effectively by leveraging social networks, cultural assimilation, personal relationships with healthcare professionals, and seeking support from community organisations like churches. - Raising awareness about healthcare rights and collaborating with NGOs and advocacy groups empowers migrants to access resources, challenge discrimination, and address systemic barriers.
Chirau et al. (2024)	South Africa.	"To describe and understand the experiences of undocumented Zimbabwean migrants in accessing healthcare services in Nellmapius, Pretoria."	- Undocumented Zimbabwean migrants who reside in Nellmapius, a high-density suburb in Pretoria, South Africa. - The sample size for the study was 13 participants ($n = 13$).	Qualitative	- Undocumented migrants in Nellmapius faced significant challenges in accessing healthcare, primarily due to discrimination and negative attitudes from healthcare staff, which can lead to alternative health-seeking behaviours. - Undocumented Zimbabwean migrants reported facing significant challenges in accessing healthcare, primarily due to their lack of documentation, which often resulted in denial of treatment or requests for payment. - The experiences of the migrants were not homogeneous; they faced various challenges rooted in systemic discrimination and the attitudes of healthcare workers. - Many migrants felt that they received less priority compared to South African patients, leading to a reluctance to seek medical care, which increased their vulnerability, especially among female migrants.

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Table 1 (*continued*)

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					- Negative attitudes and behaviours of nursing staff contributed to fear and frustration among migrants, influencing their decisions to seek alternative healthcare options. - The study indicates that the lack of understanding due to language barriers further exacerbated the difficulties faced by migrants in accessing appropriate medical care. It is suggested to: - Tackle systemic causes of medical discrimination through comprehensive solutions, including training healthcare workers in cultural sensitivity and migrants' rights to reduce discrimination. - Advocate for clear treatment guidelines, community awareness campaigns, and support networks to ensure equitable healthcare access and promote understanding of migrants' constitutional rights.
Crush and Tawodzera (2014)	South Africa.	"To examine the extent to which medical xenophobia manifests within South Africa's public health system, particularly as experienced by Zimbabwean migrants seeking access to health services."	- Zimbabwean migrants attempting to access public health services in South Africa ($n = 100$) - Fifty interviews were conducted in each of the two cities, Cape Town and Johannesburg.	Qualitative	- Medical xenophobia is prevalent in South Africa's public health system, negatively impacting Zimbabwean migrants' access to healthcare services. - A significant portion of South Africans hold xenophobic views, believing that migrants consume resources and bring diseases, which contributes to discriminatory practices in healthcare. - Many Zimbabwean migrants experience denial of treatment based on their inability to produce the "correct" documentation, which is often a barrier to accessing public health services. - Public health professionals often exhibit a disregard for legal obligations and ethical responsibilities towards migrant patients, leading to substandard and abusive treatment. - Despite constitutional guarantees for healthcare access, migrants frequently face systemic barriers and are often referred to non-governmental organisations for treatment instead of receiving care in public facilities. - The treatment of migrants is influenced by their nationality, with evidence showing that they are often subjected to poorer care compared to South African citizens, indicating a clear instance of medical xenophobia. - The healthcare system's overburdened state exacerbates the challenges faced by migrants, as many healthcare workers are stressed and overworked, which can lead to further discrimination against foreign patients. It is recommended: - To combat xenophobia in healthcare, it is crucial to implement training programs for professionals, establish clear treatment protocols, and provide language support services to ensure inclusive and respectful care for migrants and refugees. - Public awareness campaigns, community outreach, and collaboration between advocacy and health institutions can help address stereotypes, empower migrants, and promote equitable healthcare access.

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Table 1 (*continued*)

Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
David et al. (2024)	South Africa.	"To investigate the impact of the COVID-19 pandemic on Malawian immigrants living in South Africa, focusing on their vulnerabilities and challenges."	- Malawian immigrants living in South Africa ($n = 29$), which included 24 migrants and 5 key stakeholders.	Qualitative	- Malawian immigrants in South Africa faced significant barriers to accessing healthcare services due to their immigration status, which resulted in intentional discrimination by health workers. This included longer wait times and reluctance to provide care to undocumented immigrants. - The study highlighted that healthcare access was often contingent on having legal documents, with undocumented immigrants experiencing greater challenges in receiving medical attention. - Participants reported feeling vulnerable and unsafe in healthcare settings, as they were often treated differently compared to South African citizens, leading to a sense of medical exclusion. - The reluctance of healthcare providers to assist immigrants was exacerbated during the COVID-19 pandemic, with many immigrants experiencing worsened healthcare access compared to pre-pandemic times. - Stakeholders confirmed that national policies and individual prejudices among health workers significantly influenced the healthcare access of immigrants, further entrenching medical xenophobia. It is suggested that: - Advocating for inclusive health policies, addressing healthcare worker biases, and creating supportive community systems are essential to improving healthcare access and experiences for undocumented migrants and asylum seekers. - Collaboration with stakeholders and promoting legal documentation can help dismantle structural barriers and reduce discrimination in healthcare services.
Jaiswal et al. (2024)	South Africa.	"To visualise the outcome effects of barriers faced by black migrant women in accessing maternal healthcare in South Africa."	- Black African migrant women from the South African Development Countries (SADC) living in South Africa. - The sample size of SADC women citizens recorded as deaths from 2002 to 2015 ($n = 33,758$).	Quantitative	- Black migrant women from SADC countries faced heightened maternal mortality rates compared to South African women, with an odds ratio of 2.02 indicating they are more than twice as likely to die from maternal-related causes. This disparity is statistically significant and suggests systemic barriers to accessing healthcare. - Xenophobic attitudes of healthcare workers towards migrants have been identified as a significant barrier to accessing healthcare services, contributing to the increased mortality rates among black migrant women. - The analysis indicates that fear of deportation and discrimination within healthcare settings leads to reluctance among migrant women to seek necessary medical care, resulting in preventable deaths. - The study emphasises that the negative experiences of migrant women in healthcare facilities, including demands for documentation and poor treatment, reflect broader issues of medical xenophobia and exclusion. - It is noted that the lack of antenatal care (ANC) attendance among migrant women is linked to their fear of being turned away or reported due to their

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					immigration status, further exacerbating health disparities. It is suggested that: - To address medical discrimination and promote equitable healthcare, initiatives focus on training healthcare workers, establishing anti-discrimination policies, and improving communication through translation services and bilingual staff. - These efforts are complemented by community outreach to inform migrants of their rights, collaborations with migrant organisations, and regular facility assessments to ensure accountability and fair treatment for all patients.
Labys et al. (2017)	South Africa	"To gain a deeper understanding of the experiences of refugees in Durban, South Africa, particularly focusing on the problems they face, the impact of these problems on their mental health, and the coping strategies they employ."	- Refugees from Zimbabwe and the Democratic Republic of Congo living in Durban, South Africa ($n = 18$)	Qualitative	- Refugees in South Africa face significant barriers to accessing healthcare, including xenophobic treatment by local people and institutions. - Many interviewees reported experiences of abuse and exclusion from healthcare services, which negatively impacted their overall well-being. - The study highlighted that nearly two-thirds of participants struggled with acceptance by the local population, which contributed to their difficulties in accessing necessary services. - Participants expressed feelings of powerlessness and worthlessness, which were exacerbated by their experiences of discrimination and exclusion in healthcare settings. - The lack of permanent identification papers and work permits further complicated refugees' ability to access healthcare, as they often felt unwelcome and discriminated against. The study suggests: - Further research is necessary to address the overlooked challenges and coping strategies of refugees in South Africa and other host countries, where governments play a significant role in their security and well-being. - Understanding the unique circumstances of different refugee groups is crucial for developing informed policies and accessible mental health services, which can help prevent ongoing marginalisation and stagnation.
Msabah (2022)	South Africa	"To explore the complex relationship between forced migration and healthcare services in South Africa, particularly focusing on the lived experiences of refugees."	- Refugees and migrants from sub-Saharan Africa were interviewed across five South African cities: Cape Town, Durban, Port Elizabeth, Johannesburg, and Pretoria ($n = 250$)	Qualitative	- Refugees in South Africa often experience medical xenophobia, where health workers treat them with indifference or hostility upon realising they are not South African citizens. This leads to a lack of priority given to their healthcare needs. - Many refugees face discrimination in healthcare settings, including being verbally abused and having their dignity attacked by health practitioners, which exacerbates their health challenges. - Health workers frequently lack training on migration issues, confusing the rights and privileges of different categories of migrants, which contributes to the exclusion of refugees from adequate healthcare services.

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					- Refugees often encounter barriers such as being asked to pay upfront for medical services or being denied care due to the absence of local identity documents, which reflects systemic discrimination in healthcare access. - The experiences of refugees in healthcare settings lead many to avoid seeking medical attention, fearing further discrimination or inadequate care, which can result in deteriorating health conditions. It is suggested that: - Health systems should be inclusive and accessible for refugees by addressing cultural and linguistic barriers, training health workers on refugee rights, and equipping them to manage common health issues. - Implementing policies and awareness programs to combat medical discrimination and prioritise refugee health in national strategies can help eliminate discrimination and ensure equitable care.
Munyaneza and Mhlongo (2019)	South Africa	"To document the day-to-day experiences of women refugees and uncover their challenges regarding the utilisation of reproductive health services in public healthcare facilities in Durban, KwaZulu-Natal."	- Women refugees who live in the City of Durban, KwaZulu-Natal, aged between 18 and 49 years and have sought reproductive health services at one of the public institutions (n = 8)	Qualitative	- Women refugees in Durban, KwaZulu-Natal, face significant challenges in accessing reproductive health services, including medical xenophobia, discrimination, and language barriers. - Negative experiences reported by participants included unprofessionalism, failure to obtain consent, lack of confidentiality, and ill-treatment, which contributed to their vulnerability. - Language barriers were identified as a significant challenge, with healthcare providers often insisting on communicating in isiZulu, which many refugees do not understand, leading to further exclusion. - The internalised fear resulting from previous negative experiences with healthcare providers discourages women refugees from seeking necessary medical care. - Financial constraints also exacerbate the challenges faced by refugees, making it difficult for them to afford healthcare services, thus increasing their vulnerability to health-related issues. The study suggested that: - Training healthcare professionals in cultural sensitivity and refugee rights, alongside implementing policies that promote inclusivity and clear communication to ensure equitable care for refugees. - There is a need to address systemic issues like overcrowding, language barriers, and psychological support to create a more welcoming and effective healthcare environment.
Mvundura (2024)	South Africa	"To analyse the experiences of Zimbabwean migrant women seeking antenatal care services within the South African public healthcare system, particularly focusing on the phenomenon of medical xenophobia."	- Zimbabwean migrant women seeking antenatal care services within the public healthcare system in Johannesburg (n = 10).	Qualitative	- The study identifies that medical xenophobia exists within the South African public healthcare system, particularly affecting Zimbabwean migrant women seeking antenatal care. This xenophobia is reflected in the utterances and practices of some healthcare providers, which mirror the anti-migrant discourse prevalent in media and political spaces.

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					- Healthcare providers often exhibit anti-migrant sentiments, which manifest in their treatment of migrant patients, leading to discriminatory practices such as the demand for user fees and passports. These practices are often accompanied by verbal abuse and negative characterisations of migrants. - Anti-migrant discourse, which is popularised by media and political narratives, serves as a framework for healthcare providers, influencing their perceptions and interactions with migrant patients. - The findings suggest that while systemic challenges in the healthcare sector exist, they do not justify the discriminatory treatment of migrants, as anti-migrant attitudes significantly mediate their experiences when seeking healthcare. - The study highlights that the practices constituting medical xenophobia are often re-articulations of the broader anti-migrant discourse, indicating a normalisation of such attitudes within the healthcare bureaucracy. The study highlighted: - There is a need to address biases among healthcare providers through training and inclusive policies to ensure equitable access to medical services for migrants. - The role of community organisations, advocacy efforts, and positive narratives in reducing stigma and fostering better communication between healthcare providers and migrant communities.
Oginni et al. (2022)	Cameroon and Nigeria	"To explore the experiences of displaced persons in the Lake Chad Basin (LCB) regarding their access to healthcare."	- Displaced persons in the Lake Chad Basin region, specifically refugees and internally displaced persons (IDPs) from Cameroon, Chad, Niger, and Nigeria ($n = 67$), which included 25 refugees, 29 IDPs, 8 host community leaders, and 5 camp managers.	Qualitative	- The displaced persons in the Lake Chad Basin (LCB) face significant barriers to healthcare access, which were exacerbated by the influx of internally displaced persons (IDPs) and refugees due to the Boko Haram insurgency. - Barriers to healthcare access include geographical accessibility issues, such as a lack of health facilities and poor transportation options, particularly for women and the elderly. - Communication barriers were identified as a major issue, with healthcare professionals often being foreigners or transferred from other regions, leading to difficulties in understanding and accessing care for displaced persons who spoke different local dialects. This situation exemplifies medical xenophobia and discrimination. - The lack of proper identification documents for some displaced persons resulted in the denial of healthcare access, further highlighting the discrimination faced by refugees and internally displaced persons in the region. - Financial barriers, such as the inability to afford transportation and healthcare costs, were prevalent among the displaced persons, which exacerbated their exclusion from necessary medical services. - The study indicated that the influx of internally displaced persons and refugees put additional pressure on

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					already limited healthcare resources, leading to poorer quality of care and further marginalisation of these populations. The study highlighted the need for: - Addressing barriers to healthcare access for displaced persons through measures like infrastructure investment, employment opportunities, and deploying qualified healthcare professionals in the Lake Chad Basin. - A system-wide approach, including free healthcare services and accessible communication, to promote equitable healthcare and reduce exclusion.
Onoma (2020)	Senegal.	"To examine the effect of geographical proximity on targeting patterns during xenophobic outbursts by Senegalese against the migrant Peul population during the Ebola epidemic."	- Community of Pikine, which is part of the agglomeration that constitutes Dakar ($n = 80$).	Qualitative	- The study found that geographical proximity influenced targeting patterns during xenophobic outbursts against the Peul population in Senegal during the Ebola epidemic, with Senegalese sparing their immediate Peul neighbours from exclusionary practices while targeting those outside their neighbourhoods. - Historical identity formation and inter-group relations processes were identified as having more explanatory power for understanding these targeting patterns than the Ebola epidemic itself. - The research indicated that the fear generated by Ebola had little impact on the micro-dynamics of xenophobia, suggesting that the epidemic reinforced existing patterns of exclusion rather than creating new ones. - Deliberate efforts at everyday peacebuilding by Peul migrants, such as economic interactions beneficial to local Senegalese, contributed to maintaining cordial relations with their immediate neighbours. - The findings highlighted that the dynamics of xenophobia during the epidemic mirrored those in non-epidemic contexts, emphasising the importance of long-standing social networks and relationships. It is suggested that: - Migrants can foster peace and mutual understanding by engaging in positive economic interactions, building convivial relationships, and responding calmly to xenophobic attitudes, thereby improving their perception within host communities. - Prioritising harmony may involve ceding certain rights and encouraging locals to recognise migrants' contributions and shared humanity to counter stereotypes and reduce tensions.
Vanyoro (2019)	South Africa.	"To explore the practices, experiences, and perspectives of frontline health care providers in a cross-border public primary health care facility in Musina, South Africa, which is associated with high levels of migration."	- Frontline health care providers in a public health care facility in Musina, South Africa ($n = 10$), which included data capturers, nurses, administrators, clerks, and receptionists.	Qualitative	- The frontline health care providers in Musina, South Africa, despite facing institutional challenges, provided public health care services and HIV treatment to black African migrants, who are often victims of xenophobia. - The experiences of non-nationals in South Africa's public health care system are more nuanced, showing ambivalence and a range of possible experiences rather than a straightforward narrative of exclusion or discrimination. - Frontline healthcare providers often adopt a counterintuitive approach,

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					where they stereotype migrant patients as responsible for their 'indigency' while simultaneously employing innovative strategies to assist them. This reflects a form of discretion that challenges the notion of medical xenophobia. - The study emphasises that citizenship, nationality, or legal status alone do not adequately explain the treatment of migrants in the health care system; instead, concepts like bureaucratic incorporation and therapeutic citizenship are more relevant in understanding how migrants are (re) defined by health care providers. - There is a recognition that existing policies and treatment guidelines in South Africa do not effectively address the needs of migrant patients, leading to a reliance on frontline discretion to navigate these challenges. - The findings suggest that while there are instances of poor treatment linked to nationality, many negative experiences in healthcare are not solely attributable to xenophobia but may also stem from systemic issues within the healthcare system itself. It is suggested that: - Training health care providers to recognise biases, improve cultural competency, and follow standardised protocols ensures equitable treatment for migrants, while policies promoting bureaucratic incorporation foster inclusive care. - Community outreach and supportive networks can reduce stigma, enhance understanding, and improve healthcare access for migrants.
Vanyoro (2022)	South Africa.	"To explore the practices adopted by health care providers in South Africa's public health care system regarding foreign migrants and their access to health services."	- Frontline healthcare workers from a primary healthcare facility in Musina ($n = 10$) - Frontline health care workers from a primary health care facility in Johannesburg ($n = 8$)	Qualitative	- Access to public health care services for foreign migrants in South Africa is often exclusionary, a phenomenon described as 'medical xenophobia.' This exclusion is not solely based on nationality or legal status but is influenced by a vigilant preparedness among healthcare providers to identify potential 'predators.' - Healthcare providers exhibit an adversarial sensibility, interpreting black migrant bodies through a lens of suspicion that reveals repressed or hidden meanings, which contributes to the construction of 'outsiders.' This suspicion is rooted in professional mandates and reflects broader societal biases against migrants. - The concept of 'creaming' is introduced, where healthcare providers prioritise certain patients based on perceived stability and adherence to treatment, often leading to the marginalisation of migrants who do not fit these criteria. This process is embedded within a bureaucratic system that inadequately addresses the needs of migrants. - There is a tendency among healthcare providers to attribute blame to individuals for their treatment adherence issues, which overlooks the structural factors that contribute to these challenges. This attribution bias can lead to the therapeutic ostracisation of migrants and local patients alike.

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
					- The research indicates that suspicion manifests in two forms: one based on nationality and the other on biomedical considerations. Migrants are often viewed as a threat to the public good, leading to discriminatory practices in health care access. - The findings suggest that healthcare providers' responses to migrants are influenced by a combination of resource scarcity and structural violence, which complicates the dynamics of belonging and access to care. The study highlighted the need for: - Anthropological studies on suspicion in public health care to inform inclusive practices and prevent medical exclusion, particularly through strategies like ART adherence clubs that reduce stigma and support treatment adherence. - Shifting away from nationality-focused analyses to consider intersecting factors, training healthcare providers to address biases, and fostering therapeutic responsibility to create a more equitable and supportive healthcare environment.
White and Rispel (2021)	South Africa.	"To explore whether South African legislation, health policies, and the perspectives or actions of health policy actors facilitate universal health coverage (UHC) for migrants and refugees or exacerbate their exclusion."	- Key informants from various sectors, specifically from government, academia, civil society organisations, and a United Nations organisation (n = 18)	Qualitative	- Migrants and refugees in South Africa experience significant discrimination and exclusion from healthcare services, including outright refusal of care by some healthcare facilities. - Key informants reported that healthcare workers often do not adequately explain the requirements for accessing services, leading to misunderstandings and further exclusion of migrants and refugees. - There is a prevalent stereotype among the South African population that migrants are a burden on healthcare resources, which contributes to negative attitudes and discriminatory practices within the healthcare system. - The lack of a cohesive national legal or policy framework regarding the rights of migrants and refugees to healthcare exacerbates their exclusion, as healthcare providers may not be clear on the entitlements of these populations. - Civil society organisations play a crucial role in advocating for the health rights of migrants and intervening to mediate access to care, highlighting the importance of their involvement in addressing medical exclusion. The study suggested: - A multi-stakeholder coalition involving the UN, government, civil society, and health organisations is essential to combat medical xenophobia through human rights advocacy, zero tolerance for discrimination, and professional ethics training for healthcare workers. - Efforts should include clear guidelines on healthcare rights, proactive media engagement to counter xenophobia, and addressing systemic resource constraints to ensure quality universal health coverage for all, including migrants and refugees.
Zihindula et al. (2017)	South Africa.	"To explore the lived experiences of refugees from the Democratic Republic of Congo (DRC) regarding	- Refugees from the Democratic Republic of Congo (DRC) living in Durban, South Africa (n = 31)	Qualitative	- Refugees from the Democratic Republic of Congo (DRC) experience medical discrimination and exclusion when

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Authors	Country	Aim of the study	Population and Sample	Methods	Key findings
		their encounters with the health care system in Durban, South Africa."			accessing healthcare services in Durban, South Africa. - Language barriers and lack of proper documentation are significant obstacles that refugees face, often leading to denial of treatment and poor service delivery. - Medical xenophobia is evident in the attitudes of healthcare workers, including stereotyping, negligence, and cultural insensitivity, which negatively impact the quality of care provided to refugees. - Participants reported instances of being denied healthcare services due to their refugee status and lack of identification documents, contributing to feelings of trauma and stress. - Communication failures between healthcare providers and refugees exacerbate the challenges in accessing healthcare, leading to misdiagnosis and improper treatment. The study suggested: - Healthcare systems should prioritise training for workers on cultural sensitivity, provide interpreters, and enforce policies protecting refugees' rights to ensure equitable and non-discriminatory care. - Raising public awareness and implementing regular evaluations of services can help address barriers, combat stereotypes, and promote inclusivity in health care for refugees.

to and experiences with healthcare services (Table 2). Healthcare providers frequently displayed adverse attitudes toward migrants, and verbal abuse and derogatory language were prevalent forms of discrimination (Chawhanda et al., 2024; Msabah, 2022; Zihindula et al., 2017). Msabah (2022) and Zihindula et al. (2017) documented instances where healthcare workers use slurs like "kwerekwere" to demean migrants. Chawhanda et al. (2024) highlighted that young, HIV-positive migrants are especially susceptible to verbal abuse and neglect.

In South Africa, refugees originating from the Democratic Republic of Congo reported instances of neglect, verbal mistreatment and cultural insensitivity from healthcare personnel, resulting in feelings of alienation and psychological trauma (Labys et al., 2017; Zihindula et al., 2017). Healthcare providers accused refugees and migrants frequently unfairly of overburdening the healthcare system and spreading diseases (Chekero and Ross, 2018; Labys et al., 2017; Onoma, 2020). Studies by Chekero and Ross (2018) and Labys et al. (2017) documented xenophobic attitudes, with Zimbabweans being labelled as "disease bringers" and migrants perceived as a strain on scarce resources. In Senegal, a study by Onoma (2020) emphasised how stereotypes can portray entire communities, such as the Peul, as unhygienic and dangerous. Furthermore, two studies indicated that Zimbabwean migrant women residing in South Africa encountered substandard treatment and were frequently subjected to derogatory comments, insults and victimisation by nurses and other healthcare providers due to their nationality (Chirau et al., 2024; Mvundura, 2024). Five studies found that healthcare workers often overlook the needs of migrants or provide substandard care (Chawhanda et al., 2024; David et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Zihindula et al., 2017). Munyaneza and Mhlongo (2019) documented the neglect of migrant women during childbirth, while Chawhanda et al. (2024) and David et al. (2024) report discriminatory practices against pregnant migrant women. Zihindula et al. (2017) and Msabah (2022) emphasised instances in which healthcare workers neglect or completely dismiss the medical concerns of refugees. Healthcare providers in South Africa often prioritised local citizens over migrants, with migrants reporting extended wait times, denial of care and referrals to non-governmental organisations rather than public healthcare facilities (Alfaro-Velcamp, 2017; White and Rispel, 2021).

Six studies indicated that discriminatory behaviours of healthcare workers were related to unpreparedness on migration issues, care for refugees and migrants, and lack of guidelines and support (Arnold et al., 2014; Crush and Tawodzera, 2014; Msabah, 2022; Vanyoro, 2022, 2019; White and Rispel, 2021). Lack of or insufficient training on migration issues leads to confusion regarding migrants' rights and entitlements, as well as inconsistent implementation of healthcare policies (Msabah, 2022; White and Rispel, 2021). In South Africa, healthcare providers struggled or refused to treat undocumented refugees and migrants, highlighting systemic healthcare exclusion of that vulnerable population (Alfaro-Velcamp, 2017; White and Rispel, 2021). Similarly, in Kenya, communication breakdowns and strained relationships between healthcare workers and refugees were associated with inadequate training to engage with migrants (Arnold et al., 2014). The absence of guidance and support within healthcare systems further intensified these challenges, forcing healthcare workers to rely on their discretion to manage complex cases involving refugees and migrants (Vanyoro, 2022; White and Rispel, 2021). This lack of clarity delayed care and perpetuated discriminatory attitudes, with some healthcare workers perceiving migrants as a burden on limited resources (Crush and Tawodzera, 2014; Msabah, 2022; Vanyoro, 2019).

3.2.2. *Denial of care based on documentation and legal status*

Of 20 studies, 19 indicated how documentation and legal status significantly hindered refugees, asylum seekers and migrants' access to healthcare, often resulting in service denial, medical exclusion or substandard care. (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal

Table 2
Synthesis of manifestations of medical xenophobia and healthcare exclusion of migrants and refugees.

Manifestation	Key Features / Description	Authors
Discriminatory and xenophobic attitudes of healthcare providers	- Negative attitudes, verbal abuse, derogatory language from healthcare workers - Use of slurs and stereotypes portraying refugees and migrants as disease carriers or resource burdens - Neglect or substandard treatment, especially toward refugee and migrant women - Preference for treating local citizens, causing longer wait times and referrals away from public services - Lack of training and preparedness among healthcare workers to handle refugee and migrant health needs	(Afari-Asiedu et al., 2024; Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Oginni et al., 2022; Onoma, 2020; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017)
Denial of care based on documentation and legal status	- Healthcare denied to undocumented migrants or asylum seekers due to lack of official papers - Strict documentation requirements as a barrier to accessing care - Increased medical exclusion during COVID-19 pandemic - Undocumented migrants and asylum seekers forced to seek informal or private healthcare services	(Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Oginni et al., 2022; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017)
Financial exploitation and challenges	- Refugees and migrants charged higher fees than locals for similar services - Inability to afford user fees for essential care (e.g., antenatal services) - High transportation costs compound financial barriers - Systemic barriers push refugees and migrants toward costly private care or informal services	(Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Oginni et al., 2022; White and Rispel, 2021; Zihindula et al., 2017)
Linguistic discrimination	- Lack of shared language between refugees/migrants and healthcare providers leads to misunderstandings and misdiagnoses - Language differences used as a basis for discrimination and marginalisation - Absence of interpreters or translation services exacerbates exclusion - Language barriers discourage refugees and migrants from seeking care	(Afari-Asiedu et al., 2024; Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Oginni et al., 2022; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017)

Table 3
Synthesis of consequences of medical xenophobia and healthcare exclusion of migrants and refugees.

Consequence Category	Key Features / Description	Authors
Fear and vulnerability	- Refugees and migrants avoid healthcare due to fear of harassment, deportation, or discrimination - Experiences of insecurity and anxiety in healthcare settings - Feelings of unwelcomeness, powerlessness, and reluctance to seek care - Heightened fear during COVID-19 pandemic due to stricter controls and stigma	(Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Munyaneza and Mhlongo, 2019; Mvundura, 2024; White and Rispel, 2021; Zihindula et al., 2017).
Physical health deterioration	- Untreated chronic conditions increase complications and mortality - Heightened vulnerability to communicable diseases (e.g., HIV, TB) due to exclusion from services - Pregnant women face higher maternal mortality and poor child health outcomes - Reliance on self-medication, delayed treatment increases health risks and resistance	(Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019).
Mental health impact	- Anxiety, depression, alienation linked to discrimination and fear of deportation - Feelings of helplessness, worthlessness due to mistreatment - Untreated mental health issues and distrust in health systems - Psychological distress exacerbated by isolation, socio-economic challenges, and systemic exclusion - Passive suicidal ideation and desire to return home in some cases	(Chekero and Ross, 2018; Chirau et al., 2024; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017).
Maternal health adverse outcomes	- Pregnant refugee and migrant women denied care due to documentation or discrimination - Increased risks of maternal mortality, low birth weight, stillbirths - Psychological distress during pregnancy from mistreatment and substandard care - Reliance on informal, delayed, or costly private healthcare increases risks for mothers and children	(Chekero and Ross, 2018; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017).
Public health risks	- Exclusion leads to untreated communicable diseases (HIV, TB), posing community-wide health risks - Self-medication and delayed treatment foster drug resistance - Undermines public health initiatives and pandemic response efforts (e.g., COVID-19) - Poor living conditions increase vulnerability and public health burden	(Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017)

Table 4
Synthesis of the interventions to mitigate medical xenophobia and healthcare exclusion.

Intervention Category	Key Features / Description	Authors
Policy and legislative reforms	- Develop inclusive policies ensuring healthcare access regardless of legal status - Align national laws with constitutional rights and international human rights standards - Address the needs of undocumented refugees/ migrants - Standardise policies to mitigate systemic barriers, language issues and systemic xenophobia in healthcare settings	(Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019)
Cultural sensitivity and xenophobia mitigation	- Train healthcare providers in cultural competence and refugees/migrants' rights - Conduct public awareness campaigns to reduce xenophobic attitudes - Address language barriers through interpreters and bilingual staff - Promote patient-centred, compassionate care	(Alfaro-Velcamp, 2017; Arnold et al., 2014; Chekero and Ross, 2018; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Vanyoro, 2019; White and Rispel, 2021; Zihindula et al., 2017)
Community and stakeholder engagement	- Build trust and enhance healthcare access for migrants and refugees - Engage community leaders and trusted figures to disseminate information - Partner with NGOs, refugee and migrant-led groups, and civil society for support - Implement community-based educational campaigns and peer education - Use accessible venues (markets, worship places) for outreach - Foster broad collaborations for coordinated responses	(Afari-Asiedu et al., 2024; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2019; White and Rispel, 2021)
Healthcare accessibility enhancements	- Provide healthcare outreach in accessible and familiar locations - Offer free or low-cost services to overcome financial barriers - Employ interpreters, bilingual staff, or local health workers - Provide culturally relevant materials and translation services - Enhance healthcare systems to be migrant-sensitive and inclusive	(Afari-Asiedu et al., 2024; Arnold et al., 2014; Chekero and Ross, 2018; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019; Oginni et al., 2022; White and Rispel, 2021; Zihindula et al., 2017)
Monitoring and accountability	- Conduct regular assessments of facilities to detect discrimination - Integrate refugee and migrant health experiences into national health data - Establish clear treatment guidelines and protocols - Promote accountability through provider training and policy adherence - Foster collaboration among governments, civil society, and healthcare institutions	(Chawhanda et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017)

et al., 2024; Labys et al., 2017; Msabah, 2022; Mvundura, 2024; Oginni et al., 2022; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). Five out of 20 studies indicated that healthcare providers required official documentation and excluded undocumented migrants and asylum seekers (Chekero and Ross, 2018; Chirau et al., 2024; Mvundura, 2024; Vanyoro, 2019; Zihindula et al., 2017). Two studies revealed that undocumented Zimbabwean migrants in South Africa frequently encounter service refusals and are compelled to seek informal healthcare options (Chekero and Ross, 2018; Chirau et al., 2024). Similarly, a study by Zihindula et al. (2017) found that Congolese refugees in South Africa without any documentation were denied treatment at hospitals, even when severely sick. The COVID-19 pandemic exacerbated the medical exclusion, with Malawian immigrants in South Africa reporting heightened discrimination and extended wait times due to their undocumented status (David et al., 2024).

In the Lake Chad Basin Region, Oginni et al. (2022) found that there was an executive order in Cameroon preventing individuals without national ID cards from accessing essential services like healthcare. Furthermore, there was a denial of healthcare access for those who could not present identification documents to prove they were victims of the insurgency and had relocated to the community (Oginni et al., 2022). Documentation requirements not only restricted healthcare access but also perpetuated migrants' sense of exclusion and marginalisation, further entrenching systemic inequalities (Alfaro-Velcamp, 2017; Mvundura, 2024; Vanyoro, 2022, 2019; Zihindula et al., 2017). A study by Vanyoro (2019) found that undocumented migrants healthcare providers regarded undocumented migrants as "problematic patients" who might exploit the system; however, this perception did not result in their exclusion from healthcare services and antiretroviral therapy (ART).

3.2.3. *Financial exploitation and challenges*

Fifteen studies reported about the financial and systemic exclusion and migrants' access to healthcare, as they often faced higher fees than locals for identical services, creating financial barriers that disproportionately affected them (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Oginni et al., 2022; White and Rispel, 2021; Zihindula et al., 2017). Two studies found that migrant women in South Africa encountered user fees for antenatal care, which many could not afford, exacerbating their exclusion from essential services (Mvundura, 2024; Zihindula et al., 2017).

Refugees in Durban similarly struggled to afford private healthcare, relying on an overstretched public healthcare system that frequently denied them access, heightening their vulnerability (Munyaneza and Mhlongo, 2019; Zihindula et al., 2017). A study by Chawhanda et al. (2024) reported that the expenses associated with transportation to healthcare facilities represent a significant financial burden for certain migrant women and, coupled with elevated hospital charges, particularly for individuals lacking legal documentation, pose a challenge for essential services such as childbirth. Systemic barriers, such as institutionalised documentation requirements, exacerbated financial constraints, compelling many migrants to seek costly informal or private healthcare options (Alfaro-Velcamp, 2017; Chirau et al., 2024).

3.2.4. Linguistic discrimination

In 17 studies, language differences emerged as a persistent challenge, as healthcare providers, refugees and migrants often lacked a common language, creating misunderstandings, misdiagnoses and effective treatment (Afari-Asiedu et al., 2024; Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Oginni et al., 2022; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). White and Rispel (2021) found that language differences were often employed to categorise refugees and migrants as "outsiders," resulting in discriminatory practices and marginalisation by healthcare professionals. In Durban, South Africa, healthcare providers frequently required the use of isiZulu, which many refugees did not understand, further preventing them from accessing essential services (Labys et al., 2017; Munyaneza and Mhlongo, 2019; Zihindula et al., 2017). Similarly, migrant women in Ekurhuleni, South Africa, faced difficulties expressing their healthcare needs due to language barriers, leading to frustration and mistrust between patients and healthcare workers (Chawhanda et al., 2024).

In the Lake Chad Basin Region, Oginni et al. (2022) reported that linguistic obstacles exist between the displaced individuals and the healthcare practitioners who lack proficiency in the regional dialects. The absence of interpretation services in public healthcare facilities exacerbated communication issues—leaving migrants to navigate the healthcare system without adequate support (Arnold et al., 2014; Chawhanda et al., 2024; Oginni et al., 2022; Vanyoro, 2019). These barriers not only reduced the effectiveness of care but also generated frustration among already overtaxed healthcare personnel (White and Rispel, 2021) and discouraged many migrants from seeking healthcare altogether, further isolating them from critical health services (Labys et al., 2017; Zihindula et al., 2017).

3.3. Consequences of medical xenophobia and healthcare exclusion

The consequences of medical xenophobia and healthcare exclusion included fear and vulnerability, physical health deterioration, impact on mental health and adverse maternal outcomes (Table 3).

3.3.1. Fear and vulnerability

Thirteen studies identified that fear and vulnerability were prevalent among refugees and migrants seeking healthcare (Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Munyaneza and Mhlongo, 2019; Mvundura, 2024; White and Rispel, 2021; Zihindula et al., 2017). Nine of these studies revealed that migrants, particularly undocumented individuals, avoided healthcare services due to fear of harassment or deportation during interactions with authorities in healthcare facilities (Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017). In Kenya, a study by Arnold et al. (2014) found that urban refugees and migrants in Nairobi, particularly those without legal status, experienced anxiety and insecurity in obtaining healthcare because of the threat of harassment and detention by law enforcement while commuting to or from medical facilities.

Similarly, in South Africa, undocumented migrants and asylum seekers' fear of being reported to police, detained and deported was reported in five studies (Chawhanda et al., 2024; Chekero and Ross, 2018; Crush and Tawodzera, 2014; Jaiswal et al., 2024; Labys et al., 2017). In South Africa, refugees reported feelings of unwelcomeness and insecurity in healthcare settings, fostering powerlessness and reluctance to seek medical care (Labys et al., 2017; Munyaneza and Mhlongo, 2019; Zihindula et al., 2017). Zimbabwean migrants in South Africa expressed fears of mistreatment based on their undocumented status, exacerbating health vulnerabilities and deterring service access (Chekero and Ross, 2018; Chirau et al., 2024; Mvundura, 2024). Migrant and refugee women in South Africa faced increased vulnerability during healthcare interactions, as providers exhibited judgmental attitudes related to their migration status, HIV status, or communication barriers (Chawhanda et al., 2024; Munyaneza and Mhlongo, 2019). These fears intensified during the COVID-19 pandemic, as healthcare providers became increasingly reluctant to assist undocumented migrants, further deteriorating their access to care and sense of security (Chirau et al., 2024; David et al., 2024; White and Rispel, 2021).

3.3.2. Physical health deterioration

Eleven studies reported the health deterioration as a consequence of the healthcare exclusion of refugees and migrants (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). Denial of healthcare services often leads to untreated chronic conditions, increasing risks of complications and mortality (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Crush and Tawodzera, 2014). Refugees and migrants faced heightened vulnerability to communicable diseases such as HIV, tuberculosis and other infections, which remain untreated due to systemic exclusion and discrimination (Chekero and Ross, 2018; Chirau et al., 2024; Jaiswal et al., 2024). Pregnant women were particularly affected, experiencing higher rates of maternal mortality and severe health risks for themselves and their children due to the lack of antenatal care and treatment refusals (David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). Additionally, migrants' reliance on self-medication or delayed treatment, driven by fear of xenophobia and deportation, exacerbated health risks and contributes to disease resistance (Arnold et al., 2014; Chawhanda et al., 2024; Chirau et al., 2024).

3.3.3. Mental health impact

Twelve studies indicated that mental health issues were associated with medical xenophobia and healthcare exclusion (Chekero and Ross, 2018; Chirau et al., 2024; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). Feelings of anxiety, depression and alienation were common, driven by verbal abuse, denial of care and fear of deportation or arrest (Labys et al., 2017; Msabah, 2022; Vanyoro, 2022). Refugees often reported feelings of helplessness and worthlessness due to poor treatment in healthcare settings, which exacerbated their emotional pain and contributed to chronic psychological stress (Labys et al., 2017; Munyaneza and Mhlongo, 2019; Zihindula et al., 2017).

The fear of discrimination and xenophobic attitudes deterred many from seeking care, leading to untreated mental health conditions and a loss of trust in healthcare systems (Chekero and Ross, 2018; Chirau et al., 2024; Vanyoro, 2019; White and Rispel, 2021). Psychological distress was further heightened by the isolation and insecurity associated with systemic exclusion, as refugees and migrants often struggled with juggling multiple socioeconomic challenges while simultaneously facing hostility in healthcare settings (Akokuwebe et al., 2023; Msabah, 2022; Munyaneza and Mhlongo, 2019). Victims of medical xenophobia often experience passive suicidal ideation or a strong desire to return to their homeland due to feelings of rejection and a lack of integration in the host community (David et al., 2024; Labys et al., 2017; Msabah, 2022). Women and children were particularly vulnerable, suffering from psychological trauma caused by healthcare exclusion, discrimination and mistreatment (Chekero and Ross, 2018; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019).

3.3.4. Maternal health unpleasant outcomes

Eleven studies highlighted adverse maternal and child health outcomes due to medical xenophobia and healthcare exclusion (Chekero

and Ross, 2018; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). Pregnant migrant women often encounter care denial due to documentation requirements or discriminatory practices, resulting in heightened risks of complications, maternal mortality and adverse neonatal outcomes (Chekero and Ross, 2018; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). The lack of antenatal care (ANC) attendance was particularly alarming, as it correlated strongly with stillbirths, low birth weights and preventable maternal and infant deaths (Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022).

Migrant women frequently experience psychological distress during pregnancy due to discrimination, mistreatment and substandard care from healthcare providers, exacerbating their health challenges and increasing vulnerability (Chawhanda et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022). Inadequate treatment and deteriorating maternal and child health outcomes were reported to be the results of language barriers and a lack of culturally sensitive healthcare services (Chekero and Ross, 2018; Jaiswal et al., 2024; Zihindula et al., 2017). The inaccessibility of public healthcare lead migrant women to resort to informal or privatised healthcare services, which were often delayed, substandard and financially burdensome, thus exacerbating health risks for both mothers and children (Chekero and Ross, 2018; Vanyoro, 2022; White and Rispel, 2021). The fear of deportation or further discrimination deterred many women from seeking essential reproductive and maternal health services, leaving critical health issues untreated (David et al., 2024; Labys et al., 2017; Msabah, 2022; Vanyoro, 2019).

3.3.5. Public health risks

Thirteen studies discussed public health risks associated with medical exclusion (Chawhanda et al., 2024; Chekero and Ross, 2018; Chirau et al., 2024; David et al., 2024; Jaiswal et al., 2024; Labys et al., 2017; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). The deficiency in access to both preventive and curative healthcare has significantly contributed to the proliferation of communicable diseases, including HIV, tuberculosis and various other infections, thereby posing a substantial threat to migrant and refugee populations and the broader community (Chawhanda et al., 2024; Chirau et al., 2024; White and Rispel, 2021). Untreated health issues within these demographics have undermined public health initiatives, as such conditions can trigger outbreaks that potentially impact entire communities (Alfaro-Velcamp, 2017; David et al., 2024; Msabah, 2022).

Prolonged delays in seeking medical attention, frequently driven by apprehensions regarding deportation, discrimination and financial limitations, have exacerbated health conditions and heightened the risk of drug resistance, particularly in the context of diseases such as tuberculosis (Chekero and Ross, 2018; Chirau et al., 2024; Msabah, 2022; Zihindula et al., 2017). The tendency to resort to self-medication and the unregulated consumption of antibiotics among migrants has intensified the threat of disease resistance, posing considerable challenges to public health infrastructures (Chirau et al., 2024; Vanyoro, 2022). Moreover, the fear associated with utilising healthcare services has obstructed timely interventions, culminating in untreated conditions that escalate into health emergencies affecting entire communities (Chawhanda et al., 2024; Labys et al., 2017; Vanyoro, 2019; White and Rispel, 2021).

Obstacles to healthcare access have also impeded the capacity to manage pandemics effectively, as illustrated during the COVID-19 pandemic, when the exclusion of migrants from public health strategies exacerbated their vulnerability and weakened containment efforts (David et al., 2024; Msabah, 2022). The precarious living situations of refugees and migrants, further aggravated by systemic discrimination, have heightened their susceptibility to infectious diseases, thereby increasing the overall public health burden (Chawhanda et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019).

3.4. Interventions to mitigate medical xenophobia and healthcare exclusion

Several studies in this scoping review indicated the need to have adequate interventions to respond effectively to medical xenophobia and healthcare exclusion against refugees and migrants, such as policy and legislative reforms, cultural sensitivity and xenophobic mitigator, community and stakeholder engagement, facilitating accessibility to healthcare services by migrants and ensuring ongoing monitoring and accountability of healthcare systems for their inclusivity (Table 4).

3.4.1. Policy and legislative reforms

Eight studies highlighted the importance of policy and legislative reforms—emphasising the critical need for inclusive frameworks that address healthcare access for refugees and migrants, regardless of their legal or immigration status (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019). Revising national laws to align with constitutional rights and international human rights standards was recommended (Akokuwebe et al., 2023; Alfaro-Velcamp, 2017; Arnold et al., 2014). In South Africa, it was recommended to revise healthcare, immigration and constitutional laws to ensure inclusivity and equitable treatment for all populations, including refugees and migrants (Akokuwebe et al., 2023; David et al., 2024). Policies must also address the unique needs of mobile and undocumented populations through migration-aware frameworks that extend healthcare access to undocumented migrants and asylum seekers (David et al., 2024; Msabah, 2022). Furthermore, local and municipal healthcare policies should align with constitutional rights to ensure that healthcare systems are non-discriminatory and accessible to vulnerable groups (Alfaro-Velcamp, 2017; Crush and Tawodzera, 2014). Other recommendations emphasised the need for standardised policies to address language barriers, service discrepancies and systemic xenophobia in healthcare settings (Arnold et al., 2014; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). Collectively, these reforms advocate for eliminating legal and systemic barriers to healthcare, promoting equity and human dignity for all populations (David et al., 2024; Msabah, 2022).

3.4.2. Cultural sensitivity and xenophobic mitigator

Twelve studies discussed cultural sensitivity and xenophobia mitigation—essential for addressing healthcare disparities among refugees and migrants (Alfaro-Velcamp, 2017; Arnold et al., 2014; Chekero and Ross, 2018; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Vanyoro, 2019; White and Rispel, 2021; Zihindula et al., 2017). Training healthcare providers in cultural competence was recommended to reduce discriminatory practices and ensure equitable treatment (Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). This training should include education on the rights of refugees and migrants and the legal obligations to provide care without discrimination (Alfaro-Velcamp, 2017; Vanyoro, 2019; Zihindula et al., 2017). Additionally, raising awareness of personal biases among healthcare professionals and promoting compassionate, patient-centred care can mitigate medical xenophobia (David et al., 2024; Mvundura, 2024; White and Rispel, 2021).

Public awareness campaigns were vital for reducing xenophobic attitudes in communities and healthcare systems. These campaigns can highlight the contributions of refugees and migrants, reshaping perceptions and diminishing stigma (Crush and Tawodzera, 2014; Mvundura, 2024; Vanyoro, 2019). Media engagement and advocacy efforts can further amplify these messages, fostering understanding and inclusivity (Msabah, 2022; White and Rispel, 2021). Furthermore, integrating cultural competence into healthcare practices requires addressing

language barriers and providing interpreters or bilingual staff to ensure effective communication (Chekero and Ross, 2018; Jaiswal et al., 2024; Zihindula et al., 2017). Offering cultural competence training and developing guidelines for culturally sensitive care can enhance provider-patient interactions and reduce discriminatory practices (Arnold et al., 2014; Munyaneza and Mhlongo, 2019).

3.4.3. Community and stakeholder engagement

Twelve studies explored the importance of community and stakeholder engagement for building trust and enhancing healthcare access for refugees and migrants (Afari-Asiedu et al., 2024; Alfaro-Velcamp, 2017; Arnold et al., 2014; Chekero and Ross, 2018; Chirau et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Msabah, 2022; Munyaneza and Mhlongo, 2019; Vanyoro, 2019; White and Rispel, 2021). Involving community leaders and trusted figures has proven effective in disseminating health information and fostering relationships within marginalised groups (Afari-Asiedu et al., 2024; Chirau et al., 2024; Munyaneza and Mhlongo, 2019). This strategy addresses cultural differences and mitigates medical xenophobia, promoting trust in healthcare systems (Afari-Asiedu et al., 2024; Chekero and Ross, 2018).

Partnerships between healthcare providers and local organisations, including NGOs and advocacy groups, are vital for overcoming structural barriers and supporting migrant populations (Arnold et al., 2014; Crush and Tawodzera, 2014; Vanyoro, 2019). Furthermore, the support networks, including NGOs and advocacy groups, are crucial in empowering refugees and migrants by providing legal, psychosocial and logistical assistance to overcome healthcare challenges (Alfaro-Velcamp, 2017; White and Rispel, 2021). Civil society organisations are critical in assisting healthcare providers, refugees and migrants by offering legal and logistical support to ensure equitable treatment and uphold patient rights (Alfaro-Velcamp, 2017; Msabah, 2022; White and Rispel, 2021). Building alliances with migrant-led organisations and community networks also empowers refugees and migrants to navigate healthcare systems effectively and advocate for their rights (David et al., 2024; Vanyoro, 2019).

Community-based educational campaigns, peer education and outreach programs have been identified as effective methods for enhancing migrants' understanding of their entitlements and available services (Afari-Asiedu et al., 2024; David et al., 2024; Jaiswal et al., 2024). Outreach efforts that use familiar and accessible venues, such as markets, places of worship, or community centres, have been particularly successful in increasing participation in health programs and reducing feelings of alienation (Afari-Asiedu et al., 2024; Chekero and Ross, 2018). Broad stakeholder engagement, which includes local governments, international organisations and community groups, is essential for creating coordinated responses to healthcare challenges faced by refugees and migrants (Arnold et al., 2014; White and Rispel, 2021). These collaborations ensure that health interventions are culturally sensitive, contextually relevant and tailored to address the unique needs of migrant populations (Afari-Asiedu et al., 2024; David et al., 2024).

3.4.4. Accessibility enhancements

Nine studies highlighted the need for enhancing accessibility to healthcare services (Afari-Asiedu et al., 2024; Arnold et al., 2014; Chekero and Ross, 2018; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019; Oginni et al., 2022; White and Rispel, 2021; Zihindula et al., 2017). Conducting healthcare outreach in familiar and accessible locations, such as markets, places of worship and community centres, has been shown to increase participation and alleviate feelings of exclusion among migrants (Afari-Asiedu et al., 2024; Chekero and Ross, 2018). Achieving equity in healthcare access also requires addressing socioeconomic barriers, such as cost and disparities in service availability. Studies pointed out the need to offer free or low-cost healthcare services and standardise service charges to enhance accessibility for vulnerable populations (Arnold et al., 2014; David et al., 2024; Oginni et al., 2022). Furthermore, engaging local health workers and community members as mediators can help build trust and improve the dissemination of health information (Afari-Asiedu et al., 2024; Chekero and Ross, 2018).

Developing migrants/ refugees-sensitive healthcare systems, enhancing cultural competence among healthcare providers and creating policies prioritising equitable treatment to facilitate access to healthcare (Arnold et al., 2014; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). Furthermore, access to healthcare services for refugees and migrants requires employing interpreters, bilingual staff, or local health workers who understand these populations' cultural and linguistic needs (Chekero and Ross, 2018; Jaiswal et al., 2024; Zihindula et al., 2017). Additionally, providing culturally relevant materials and translation services in healthcare settings can improve communication and reduce misunderstandings (Arnold et al., 2014; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019). These combined efforts aim to create a healthcare environment where all individuals, regardless of language, culture, or socioeconomic status, can access necessary services without discrimination or fear of exclusion (David et al., 2024; White and Rispel, 2021; Zihindula et al., 2017).

3.4.5. Monitoring and accountability

Ten studies discussed the monitoring and accountability—critical components in addressing healthcare disparities and ensuring equitable access for refugees and migrants (Chawhanda et al., 2024; Crush and Tawodzera, 2014; David et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019; Mvundura, 2024; Vanyoro, 2022, 2019; White and Rispel, 2021; Zihindula et al., 2017). Regular assessments of healthcare facilities are essential to identify and address discrimination and neglect, ensuring that healthcare workers adhere to inclusive policies and ethical standards (Jaiswal et al., 2024; White and Rispel, 2021; Zihindula et al., 2017). Monitoring national healthcare systems, including incorporating migrant health experiences in official statistics, provides valuable insights to guide policy adjustments and interventions (Chawhanda et al., 2024; Crush and Tawodzera, 2014; Vanyoro, 2022). Establishing clear guidelines and protocols for treating migrants helps ensure accountability and consistency in healthcare delivery (Crush and Tawodzera, 2014; Munyaneza and Mhlongo, 2019; Mvundura, 2024). Promoting accountability within healthcare systems involves training providers to recognise and challenge biases and to ensure adherence to policies prioritising patient rights and dignity (Crush and Tawodzera, 2014; Mvundura, 2024; Zihindula et al., 2017). Collaborative efforts between governments, civil society and healthcare institutions are necessary to foster transparency and implement sustainable strategies for migrant inclusion (David et al., 2024; Vanyoro, 2019; White and Rispel, 2021).

4. Discussion

This scoping review aimed to map evidence of what was known about medical xenophobia and healthcare exclusion of refugees and migrants in Africa. This study indicated that medical xenophobia, medical exclusions and discriminatory practices within healthcare systems pose significant challenges, as numerous studies demonstrate their prevalence and detrimental effects among refugees and migrants. In Africa, healthcare discrimination against refugees and migrants has been observed, with implications for trust and access to care, necessitating comprehensive interventions to enhance equity and cultural competence among healthcare providers (Arnold et al., 2014; Crush and Tawodzera, 2014; Vanyoro, 2019; Zihindula et al., 2017). Similarly, in France, 3.9 % of the population reported discrimination, particularly affecting women, first-generation immigrants and specific ethnic and religious groups, resulting in decreased healthcare utilisation (Rivenbark and Ichou, 2020). The results of this study uncovered significant bias in the behaviours of healthcare providers towards refugees and migrants, obstacles to medical access related to immigration status, economic and systemic disenfranchisement and prejudice stemming

from language disparities. Similarly, a study in Malaysia by Loganathan et al. (2019) revealed that migrant workers experience xenophobia and discrimination, exacerbated by language barriers and financial constraints, resulting in delayed or avoided healthcare, which compromises patient outcomes and burdens healthcare systems.

Formal policies, their interpretation, application and informal practices intensify the exclusion of migrants from healthcare services (White and Rispel, 2021). Although the South African Constitution and the National Health Act advocate for universal healthcare access in South Africa, the Immigration Act and the 2019 NHI Bill impose legal barriers that position migrants' legal status as a crucial determinant of healthcare access. This legislative disjunction is further complicated by uneven policy implementation at the provincial level, leading to exclusionary practices (White and Rispel, 2021). Moreover, the unequal application of policies extends beyond healthcare to employment practices, as observed in Botswana, where foreign nationals encounter inconsistent contract renewals and demotions based on nationality despite operating under the same government policies as locals (Thupayagale-Tshweneagae et al., 2020). In Spain, Peralta-Gallego et al. (2018) reported that the amendment in policy has excluded approximately 870,000 undocumented immigrants from public healthcare, resulting in marginal escalations in infectious diseases and mortality rates. The economic implications of migration and the accessibility of public healthcare services are pivotal areas of discussion in Europe, with numerous countries permitting only limited or no access to such services for undocumented migrants (Mipatrini et al., 2017).

This study revealed that discriminatory practices have increased during COVID-19 towards refugees, asylum seekers and migrants. Huang and Liu (2020) argued that the COVID-19 pandemic has profoundly impacted society, revealing vulnerabilities and worsening existing inequalities. Furthermore, COVID-19 has highlighted the differing vulnerabilities among sub-populations, prompting a re-evaluation of the relationship between humans and microbes and challenging traditional views on immunity and belonging (Mattes and Lang, 2021). In Europe, the pandemic exacerbated racial and ethnic inequalities, particularly affecting immigrants, asylum seekers and refugees, who encountered increased barriers to integration in employment, healthcare and education (Fouskas et al., 2022). During this time, anti-immigrant rhetoric and right-wing populism surged, further marginalising these groups and perpetuating social exclusion (Fouskas et al., 2022). A study conducted by Huang and Liu (2020) revealed that the pandemic has further exacerbated existing biases, as evidenced by an increase in reported hate crimes against Asian Americans and incidents of harassment within the healthcare sector. Patients have preferred non-Asian medical practitioners, highlighting the persistent prejudices prevailing in contemporary society (Huang and Liu, 2020). Furthermore, the proliferation of social media and the spread of misinformation have intensified racial stereotypes, thereby further marginalising Chinese and Asian communities during this global health crisis (Huang and Liu, 2020).

This research emphasised the necessity for public health organisations to develop policies that guarantee fair access to healthcare for everyone, irrespective of their nationality or legal standing, which includes compliance with constitutional and international human rights commitments (Arnold et al., 2014; Crush and Tawodzera, 2014). Stakeholders and policymakers should comprehensively review provincial and local healthcare access policies to ensure alignment with constitutional rights, facilitating healthcare accessibility for all individuals, including refugees and migrants (Alfaro-Velcamp, 2017). Training healthcare providers on cultural sensitivity and educating refugees and migrants regarding their rights can serve as tools to facilitate equitable treatment within healthcare settings (Chawhanda et al., 2024; Jaiswal et al., 2024; Munyaneza and Mhlongo, 2019).

Overall, this scoping review reveals that medical xenophobia and healthcare exclusion of refugees and migrants in Africa have been documented, particularly regarding discriminatory practices, denial of care based on legal status, financial barriers, and language challenges faced by refugees and migrants. These manifestations contribute to profound consequences, including avoidance of healthcare services, physical health deterioration, mental health distress, and adverse maternal and neonatal outcomes, alongside broader public health risks. While several interventions have been proposed—such as policy reforms, cultural competency training, community engagement, and improved service accessibility—there remains a need for further research to evaluate their effectiveness and to address existing knowledge gaps across diverse African contexts. The findings of this scoping review have crucial implications for refugees and migrants, healthcare providers, and policymakers. Refugees and migrants urgently need safe, equitable, and non-discriminatory healthcare environments to access essential services promptly and protect their physical and mental health. Healthcare providers must prioritise cultural competence, unbiased care, and effective communication to reduce discriminatory practices and offer respectful, patient-centred services, regardless of a patient's legal status. Public health systems should adopt inclusive, refugee and migrant-sensitive strategies to enhance health equity and improve population health outcomes. NGOs and civil society organisations must continue advocating for the rights of refugees and migrants while collaborating with governments to implement community-based interventions that address service gaps and build trust in healthcare systems. For policymakers, this scoping review highlights the importance of developing and enforcing inclusive health policies, investing in comprehensive training for healthcare workers, and establishing robust monitoring systems to tackle and prevent medical xenophobia and healthcare exclusion of refugees and migrants across diverse African contexts.

5. Limitations and recommendations

Despite valuable insights, this scoping review highlights significant gaps in the current evidence base on medical xenophobia and healthcare exclusion of refugees and migrants in Africa. A significant majority of the studies (85 %) utilised qualitative methodologies, focusing on in-depth experiential insights rather than quantifying prevalence or statistically analysing associations related to medical xenophobia and healthcare exclusion. This reliance on qualitative data limits the generalisability of the findings to broader populations. Additionally, many studies relied on self-reported data, introducing potential risks of recall and response bias, and often involved small sample sizes that may not adequately represent the diverse experiences of various migrant and refugee groups.

Geographically, 75 % of the studies were conducted in South Africa, which may restrict the applicability of results to other African nations with differing socioeconomic contexts, migration patterns, and healthcare systems. There was also a notable lack of exploration into the perspectives of healthcare providers, which hinders the understanding of systemic challenges contributing to medical xenophobia and healthcare exclusion. Furthermore, few studies examined how intersecting factors such as gender, age, or disability influence migrants' healthcare experiences, leaving significant nuances unaddressed. Lastly, 60 % of the studies were conducted during or after the COVID-19 pandemic, which may bias findings towards crisis-related issues and limit the understanding of how medical xenophobia and healthcare exclusion manifest under typical conditions.

Future research should incorporate more quantitative and mixed-methods studies to measure the prevalence and statistical associations related to medical xenophobia and healthcare exclusion, thereby improving generalisability across diverse refugee and migrant populations. Future research should broaden its geographical scope to encompass various African countries and regions, thereby facilitating a comprehensive understanding of the healthcare challenges faced by refugees and migrants in these regions. Furthermore, larger sample sizes and diverse participant groups are needed to enhance

representativeness. Future research should prioritise longitudinal studies to examine the long-term health impacts of medical xenophobia and healthcare exclusion on refugees and migrants and guiding sustainable policy and intervention strategies. There is a need for rigorous research to assess the effectiveness of interventions aimed at reducing medical xenophobia and enhancing healthcare access. Studies examining non-crisis contexts are essential to distinguish routine patterns of medical xenophobia and healthcare exclusion from those intensified during emergencies like the COVID-19 pandemic. Including healthcare providers' perspectives would offer valuable insights into systemic factors influencing xenophobia and healthcare exclusion. Research should also explore the intersectionality of gender, age, disability, and other social factors to deepen understanding of refugees' and migrants' experiences.

6. Conclusion

This research highlights significant and widespread obstacles associated with medical xenophobia and healthcare exclusion that refugees and migrants encounter in accessing fair healthcare. Discriminatory practices have led to biased actions and attitudes among healthcare professionals. These issues are compounded by language barriers, systemic exclusions related to documentation and financial constraints and a pervasive climate of fear and vulnerability within migrant communities. The lack of preparedness and cultural competence among healthcare providers further intensifies these challenges, resulting in neglect, stigmatisation and denial of services. These systemic and personal obstacles are deeply rooted in xenophobic sentiments, reflecting broader societal biases against refugees and migrants.

In countries like South Africa and Kenya, despite constitutional guarantees for universal healthcare access, the implementation of these policies often falls short, leading to marginalisation and inadequate service provision for migrants. Structural reforms are essential to address these disparities, including enhanced training for healthcare professionals, adopting culturally and linguistically inclusive practices and eliminating discrimination based on documentation. Additionally, fostering trust through inclusive policies and advocacy initiatives is crucial for enabling migrants to access healthcare services securely and confidently. These findings emphasise the urgent need for systemic transformation to uphold all individuals' fundamental right to health, regardless of their migration status.

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CRediT authorship contribution statement

Alexis Harerimana: Writing – review & editing, Writing – original draft, Software, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Julian David Pillay:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Gugu Mchunu:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jmh.2025.100343.

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