SSM - Qualitative Research in Health 9 (2026) 100672

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Migrants' and refugees' experiences of healthcare access in Egypt: An exploratory qualitative study

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A B S T R A C T

Background: In Egypt, migrants and refugees are formally entitled to access public healthcare services under the same conditions as Egyptian citizens. However, they continue to face barriers. This qualitative study explores migrants' perceptions of healthcare access and service provision in Egypt.
Method: We conducted six focus group discussions with 23 migrant men and 25 women in vulnerable situations, grouped by sex and language, and 15 individual semi-structured interviews with ten migrant community leaders and six non-governmental organisation staff. Participants were recruited using purposive and snowball sampling at the International Organisation for Migration- Migration Health Assessment Centre. Data were analysed using a hybrid thematic approach, combining deductive coding from Levesque's framework with inductive emergent themes.
Result: Participants identified several social determinants that negatively affect their health, including insecurity, social isolation, limited employment opportunities, and poor working conditions. The participants reported complex health needs, including infectious diseases and non-communicable conditions. Key barriers to accessing healthcare included low health literacy, cultural and religious beliefs, limited awareness of the healthcare system, inadequate documentation, language barriers, health misconceptions and mistrust of public healthcare facilities. They encountered perceived poor service quality, financial limitations, and insufficient coordination among service providers. Additional obstacles included high transportation costs, geographic isolation, limited availability of medical services, and prolonged waiting times.
Conclusion: In Cairo's urban context, migrants and refugees in vulnerable situations often face barriers to accessing healthcare. Achieving health for all requires targeted policies that expand access to culturally competent healthcare services, empower migrant communities, and regularise migrants' legal status.

1. Introduction

Refugees and migrants often come from communities affected by war, conflict, natural disasters, environmental degradation, or economic crises (World Health Organisation, 2022a). Their health profiles typically differ from those of the host population (Norredam, 2010). Migrants also face barriers, including language, legal status, and unfamiliarity with the healthcare system, which can limit their access to care (Norredam, 2010). From a public health perspective, integrating migrants and refugees into national healthcare systems is essential for

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https://doi.org/10.1016/j.ssmqr.2025.100672
Received 8 July 2025; Received in revised form 1 October 2025; Accepted 20 November 2025
Available online 21 November 2025

improving population health and reducing socioeconomic disparities (Nandi et al., 2009; Onarheim et al., 2018).

Egypt is a key destination for migrants, refugees, and asylum seekers from the Middle East and North Africa (MENA) region, as well as sub-Saharan Africa (Andrade, 2021). As of August 2022, the International Organisation for Migration reported that Egypt hosted approximately nine million international migrants from 133 countries (IOM Egypt, 2022). This number has continued to rise amid escalating regional crises, most notably the ongoing conflict in Sudan, which has triggered a severe humanitarian emergency with more than 1.2 million Sudanese arriving in Egypt since the outbreak of the conflict (UNICEF, 2025).

Migrants and refugees in Cairo, especially Sudanese refugees, face numerous challenges, such as harsh economic conditions and inadequate financial assistance, making life in Egypt extremely difficult and uncertain (CONE & SULLIVAN, 2025). The almost impossible task of securing work permits forces many to seek employment in informal labour markets, primarily in fields that do not require official documentation, like construction, domestic services (for instance, house cleaning), or small-scale trading. This situation makes them vulnerable to discriminatory and exploitative working conditions. Migrants and Refugees employed in these fields without official documentation face several risks, including unstable employment, lack of social security and health coverage, exposure to occupational safety hazards, and unreasonably low wages (Thomas, 2010; Wafaa Morsi, 2024).

In Egypt, migrants and refugees in vulnerable situations—mainly from Sudan, Eritrea, and Syria—are legally entitled to access public healthcare services on the same basis as Egyptian citizens, particularly at secondary and tertiary levels. Yet, in practice, many continue to rely on NGOs and UN-supported programs for guidance in navigating the health system. Barriers such as the high cost of medical services relative to migrants' limited financial capacity, overcrowded facilities, discrimination, and challenges with documentation continue to restrict access (United Nations Egypt, 2022).

These difficulties are further compounded by constraints in Egypt's current health resources, including funding, infrastructure, and healthcare personnel, as well as limited awareness and training among providers regarding the rights and specific needs of displaced populations (United Nations Egypt, 2022). Evidence from the United Nations High Commissioner for Refugees (UNHCR) survey highlights these challenges: although most refugees who sought care in the preceding three months were able to access it, a considerable proportion could not, mainly due to financial barriers, limited service availability, poor quality of care, or lack of legal authorisation (UNHCR, 2023).

To better understand such multifaceted barriers to care, a patient-centred theoretical model developed by Levesque et al. (2013) conceptualises healthcare access as the opportunity to identify healthcare needs and, further, seek, reach, receive, or use healthcare services (Levesque et al., 2013). It suggests five dimensions of accessibility (Approachability, Acceptability, Availability, Accommodation, Affordability, and Appropriateness) and five corresponding abilities of populations (the Ability to perceive, to seek, to reach, to pay, and to engage). Since its introduction, it has been used in qualitative research and applied to the global study of refugees' access to healthcare (Cu et al., 2021; Sundareswaran et al., 2024).

On the other hand, addressing barriers to healthcare access requires engaging with the lived experiences of migrants and refugees. While epidemiological statistics may reveal disparities, there is limited insight into how migrants and refugees perceive and navigate these challenges, especially in Cairo, Egypt. To date, no study has specifically explored the perspectives of migrants and community organisations on healthcare access in Egypt. This study addresses that gap by examining the perceptions and views of migrant and refugee populations, civil society organisations, and other key stakeholders on barriers to care and suggestions for improving access.

2. Materials and methods

2.1. Study design and setting

We conducted a qualitative study from April 2024 to June 2024, utilising focus group discussions (FGDs) with migrants and individual semi-structured interviews (ISIs) with migrant community leaders (MCLs) and non-governmental organisation (NGO) staff, guided by an exploratory research paradigm (Chafe, 2024). Our qualitative study was conducted and reported in accordance with the Standards for Reporting Qualitative Research (SRQR) [see Appendix A] (O'Brien et al., 2014).

Due to the demanding schedules of NGO professionals, several interviews were conducted remotely via video conferencing using the institutional Microsoft Teams platform. All activities were conducted at the International Organisation for Migration- Migration Health Assessment Centre in Cairo, Egypt. The activities concentrated in Cairo, an urban environment, which is a significant destination for migrants from neighbouring Middle Eastern, North African, and Sub-Saharan regions. The city's relatively advanced infrastructure and availability of essential services, such as education, healthcare, and social welfare, make it a strategic focal point for studying urban integration and service accessibility for migrant populations (Real Estate Cairo, 2022).

2.2. Participant recruitment

Our study targeted migrants and refugees in Egypt in vulnerable situations. A migrant is defined as" a *person who moves away from his usual residence, whether within a country or across an international border, temporarily or permanently, and for various reasons. This included refugees, asylum seekers, undocumented migrants, labour migrants, and internally displaced persons (IDPs)*"(International Organisation for International Organization for Migration, 2019). For simplicity and consistency, the term **"migrant"** is used throughout the methods, results, and discussion to represent both migrants and refugees in vulnerable situation, while the introduction occasionally specifies **"migrants and refugees"** to highlight these particular groups.

International Organisation for Migration staff recruited the participants using purposive and snowball sampling techniques, with invitations sent via phone or email. The inclusion criteria for migrants and community leaders included being over 18 years of age, residing in Cairo, and being fluent in Arabic or English. Non-governmental organisation staff (NGO) were recruited based on their professional experience working with migrant communities. There were no exclusions based on race or gender.

2.3. Researcher characteristics and reflexivity

After formal training, two Sudanese researchers (EE, HE) facilitated the focus group discussions and interviews. Both field researchers shared similar migration stories with many of the study participants. Regular discussions with senior authors ensured that the researchers' backgrounds were acknowledged and reflexivity was maintained throughout the analytical process, thereby mitigating potential bias. These steps ensured that theme development remained faithful to the data, maintaining the integrity of the analysis.

2.4. Data collection

The composition of the FGDs was based on sex and the language spoken. Sociodemographic data were collected using a standardised form for each participant's profile. For migrants and migrant community leaders, the form included age, sex, country of origin, current employment, legal or administrative status, and duration of stay in Egypt. For NGO staff, the form captured age, sex, position, name, and type of organisation, as well as years of experience within the organisation and years of experience working with migrants.

Individual semi-structured interviews lasted 30–45 min, while FGD lasted approximately 90 min. Two separate topic guides were used, one for migrants and another for migrant community leaders and NGO staff. The guides were developed iteratively by the research team and piloted during the initial sessions. The topic guides explored perceptions of health needs, health-seeking behaviours, and the challenges migrants face in accessing healthcare services [see Appendix B].

The sessions were conducted in Arabic or English. They were audio-recorded, transcribed verbatim, and checked for accuracy and anonymity. During each session, one field researcher acted as the facilitator, while the other assumed the role of observer. The female researcher facilitated the sessions with migrant women, while the male researcher facilitated the sessions with migrant men. Sessions with migrant community leaders and NGOs were split between the two researchers based on their availability. Field notes were taken on a predetermined observation grid to capture nonverbal behaviours and contextual information.

Data collection was guided by the concept of information power (Malterud et al., 2016), which posits that fewer participants are required when their contributions are highly relevant, rather than adopting the notion of data saturation, which is criticised for its conceptual ambiguity (Virginia Braun et al., 2019). We concluded data collection once the data were sufficiently rich and relevant to address the study aims, while also accounting for practical constraints related to time and access.

2.5. Data analysis

Arabic transcripts were translated into English using DeepL Pro ("DeepL Pro," n.d.). Cultural adaptation of the Arabic language was applied when appropriate. Thematic analysis was carried out using a hybrid approach combining Fereday and Muir-Cochrane's framework (Fereday & Muir-Cochrane, 2006), integrating Boyatzis' inductive technique (Boyatzis, 1998) and Crabtree and Miller's deductive a priori template of codes (Crabtree, Miller, & William, 1992)

The dimensions of healthcare access, as defined by Levesque et al., were employed as overarching deductive thematic categories to analyse barriers to accessing healthcare. Concurrently, inductive coding facilitated the emergence of additional themes from the data, including "Health Needs and Vulnerabilities," "Health Care Consequences," and "Calls for Future Action." QSR NVIVO 14 ("NVivo," n.d.) was used to manage the data analysis. Each researcher (EE, HE) independently developed a codebook for the sessions they had facilitated. These were subsequently triangulated to ensure conceptual congruence and then merged into a single, unified codebook. Multiple rounds of discussion were held among EE, HE, and SE to ensure the accuracy of the codes, with consensus reached through collaborative refinement of the thematic framework.

3. Results

3.1. Sociodemographic characteristics of participants

We carried out six FGDs with migrants (three FGDs with 25 women, three FGDs with 23 men), 15 ISIs with migrant community leaders (n = 10) and NGO staff (n = 6). On one occasion, two NGO staff members joined the online session in a group interview (GI).

The reported countries of origin among migrants were Sudan (n = 29), Yemen (n = 10), Syria (n = 8), and Ethiopia (n = 1). The mean age among migrants was 30 years (SD, 9 years), and half of them (n = 25, 52 %) were female. The mean duration of stay in Egypt was 10 months (SD: 5 months). Twenty-nine (60 %) migrants had been in Egypt for less than 18 months, most of them graduated from university (n = 30, 62 %), and 36 (75 %) were unemployed, five (10 %) volunteered with NGOs, while seven (15 %) participants were employed in in jobs such as cooking, teaching, or manual labour -without specifying whether this employment was regular or otherwise.

The migrant community leaders were from Sudan (n = 4), Yemen (n = 5), and Syria (n = 1). The mean age across migrant community leaders was 45 years (SD: 7 years), and six out of ten (60 %) were female. Their mean duration of stay in Egypt was 64 months (SD: 60 months), with four participants (40 %) having been in Egypt for less than 18 months. Six participants (60 %) graduated from university, while four (40 %) had higher education degrees.

Furthermore, we interviewed six NGO staff, five from Egypt and one from Sudan. The mean age of the NGO staff was 31 years (SD: 3 years), and three (50 %) were female. The mean duration of working with migrants was six years (SD: 2.5 years), while the mean duration of working in the organisation was four years (SD: 2 years) (see Table 1)

The findings were organised into four major themes. First, "Health Needs and Vulnerabilities" encompassed the social determinants of health, the perceived health needs of migrants and women-specific vulnerabilities. Second, "Barriers to Accessing Healthcare" comprised four categories: perceptions of health needs and desire for care, healthcare-seeking, healthcare reaching, and healthcare utilisation. Third, "consequences of healthcare," and fourth, "calls for future actions." See Fig. 1 for a visual representation of the themes. The code book is summarised in Appendix C.

3.2. Theme 1: Health Needs and Vulnerabilities

3.2.1. Social determinants of migrant health

Social needs are foundational to healthcare access. For migrants, they can act as both barriers and facilitators, shaping when, where, and

Table 1
Sociodemographic characteristics of the participants.

Migrant and migrant community leader		
Characteristic	Migrants	Migrant community leader
Average age in years ±SD	30 ± 9	45 ± 7
Duration of stay in months ±SD	10 ± 5	64 ± 60
Sex		
Male	23 (48 %)	4(40 %)
Female	25(52 %)	6(60 %)
Age category		
<30 years	10(21 %)	0
30–50 years	22(46 %)	9(90 %)
>50 years	15(31 %)	1(10 %)
Missed	1(2 %)	0
Country of birth		
Sudan	29(60 %)	4(40 %)
Ethiopia	1(2 %)	0
Syria	8(17 %)	1(10 %)
Yemen	10(12 %)	5(50 %)
Duration of stay category		
<18 months	29(60 %)	4(40 %)
>18 months	18(38 %)	6(60 %)
Missed	1(2 %)	0
Education		
Primary school	6(13 %)	0
Secondary school	10(21 %)	1(10 %)
University	1(2 %)	0
Graduated	30(62 %)	6(60 %)
Higher education	1(2 %)	3(30 %)
Employment status		
Unemployment	36(75 %)	0
Employment	7(15 %)	7(70 %)
Voulenter	5(10 %)	3)30 %)
NGO professional		
Age in years, mean (SD)	31 ± 3	
Years of work in the org/institution mean (SD)	4 ± 2	
Years of work with migrants mean (SD)	6 ± 2.5	
Sex		
Male	3(50 %)	
Female	3(50 %)	
Country of origin		
Egypt	5(83.3)	
Sudan	1(16.7)	

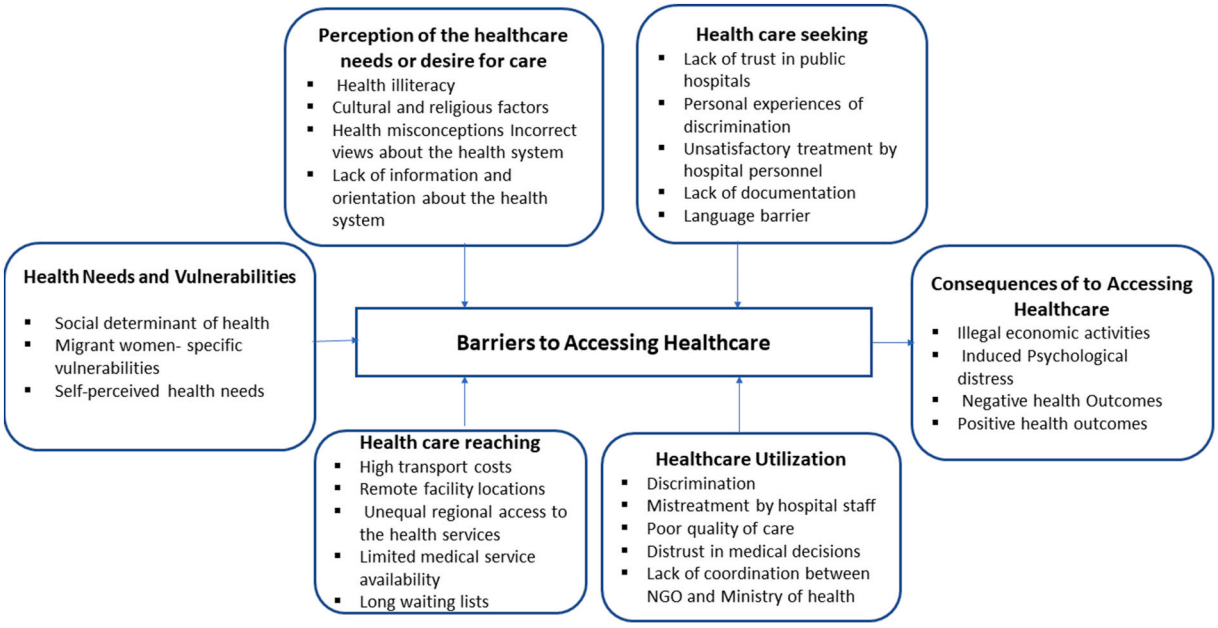

Fig. 1. Thematic analysis results.

how services are sought and received. Housing, food security, employment, and social integration are active determinants that influence health outcomes and the ability to navigate healthcare systems.

Economic hardship emerged as a central barrier to healthcare access. Limited employment opportunities left many migrants unable to afford necessities, including medical care. Financial instability also made it challenging to cover housing costs, which were often significantly higher for migrants than for Egyptian nationals. As one participant described: "All rents in general for foreigners … have had an abnormal increase and very high prices, and apartments were 4000, now 15000 EGP" (MM, Sudan). These strains forced many migrants to prioritise immediate survival needs over healthcare, resulting in delayed or foregone treatment.

Poor living conditions further compounded health risks. Overcrowding, unsafe drinking water, and exposure to air pollution increased vulnerability to infectious diseases. As one participant noted, "Seven families live together in one apartment, increasing the spread rate of infections such as upper respiratory tract infections. We do not find organisations that help us provide homes" (MCL, female, Sudan). These conditions worsened health outcomes and created barriers to seeking care, especially when illnesses were perceived as normal.

Challenging work environments also impacted health and access to healthcare. Migrants described long hours, low wages, and mistreatment by co-workers, which intensified economic vulnerabilities and limited their ability to afford health services. One participant explained:

> I used to work at a Yemeni restaurant in Egypt from 11 a.m. to 1 a.m., where the extended hours and low pay were challenging. and I also faced mistreatment from Yemeni co-workers … … … Working long hours, especially for those with children, made the job even more challenging. I just wanted to have a peaceful and relaxing work environment. (MW, Yemen)

Social isolation also played a critical role. Many migrants lacked connections to Egyptian communities, which restricted access to reliable health information and resources. One participant explained:

> Secondly, closure and lack of integration are challenges. There are large communities of migrants who have migrated or been displaced to Egypt for 6 or 5 years, but they are closed, moving within a specific range and dealing with certain people. Any issue or challenge they face, they do not know how to behave, and the information they receive is limited to their surrounding community, regardless of whether it is right or wrong. (NGO staff, female, Sudan)

Isolation not only restricted migrants' awareness of available services but also undermined their trust in organisations, reducing their likelihood of seeking help even when services were accessible. Overall, these social determinants interact and compound one another, creating interconnected barriers to healthcare access.

3.2.2. *Migrant women - specific vulnerabilities*

Across themes, migrant women reported distinct vulnerabilities that compounded the general challenges of accessing healthcare. These gender-specific risks were particularly pronounced in relation to violence and reproductive health, with significant effects on psychological well-being.

Migrant women in Egypt experienced multiple forms of violence, including physical violence in public spaces, domestic abuse, and gender-based violence (GBV), with GBV emerging as the most common. One participant described feeling unsafe due to harassment in the street, while another mentioned experiencing sexual harassment by a doctor but felt disbelieved when reporting the incident, highlighting gaps in protection mechanisms. In some extreme situations, participants suggested that sexual violence or underage marriage could be linked to suicidal thoughts or attempts. As one woman explained:

> Other than depression, a large part of the problem is due to insufficient awareness of the services provided by the government, which makes psychiatric conditions such as psychosis worsen with time and may lead to suicide before receiving a diagnosis … For example, Women committed suicide due to the pressures of rape and underage marriage (NGO staff, female, Sudan).

The consequences of GBV extend to children with disabilities. One participant described the impact on her daughters, "My daughters with disabilities were subjected to bullying and sexual harassment in the street. They became afraid to go out on the street, and when we decided to go out, they developed involuntary urination." (MW, Sudan)

Women also encountered significant barriers to reproductive and maternal healthcare. Access to prenatal care was often limited, and the high cost of caesarean deliveries frequently hindered timely medical attention. Abortion and miscarriage also emerged as important concerns. One participant described the experience of a pregnant woman

who miscarried while detained at the Egyptian border, which may have been related to psychological stress and fear associated with arrest and detention:

> I have experience with people detained in prison or at the Egyptian border. They could have been sent back to their country instead of being imprisoned. Some pregnant women miscarried because of being detained for two months at the Arqin crossing. (MW, Sudan)

Gynaecological complications were commonly reported, reflecting both physiological and systemic barriers to care. For example, one community leader highlighted that healthcare providers were often untrained in managing childbirth complications related to female genital mutilation. Which restricted safe delivery options: "Some pregnant women suffer from circumcision, and most Egyptian doctors do not know how to deal with it. Hence, they resort to caesarean delivery when it is possible to give birth naturally" (MCL, Female, Sudan).

Other participants described additional reproductive health challenges, including irregular menstrual bleeding attributed to psychological distress and the inability to undergo needed procedures, such as a hysterectomy, due to a lack of support networks. Overall, migrant women in Egypt faced layered vulnerabilities, including gendered health risks, economic hardship, and housing insecurity, that compromised their physical and mental health.

3.2.3. Self-perceived health needs

Challenging social conditions adversely affected migrants' health, as they often lacked access to nutritious food, adequate housing, and financial resources to afford healthcare services. Participants reported a range of health issues, which were also common among their children, including anaemia, disabilities, respiratory infections, thyroid disorders, neuritis, general body pain, gastrointestinal disorders, nutrition transition-related health issues, and vitamin D deficiency. Migrants highlighted how changes in diet and lifestyle contributed to these outcomes. For example, Sudanese migrants perceived that they might have developed anaemia as a result of dietary changes. They linked vitamin D deficiency to spending most of their time indoors due to fears of deportation, unemployment, or lack of education, particularly for children. One participant explained: "Additionally, most of them have vitamin D deficiency because they do not leave their homes and are not exposed to sunlight, making it difficult for them to adapt." (MCL, Female, Sudan)

In addition to nutritional and lifestyle-related issues, migrants frequently reported non-communicable diseases (NCDs), including hypertension, diabetes, cancer, and kidney failure. Without health insurance, covering the costs of treatment for these conditions posed significant challenges. One participant described, "For hypertensive and diabetic patients, there is no money for treatment; we collect money from charities and ask pharmacies to give us discounts" (MCL, Female, Sudan).

Psychological distress was also widespread among migrants, reflecting the cumulative impact of health, social, and financial challenges. Migrant community leaders and NGO members reported episodes of mood disorder and suicidal thoughts. One participant described the emotional burden experienced by migrants coping with illness and family responsibilities: "We suffer from psychological stress from our husbands because they are unemployed and from our children for not being educated" (MW, Sudan)

Communicable diseases were another concern. NGO members reported tuberculosis (TB) as a public health issue, referring four migrant cases to the national tuberculosis program last year, which provides free treatment to both Egyptians and migrants. Hepatitis C virus (HCV), which is endemic in Egypt, was also frequently reported. Unlike Egyptians, migrants were required to pay for HCV screening, creating barriers to timely diagnosis and increasing the risk of disease transmission. One participant highlighted these challenges:

> They must pay for hepatitis C testing, and there is resistance due to their sense of shame and the high cost of hepatitis C testing. Afterwards, we suffered because they had the disease. We had hoped that testing would be available for migrants at no cost, as it is for Egyptians. If hepatitis C testing is free, it may have been accepted. (MCL, Male, Yemen)

3.3. Theme 2: Barriers to accessing healthcare

3.3.1. Barriers to perception of the healthcare needs or desire for care

Migrants' decisions to seek healthcare were shaped by a complex interplay of factors, including health illiteracy, cultural and religious factors, misconceptions about vaccines and screening tests, misunderstandings of the healthcare system, and reliance on informal networks rather than official sources. These factors delayed access to care and increased health risks.

Misconceptions about malaria and hospital services were common. For example, one participant explained that many community members believed tropical disease hospitals were exclusively for AIDS patients, leading them to avoid these facilities in favour of private hospitals, which often caused treatment delays and, in some cases, death:

> In six months, we dealt with seven malaria cases …. Here, the wrong concept appears among communities towards the tropical medicine hospital units, thinking that it is for AIDS patients, which prevents them from going to it, and they would rather go to a private hospital, which wastes a lot of time until they reach these hospitals. Sometimes, some cases die due to delays in going to the hospital … …. Another destructive misconception is that there is no malaria in Egypt. People think they will be quarantined if they go to the hospital, so they prefer not to go. (NGO staff, Female, Sudan)

Misconceptions also affected COVID-19 vaccination uptake initially, though awareness campaigns improved acceptance. As one participant explained, "Yes, COVID-19 vaccination is free, but migrants do not significantly accept it. Yes, there were misconceptions initially, but after awareness campaigns, they were accepted" (MCL, Male, Yemen)

Cultural norms and religious beliefs further limited timely and appropriate care. One participant explained that Yemeni men often feel embarrassed and reluctant to discuss their wives' pregnancies, as topics related to sex, reproduction, and women's bodies are considered private and often taboo. This fear of social scrutiny can discourage men from addressing their wives' health needs. Religious objections to medical interventions also posed life-threatening barriers. One NGO staff described a fatal case:

> Sometimes, the obstacle to accessing healthcare is the parents' religious beliefs. There was a child who suffered burns from a fire and needed to be hospitalised. Blood transfusion is prohibited in their Christian religion(haram) …. The mother was afraid of blood transfusions and fled with the child from the hospital … … … ….and unfortunately, the child died in the end. (NGO staff, Female, Sudan).

Finally, insufficient information about available services and their locations contributed to delays or missed opportunities for care, including mental health support. This lack of awareness often worsens psychiatric conditions, as one participant noted:

> A large part of the problem is due to insufficient awareness of the services provided by the government, which makes psychiatric conditions such as psychosis worsen with time and may even lead to suicide before receiving a diagnosis. Furthermore, the lack of community awareness about where to seek and receive services also contributes to this issue. (NGO staff, Female, Sudan).

Misperceptions, cultural and religious norms, and limited knowledge of available services were identified as key barriers that delayed or prevented migrants from accessing healthcare, including mental health

support.

3.3.2. Health care seeking

Healthcare-seeking refers to an individual's ability to recognise their health needs and seek care, which is shaped by their knowledge and autonomy in accessing services tailored to their unique cultural and social contexts. Migrants reported several barriers to seeking care, including limited trust in public hospitals, language barriers, and lack of documentation, which delayed access to medical services and compromised health outcomes. These challenges reflect personal and systemic factors that restrict equitable healthcare for migrant populations.

Limited trust in the public healthcare system, often stemming from personal experiences of discrimination, unsatisfactory treatment by hospital personnel, and being charged higher fees than Egyptians in public and private hospitals. One participant explained that some people prefer private hospitals due to concerns about poor treatment in public facilities:

> I have a friend … … … found out he had pelvic cancer …. I don't know because he was diagnosed a week ago and walked into a general hospital …. It's better to go to a private hospital because, in a public hospital, his condition can worsen, and he can be treated poorly. (MM, Sudan)

Language barriers also hindered access to care. According to one NGO staff member, variations in Arabic dialects between Sudanese patients and the Egyptian health administration may impede effective communication:

> The first challenge is the language …. for example, the difference in slang between Arabs, especially for newly arrived migrants and those who do not speak Arabic. Sometimes, the language barrier prevents them from seeking medical assistance; for example, he says If I call the hospital, they will not understand my language. (NGO staff, Female, Sudan)

Lack of documentation further discouraged migrants from seeking care, particularly those fleeing war in Sudan. Fear of arrest or deportation prevented them from attending public hospitals: As one participant explained, "They avoid seeking immunisation for their children and do not go to hospitals due to fear of being arrested for their undocumented status" (MCL, Male, Sudan). Collectively, these barriers illustrate how structural, linguistic, and legal challenges intersect to limit migrants' access to healthcare.

3.3.3. Health care reaching

Healthcare reaching refers to the ability to physically access services promptly. Participants in this study reported that geographic and systemic factors frequently hindered prompt access to care, causing delays in diagnosis and treatment. Key barriers included high transport costs, remote facility locations, limited service availability, and uneven distribution of healthcare facilities across districts in Egypt.

High transport costs and distant facilities posed significant challenges. One participant described the difficulty of accessing specialised care for her daughter:

> I'm having a hard time finding affordable neurologists for my daughter. Once, I visited a very faraway centre and had to take a taxi to get there. When I arrived, they asked me to go back to the hospital to find out the examination cost and then return to them. This process is costly; I wouldn't need to endure all this trouble if I had enough money (MW, Sudan).

Limited availability of medical services and long waiting lists further restricted access, an issue exacerbated by the increasing number of Sudanese refugees. As perceived by one NGO staff: "However, this is due to the availability of the service. In Cairo, they said they could not find the service there, and they will be on the waiting list." (NGO staff, Egypt). These obstacles illustrate how structural challenges in the healthcare system disproportionately affect migrant populations and contribute to delayed or interrupted care.

3.3.4. Healthcare utilisation

Healthcare utilisation refers to an individual's ability to navigate and use appropriate, effective services and make informed decisions. Migrants reported multiple barriers, including perceived discrimination, mistreatment by hospital staff, mistrust in the quality of care, continuity of care issues, and systemic challenges in referral mechanisms, which collectively reduced the timeliness and quality of healthcare access.

Some migrants reported experiences of mistreatment from medical personnel or from other Egyptian patients. One community leader explained, "When they go to the hospital we refer them to, they face bullying and non-acceptance from the Egyptian community. The Egyptian citizens believe that the migrants are taking away services from them" (MCL, Female, Yemen)

Mistrust in the quality of care and medical decisions is an additional barrier. Migrants perceived potential misdiagnoses and expressed concerns about the effectiveness of medicines in local pharmacies. These issues are further compounded by the perceived lack of adequate training among healthcare professionals in managing tropical diseases such as malaria. As one participant described, "When they reach hospitals, they struggle to find the appropriate doctor and treatment, leading to delays in receiving suitable malaria treatment" (MCL, Male, Yemen).

Continuity of care and financial barriers posed additional challenges. Frequent interruptions in treatment, primarily due to cost, combined with extra payments that migrants perceived as unofficial, undermined their experience of care. One participant recalled, "After the surgery, they asked us to pay more money because they installed an internal fixation plate. We felt that the ambulance driver and the hospital cheated us, and we are waiting for the outcome of the surgery" (MW, Sudan).

Referral mechanisms and NGO coordination varied across contexts. Some NGO members highlighted successful collaborations with partner organisations or the Ministry of Health, showing that effective referral pathways help overcome specific barriers. Others reported poor coordination and the absence of a functional referral system. As one participant explained:

> We provide primary healthcare services, but many cases require referral to more specialised hospitals, and we do not have a referral system in place. We have no obvious referral system in Egypt. I believe the most valued referral system, if available, would be with government hospitals (NGO staff, Male, Egypt).

Overall, migrants face barriers such as discrimination, mistrust, fragmented care, and poor referral systems, which together hinder their timely and effective access to healthcare services.

3.4. Theme 3: Healthcare consequences

Limited access to healthcare from recognising health needs to utilising appropriate services and managing associated costs—had wide-ranging consequences for migrants. Some participants reported significant financial strain due to healthcare expenses, which, in some instances, led to involvement in informal or illegal economic activities or the onset of psychological distress. As one participant explained, "They are unable to continue receiving their treatment after depleting their funds, leading them to resort to violence or illegal means to obtain money" (MCL, Female, Yemen). This highlights the profound socioeconomic and mental health impacts of insufficient access to healthcare.

Migrants also described severe health deterioration among family members, with some cases resulting in death, illustrating the life-threatening consequences of delayed or inadequate care. In contrast, several NGO highlighted positive health outcomes among youth, particularly when healthcare services were coupled with adequate

psychological support, demonstrating the protective effect of comprehensive, integrated care. These findings show that barriers across the healthcare continuum—seeking, reaching, and utilisation—can lead to severe financial, psychological, and physical consequences for migrant populations.

3.5. Theme 4: Call for future action- recommendation for improving healthcare access

This sub-theme highlights participants' suggestions for improving healthcare access for migrants in Egypt. The participants underlined the need for support in addressing administrative barriers, particularly legalising migratory status, as a prerequisite for accessing many services. They also urged NGO to strengthen referral systems and enhance collaboration with the Ministry of Health to ensure access to secondary and tertiary care. In addition, participants called for greater social support and advocated for free, affordable, and accessible medical services for migrants (See Table 2 for more details.).

4. Discussion

Our study examines the healthcare experiences of migrants in Egypt, highlighting the complex interplay of factors shaping their access to the healthcare system. Drawing on the perspectives of migrant communities, community leaders, and NGO staff, it provides critical insights into both the challenges and facilitators of healthcare access in South-to-South migration contexts. Migrants reported a broad spectrum of health challenges, ranging from infectious to non-communicable diseases (NCDs). Yet, healthcare access is neither separate nor straightforward; its dimensions are deeply interconnected. Financial difficulties, lack of trust, experiences of discrimination, and the absence of legal documentation all created barriers to both seeking and utilising health services. This study contributes to the underexplored field of South-to-South migration (Izaguirre et al., 2021) and aligns with the WHO Triple Billion Targets and Global Research Agenda on Health, Migration and Displacement, which aim to strengthen research and inform policy (World Health Organisation, 2023).

Non-communicable diseases (NCDs) emerged as the most common health concern among participants, prompting our focus on this area. This was further supported by the lack of health insurance and high treatment costs, which limited migrants' access to essential care. A systematic review of NCDs among urban refugees in developing countries supports our findings, showing that while primary healthcare may be accessible, secondary and tertiary services remain problematic in Egypt, Malaysia, and Iran (Amara & Aljunid, 2014). However, these services often require out-of-pocket payments, which many migrants cannot afford, leaving conditions untreated. The UNHCR Access and Utilisation Survey in Egypt highlights this issue, reporting that only 23 % of migrants with non-communicable diseases (NCDs) received care at a public facility (UNHCR, 2023). Egypt's public health system primarily focuses on infectious diseases, leaving NCDs management to organisations such as the UNHCR and IOM (Amara & Aljunid, 2014; World Health Organisation, 2022b). This oversight of chronic conditions underscores the need for targeted interventions to improve health outcomes.

Mental health also emerged as a critical concern and was consistent with previous literature, reporting that many migrants experienced psychological distress, symptoms of depression and suicidal thoughts (UNICEF, 2025). This distress results from forced displacement, job insecurity, inadequate housing, and social exclusion (Alegría et al., 2017; GOV.UK, 2022). These findings underscore the complex interplay between social determinants and mental health among migrant populations. They also highlight the urgent need for culturally sensitive mental health services and inclusive policies to support vulnerable migrants and refugees in Egypt.

Financial barriers further impede access across all stages of the care

Table 2
Recommendation to improve migrant's access to health services.

Recommendation	Quotes
Sub-theme 1: Administrative discretion	
Health and social equity	"Forget any nationality and, as a doctor, act like a human being before you get paid; forget anything and deal with him humanely, without looking for his colour, nationality and religion." (MM, Sudan)
Legalisation of their migratory status	"We ask our embassy to support us in residency and passport issuance." (MW, Sudan)
Referral system enhancement	"I think the first one is to find a way to hold an interactive and real communication between all NGOs, all stakeholders from NGOs who are Serving migrants and refugees from one side, and the government of Egypt from the other side. We need Interactive communication and a clear referral system for those who need secondary or tertiary health services. For example, this is the first one." (NGO staff, Female, Egypt)
Strengthen the communication	"Adding an email is an alternative to the phone because the Egyptian number may be closed by the company if there is no Egyptian residency or receipt. So far, there is no organization that supports us with anything." (MM, Sudan)
Promotion of ethical healthcare	"We want to be treated with dignity without humiliation when we undergo surgery or take doses of medication." (MW, Sudan)
Sub-theme 2: Enhanced community-based interventions	
Migrant clinic per area	"We demand that a specific place be provided for Sudanese refugees where all medical specialities are available. Even if two days a week, there are doctors dedicated to Sudanese, and the government is responsible for them, we propose the construction of a residential compound for Sudanese, including a health unit specifically for immigrant care under the Egyptian government." (MW, Sudan)
Psychological intervention	"Psychological support for all Sudanese and immigrants to alleviate the bullying they are subjected to" (MCL, Female, Sudan)
Sub-theme 3: Expanded provision of free services	
Provision of diagnostic and treatment services	"Provision of services for dental care because it is costly, and organisations do not support it." (MW, Sudan_)
Provision of services for elderly people	"In addition, the elderly must focus on themselves, as a large percentage of them need vitamins for their nerves and many medicines. I hope there is support for refugees in general." (MCL, Male, Yemen)
Provision of care for people who have a disability	"They can search for needy families or those with special needs and support them, for example, the disabled and those in need of physical therapy" (MM, Sudan)
Sub-theme 4: Enhancing social support	
Support children education	I hope if there is a possibility to open special schools for them and for refugees, to cooperate with them and help them, it would be a very good idea(MCL, Male, Yemen)
Financial support	We want organisations, especially IOM, to provide a certain monthly amount, such as the World Food Organisation, which supports a person with 400; if there are six people in the family, the total is 2400, which helps with rent. We want all organisations to become like it (MW, Sudan)
Improve living condition	"Provision of refugee shelters to avoid the increase in rental prices." (MCL, Male, Sudan)
Sub-theme 5:	
Investing in awareness or health orientations	We ask the Egyptian public health system to familiarise migrants with the available services, such as those leaflets that were disseminated at the time of the coronavirus, to raise awareness of the importance of the vaccine and its availability for Egyptians, migrants and refugees and to write

(*continued on next page*)

Table 2 (*continued*)

Recommendation	Quotes
	leaflets in different languages. I noticed that central health units that provide immunisation and maternal health care services started to use leaflets in many languages to emphasise that if a service is offered to all Egyptian citizens, it will be provided to migrants as well. I also recommend extending this service to large hospitals, as it will give good results. (NGO staff, Female, Sudan)
Sub-theme 6: Higher proximity of services	Mapping out the places that provide services, raising awareness of places that provide services, and networking. The last thing is a database for refugees and migrants. Centralised base with all the places that offer services to them. I do not know how to mark words, but it needs to be prevalent among them.(NGO staff, Female, Egypt)

continuum. Comparable barriers have been identified among migrant populations in other contexts, including the United States, Canada (Ngondwe & Tefera, 2025), and Mexico (Yessica Elizabet & Tuur, 2021). These results are further substantiated by a UNHCR survey conducted in Egypt, which found that 44 % of individuals seeking healthcare could not afford the user fees (UNHCR, 2023).

Documentation requirements constitute a major structural barrier, particularly for women, who sometimes declined free vaccinations due to fears of deportation. This concern was also noted by Wong et al. (2024), who explored the role of documentation status in vaccination hesitancy (Wong et al., 2024). The July 2024 government decree, mandating valid residency permits to access public services in Egypt, has further exacerbated these challenges (Refugee International, 2024). Another significant barrier was found to be a lack of trust in the health system and medical decisions. Migrants frequently mistrust public hospitals and prefer private healthcare facilities, driven by past experiences and perceptions of higher-quality service. However, this lack of trust is also reported among Egyptians, who often opt for private care, paying out of pocket despite having access to social health insurance (World Health Organisation, 2021).

In line with previous research, our findings highlight that limited health literacy among migrants significantly restricts access to healthcare services and contributes to poorer health outcomes (Wångdahl et al., 2015). Additionally, cultural and religious beliefs can sometimes discourage individuals from seeking care, particularly for sensitive health issues (Ahmad et al., 2012; Cassim et al., 2022; Ngondwe & Tefera, 2025; Steven et al., 2004; Vahabi et al., 2015), while healthcare providers sometimes avoid discussing these issues to respect cultural norms, this approach often leads to misunderstandings, unaddressed health concerns, and ultimately, suboptimal care for migrant patients.

Our findings also align with research suggesting discrimination in healthcare. For example, Syrian refugees in Lebanon reported restricted access to services and denial of hospital admission (Khalifeh et al., 2023), which underscores the significant role of healthcare-related discrimination in exacerbating health inequities and limiting access to essential medical care.

Consistent with existing literature, our study highlights the distinct challenges migrant women face, shaped by gender-specific needs, experiences of violence, and intersecting structural factors such as legal status, ethnicity, and disability. (Liu et al., 2019; Salih et al., 2025; Trentin et al., 2023). These vulnerabilities are further compounded by economic instability, which restricts access to care due to unaffordable out-of-pocket costs. (Salih et al., 2025). An intersectional perspective reveals how overlapping forms of marginalisation collectively disadvantage migrant women and other vulnerable groups.

Our findings highlight that multiple, compounding factors shape migrants' access to healthcare. The intersection of legal status, gender, and disability creates particular barriers, which are further amplified by institutional rules, social norms, and socioeconomic precarity. This perspective exposes the power dynamics underlying healthcare inequities, showing how structural mechanisms systematically disadvantage migrant women and other vulnerable groups (Izaguirre et al., 2021; Tummala-Narra, 2020).

To our knowledge, this is the first qualitative study to examine the barriers that migrants face in accessing healthcare in Egypt. A key strength is its inclusive data collection approach, which utilises ISIs, FGDs, and GI with migrants, community leaders, and NGO staff, thereby ensuring diverse perspectives. Also, it empowers migrants to be heard in a private and confidential place. We also voiced their recommendations for the call to action. Additionally, the lead researcher's fluency in the participants' language and dialect facilitated communication, encouraging more open expression of concerns. However, this study has several limitations. The extrapolation of results to other regions may not be relevant, as the study's focus was on the Egyptian capital. Moreover, the majority of participants were Sudanese migrants, with limited representation from other migrant communities.

Our findings have important clinical and public health implications for improving migrants' access to healthcare. These insights are grounded in grassroots-level recommendations voiced by the migrants themselves. First, expanding access to culturally competent healthcare services through migrant-friendly clinics that offer free diagnostic, treatment, and preventive care can help reduce structural inequities and build trust in the Egyptian healthcare system. Additionally, these initiatives must be supported by strong referral systems and effective communication strategies that develop a centralised database to consolidate information on migrants and the organisations providing them services. Second, empowering migrant communities through targeted health education can enhance health literacy and promote timely healthcare-seeking behaviour. Third, regularising migrants' legal status could reduce fears of deportation and facilitate access to inclusive healthcare. Finally, improving migrants' socioeconomic conditions is also essential. Measures such as enhancing safety and addressing violence, as well as simplifying work permit procedures, can support employment. Additionally, promoting affordable housing can further improve living conditions, ultimately contributing to better health outcomes.

These policy interventions should adopt a gendered and intersectional approach, ensuring health services for migrant women address gender, legal status, ethnicity, disability, and socioeconomic vulnerability. This includes targeted reproductive and maternal health programs, support for survivors of gender-based violence, financial protections, and inclusive data collection to inform equitable policies. Incorporating these insights into national health planning can enhance the health of migrants and promote equity. Future research should focus on scalable interventions to improve migrants' healthcare navigation.

5. Conclusion

In Cairo's urban context, migrants and refugees in vulnerable situations often face significant barriers to accessing healthcare. Achieving health for all requires targeted policies that expand access to culturally competent healthcare services, empower migrant communities through tailored health education, and regularise migrants' legal status to reduce fears of deportation and facilitate access to inclusive care. Improving the socioeconomic conditions of migrants is also crucial; for example, enhancing safety and addressing violence, alongside simplifying work permit requirements for migrants, would support employment and housing affordability, ultimately contributing to better health outcomes. By adopting inclusive, gender-sensitive, and intersectional policies, Egypt can move closer to universal health coverage while ensuring that no migrant or refugee is left behind.

CRediT authorship contribution statement

Eman Elafef: Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Hassan Edries:** Writing – review & editing, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Shaimaa Abdelrahman:** Methodology, Investigation. **Wessam Elnahry:** Methodology, Investigation. **Samir Hadjiabduli:** Methodology, Investigation. **Adel Abdelkhalek:** Methodology, Investigation. **Asad Adam:** Supervision. **Mahmoud Hilali:** Methodology, Funding acquisition, Conceptualization. **Ahmed Hamed Arisha:** Methodology, Investigation. **Ibrahim Bani:** Writing – review & editing, Supervision. **Farah Seedat:** Supervision, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Sally Hargreaves:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization. **Stella Evangelidou:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Ana Requena-Méndez:** Writing – review & editing, Visualization, Validation, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Consent for publication

No person's data in any form is part of the manuscript. All participants gave consent for participation.

Data statement

The dataset is qualitative and contains several quotes that could potentially identify participants. Therefore, the raw dataset will not be available. However, additional quotes supporting each theme can be provided upon request from the corresponding author.

Ethical considerations and consent

The study received approval from the BUC Institutional Ethical Committee (BUC-IACUC-231217-53) and the Ethics Committee of Hospital Clínic de Barcelona (HCB/2022/0655). All participants were informed about the study both verbally and through an information sheet before signing the informed consent form, which allowed them to participate and be audio recorded. Audio recordings were anonymised, and personal data were removed to ensure confidentiality. Given the topic's sensitivity, careful consideration was taken to ensure that the findings would not compromise migrant security or lead to adverse legal or political consequences.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work, the author (EE) used Grammarly and ChatGPT with caution to enhance language and readability. Following the use of these tools, the author (EE) carefully reviewed and edited the content and takes full responsibility for the final version of the publication.

Funding

This work was supported by 'la Caixa', LCF/PR/SP21/52930003. SH is also funded by the National Institute for Health Research (NIHR 300072 and NIHR 134801), the Medical Research Council (MRC/N013638/1), the Wellcome Trust, and the World Health Organisation (WHO). AD is funded by the Medical Research Council (MRC/N013638/1).

Declaration of competing interest

None of the authors reports any conflict of interest.

Acknowledgements

We appreciate all participants for sharing their insights and experiences with us. We are grateful to the IOM Health Assessment Centre in Cairo for their assistance with logistics and for providing a venue for the study. We also extend our gratitude to the NGO professionals for taking the time to engage with us, despite their many commitments. Our thanks go to all members of the Middle East and North Africa Migrant Health Working Group**:** Adnene Ben Haj Aissa (Office National de la Famille et de la Population, Tunisia), Charles Agyemang (University of Amsterdam, Netherlands), Salma Altyib (Ministry of Health, Sudan), Ali Ardalan (WHO Regional Office for the Eastern Mediterranean), Anna deal (City St George's University of London, London, UK), Hanen Ben Belgacem (IOM Tunisia), Imane Belkhammar (Maroc Solidarité Médico-Sociale MS2, Morocco), Thomas Calvot (Médecins du Monde, Tunisia), Nuria Casamitjana (University of Barcelona, Spain), Anissa Ouahchi (Office National de la Famille et de la Population, Tunisia), Taha Maatoug (Université de Sousse, Tunisia), Oumnia Bouaddi (Mohammed VI University of Sciences and Health, Morocco), Moudrick Abdellatifi (Mohammed VI University of Sciences and Health, Morocco), Luciana Ceretti (IOM Morocco), Nelly Chavassieux (Maroc Solidarité Médico-Sociale MS2, Morocco), Hassan Chrifi (Ecole Nationale de Santé Publique, Morocco), Mohamed Douagi (Office National de la Famille et de la Population, Tunisia), Algdail Elnil (Sudan Organization Network for Peace & Development, Sudan), Gonzalo Fanjul (Institut for Global Health Barcelona, Spain), Fouad M Fouad (American University of Beirut, Lebanon), Chiaki Ito (IOM MENA), Abdedayem Khelifi (Ecole Nationale de Santé Publique, Morocco), Lora Makhlouf (Médecins du Monde, Morocco), Maissa Mokni (Médecins du Monde, Tunisia), Davide Olchini (Médecins du Monde MENA), Tarik Oufkir (Maroc Solidarité Médico-Sociale MS2, Morocco), Nasong Park (IOM Egypt), Giuseppe Raffa (Médecins du Monde, Tunisia), Wafa Saidi (Ministry of Health, Tunisia), Sandra Santafé (Institut for Global Health Barcelona, Spain), Alice Sironi (IOM Tunisia), Fatma Temimi (Office National de la Famille et de la Population, Tunisia), Zeineb Turki (Médecins du Monde, Tunisia). We acknowledge support from the grant CEX2023-0001290-S funded by MCIN/AEI/ 10.13039/501100011033, and support from the Generalitat de Catalunya through the CERCA Program.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2025.100672.

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