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Access to Healthcare in the European Union: Experiences and Challenges of West African Migrants

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Abstract

This paper examines the trends and dynamics of accessing healthcare among West African migrants in Europe. It also analyses the role conflicts and socio-economic situation plays as a driver of migratory inflows into the EU, including through irregular means. Using the library instrument and secondary-descriptive method, findings show that migrants face higher barriers to accessing healthcare services in comparison to non-migrant population, especially those born in the country. Migration presents societies with unique social, economic, legal and cultural challenges as well as opportunities, which in turn could affect their access to timely and appropriate healthcare. The paper concludes that outward migratory trends from West Africa continue to remain a phenomenon, including towards the EU, which gives rise to new requirements for healthcare services and increases the need for an inclusive health policy for mobile and vulnerable populations. The paper recommends that inclusive policies, culturally competent healthcare services and healthcare information systems are imperative, to increase the use of healthcare services among migrants and to reduce health inequalities.

Keywords: Conflicts; Migrants; Healthcare; Regional-conflict; Health-policy

Introduction

The twin challenges of insufficiency and/or inadequacy of unemployment opportunities and conflicts in West Africa have significantly influenced the migratory trends experienced across the sub-region. These trends broadly portray mixed migration flows, encompassing internal displacement within national borders, refugees and asylum seekers, migrant workers, as well as trafficked or smuggled individuals. From a conflict lens and narrowing the discourse to the evolutionary era of post-cold war, most Africa countries have been enmeshed in a series of protracted and obstinate conflicts which has led to loss of lives and properties (Cilliers 2018; Hussein 2015). The inability of successive regimes to address the scourge of these obstinate conflicts has increased the level of human insecurity influencing migratory trends towards safer regions, including Europe (Annan 2014; De Coning et al 2016). Indeed, scholarly reviews posit that while it may be difficult to trace or identify the exact periods these frustration and human insecurity catalyzed significant migration to Europe, the 1980s witnessed an unprecedented migration out of Africa to Europe and across the globe (Flahaux 2016; Okome 2017; Sohst et al

2020). These migratory trends has led to attendant challenges and consequences for host countries across Europe. Since then, the European continent persistently struggles in adjusting to the influx of migrants (Persaud 2017) and especially from West Africans.

Conversely from an unemployment lens, a rapidly growing population in West Africa and inability of successive governments to generate sufficient employment opportunities and absorb expanding labour forces has heightened economic insecurity and constrained livelihood prospects, especially for young people. These labour market pressures have contributed to sustained migration flows from Africa, particularly West Africa, shaping migration dynamics between Europe and Africa and presenting both opportunities and integration challenges for destination countries. (de Haas, 2021; ibid).

Over the years, influx of migrants in Europe has led to the over-stretching of social services and including access to quality and affordable healthcare. Indeed, a major challenge to citizens across the globe is the unending problem of access to healthcare, and this has led to the death of several persons and including the aged (IOM 2018; WHO 2018: 9). Despite existing legal and institutional framework initiated across European countries to ensure equal and affordable access to healthcare among migrants, accessing healthcare remains challenging among migrants in the EU (Woodward et al 2013; Ledoux et al 2018; Nagy 2011).

In relation to availability of migration policy frameworks, countries of origin in West Africa are largely in varying stages of the policy cycle (development, adoption, implementation or revision), facilitated largely within the broader regional governance architecture of the Economic Community of West African States (ECOWAS) application of – the Common Approach on Migration, the Regional Migration Policy, and the Labour Migration Strategy. Within the EU context, and in comparison to West Africa's regionally coordinated migration governance under ECOWAS, migration governance within the EU is embedded within a highly institutionalized supranational governance architecture. While Member States retain varying degrees of responsibility for implementation, migration and mobility policies are guided by common EU frameworks, including the New Pact on Migration and Asylum, the EU legal migration acquis, and labour mobility arrangements, which provide strategic direction for the governance of migration, asylum, integration and labour mobility across the Union.

With various stringent migration policies adopted among EU countries to discourage mass influx of migrants, the continent continues to grapple with challenges associated with migratory flows, which when not properly managed have propensity to over-stretch the respective home government's ability to distribute social benefits and policy thrusts, including in the area of access to quality and affordable healthcare. Across the globe and especially in Europe, access to quality and unhindered healthcare has gained increased attention among contemporary literature. Despite global awareness and numerous local and international instruments aimed at addressing the problem, access to healthcare remains challenging (Matlin et al 2018; Nagy 2011; Ledoux et al 2018; Ward et al 2018; Sweileh et al; Winters et al 2018). Moreso, the challenge has further worsened the health conditions of both documented and undocumented migrants from Africa and other developing countries (Lebano et al 2020; Shabban et al 2020).

Despite the dazzling contributions of these studies, a major drawback is that these studies were carried out in a broad context, and this presents a plausible justification of the need for more

context specific research with reference to West Africa migrants. Specifically, this research would focus on the plights of West African migrants with regards to accessing healthcare in countries within the EU, existing frameworks which supports access to healthcare, emerging and contending issues, and what greater implications these challenges portray for migration and the global context.

Literature Review and Theoretical Framework

Migration has been a constant phenomenon over historical times, and has been a key element of social, economic and political development in societies throughout history. In general, migration is the movement of people or groups from one geographic area to another for a temporary or permanent period. The International Organization for Migration (IOM) defines migration as the movement of people, of any length, of any composition, for any reason across international borders or within a state. Migration has been studied in various ways. Castles, De Haas and Miller (2020) conceptualize migration as a movement of people from one place to another in response to economic opportunities, political instability, environmental stresses and social aspirations. Likewise, King (2012) suggests that migration is a result of individual choices but also the result of structural factors that affect mobility. Migration is therefore now a multidimensional phenomenon in which a political, economic, demographic and cultural context plays a role. Recent migration research has focused on the process of migration and its impact on the sending community as well as the receiving community (with transfer of labour, skills, culture, and social networks) (Massey, Arango, Hugo, Kouaouci, Pellegrino & Taylor, 1993). For this reason, migration has been a focus of academic research due to its development, security, governance and social welfare implications around the world.

Migration can be classified based on the reasons, length and distance of migration. Migration can be internal or international – international when migrants cross national borders and internal when they move within the country. It could also be voluntary or involuntary as the decision to migrate could be taken voluntarily or by force. Richmond (1993) defines a voluntary migrant as one who moves to take advantage of economic opportunities, educational advancement, family reunification or improved living conditions, while a forced migrant is one who leaves because of conflict, persecution, environmental disaster, or political instability. Other types of migration include temporary, permanent, circular, labour, irregular and refugee movements. Increasingly, the levels of migration have created a distinction between types of migrants, with many people having more than one type of migration in their life (Castles, De Haas & Miller, 2020).

Migration in Africa is frequently motivated by a mix of economic deprivation, insecurity, governance challenges, and a desire for better living conditions. Adepoju (2008) notes that migration in West Africa has shifted from largely intra-regional migration to growing migration towards Europe and North America, a phenomenon which has gained momentum over the years. The various types of migration illustrate the complexity of population movement and the importance of having more complete frameworks to explain its cause and effect.

The linkage between migration and globalization has evolved through the decades, becoming more relevant in contemporary academic and governance discourse. Globalization has promoted an unprecedented interdependence, with the growth of communication technologies, transportation networks, financial integration and transnational networks. Held and McGrew (2007) state that globalization has led to the diminishing of boundaries and the strengthening of the movement of individuals, goods, information and capital across national borders. Globalization offers

opportunities for movement but also fosters inequalities that spur migration from underdeveloped areas into more prosperous economies. De Haas (2021) suggests that economic development and globalization may drive migration, as an expansion of access to information and increased income can boost an individual's capacity and aspirations to migrate. The proliferation and growth of transnational social networks also contribute to migration by disseminating information, resources, and support networks for potential migrants. Concurrently, globalization has stirred up debates on border control, national identity, labour market dynamics and access to social services in the destination countries.

Today, migration is a central aspect of globalization, and the movement of people is linked to the interconnection of today's societies and economies. The growing mobility of people across borders has also helped in the development of multicultural societies and new forms of transnational citizenship and belonging.

Over the last few decades, migratory patterns towards and across Europe have changed drastically. The continent is now one of the world's top destinations for migrants, thanks to its economic prospects, political stability and generous welfare systems. Triandafyllidou (2018) noted that Europe has been and continues to receive large numbers of migrants from Africa, Asia, the Middle East and Eastern Europe, resulting in new policy challenges and demographic realities. The 2015 European migration crisis, which saw the arrival of more than 1.3 million migrants and refugees, primarily from Syria, Afghanistan, and Iraq, posed a major humanitarian challenge and exposed deep divisions within the European Union over border management, asylum policies, and responsibility-sharing among member states. also underscored the complexity of migration governance in the European Union, with a massive number of refugees and asylum-seekers coming from conflict areas. Particularly, migrants from West Africa are an important part of these migration movements, partly because they lack employment, are poor, insecure, and look for better opportunities (Flahaux & De Haas, 2016).

Irregular migration, tightened border management measures and debates on integration and social inclusion are also hallmarks of contemporary migration in Europe. However, Koser (2016) points out that European governments are still weighing humanitarian versus security, labour market, and public service concerns. These developments have led to relevant debates about migrants' rights to healthcare, education and social protection. Migration continues to influence demographic and socio-economic developments in Europe and the understanding of the current and changing patterns of migration is crucial for policy making and research.

Conceptual Framework of Healthcare Access

Access to healthcare means the ability to access healthcare in a timely and affordable manner in a manner that is appropriate. It includes access to health services, including health providers, as well as the extent to which people can access them when necessary. Healthcare access is well known as a key element of a functional health system and an important contributor to health outcomes of the population. Penchansky and Thomas (1981) noted that access to health care is a multidimensional phenomenon that includes availability, accessibility, affordability, accommodation and acceptability. These dimensions impact on the ability of individuals to access preventive, curative, rehabilitative and palliative health care services. Access is also influenced by predisposing factors, enabling factors, and by health needs (Andersen, 1995), suggesting that social and economic status play a significant role in healthcare utilization.

In many countries, inequalities in income, education, employment and place of residence are associated with inequities in access to health services and health outcomes for various groups in society (Levesque, Harris & Russell, 2013). Access to healthcare is therefore not only about the services provided, but also about the structures in society that create opportunities for people to enjoy and sustain good health.

The right to health services has become an ever more pressing topic in the context of the implementation of Universal Health Coverage (UHC), defined as the provision of health services without facing financial hardship. Healthcare systems seek to achieve UHC as a key goal, as it ensures access to quality healthcare services and prevents undue health spending by individuals and families, particularly in developing countries, where the majority of people do not have sufficient funds for health care (World Health Organization, 2023). Even with the declaration of the Universal Health Coverage (UHC) agenda, access to healthcare is a major hurdle for migrants.

Legal, linguistic, cultural, and administrative challenges are frequently faced by international migrants that prevent them from accessing healthcare services in their host country (Abubakar, Aldridge, Devakumar, Orcutt, Burns, Barreto, Dhavan, Fouad, Groce, Guo, Hargreaves, Knipper, Miranda, Madise, Kumar, Mosca, McGovern, Rubenstein, Sammonds, Sawyer, Sheikh, Tollman & Zimmerman, 2018). Migrants with irregular legal status are especially vulnerable because they might not be able to access national health insurance schemes, or because they are worried about immigration enforcement stopping them from accessing healthcare (Rechel et al., 2013). This growing trans-border population mobility has thus been driving the debate to further strengthen the need for inclusive health systems and to ensure that migrants benefit from UHC irrespective of their migrant status. There are arguments that expanding access to healthcare for migrants does not only benefit their health and wellbeing, but also public health objectives, such as disease prevention and health security (Wickramage, Vearey, Zwi, Robinson & Knipper, 2018).

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Another key aspect of access to healthcare is *health equity*, which is broadly described as the absence of unfair and avoidable differences in health status and healthcare opportunities between people and groups (Whitehead, 1992). It highlights the concept of equity in achieving optimal health for all, irrespective of socioeconomic status, ethnicity, nationality, gender or migration status. Health equity is closely connected to access to healthcare, which is frequently linked to unequal access to health care resources resulting in unequal health outcomes. Marmot (2005) contends that social factors – like income, housing, education and employment – can have a significant impact on health opportunities and health inequalities.

Disadvantages across these determinants place migrants at greater risk of poor health and limited healthcare access. Moreover, structural discrimination and institutional barriers can further compound inequalities by restricting migrants' access to basic services in the healthcare sector (Solar & Irwin, 2010). Therefore, working towards health equity means tackling healthcare barriers and social determinants of health, including those that prevent access by migrant populations.

Access to healthcare services, health equity and social justice have emerged as key themes in the current debate on health policy. Social justice in healthcare is based on the ethical idea that health is a fundamental human right, and societies are obligated to provide equal access to healthcare services for everyone (Daniels, 2008). This view holds that healthcare resources should be allocated based on need, not social status or economic means. Social justice issues are significant ethical concerns from a health equity perspective, when migrants and other marginalized groups

have unequal access to healthcare, which limits their opportunities for health and wellbeing. Sen (2002) stresses that social institutions should reinforce people's capacities to live healthy and productive lives; Rawls (1971) argues that institutions should be structured to work for the most disadvantaged members of society.

These principles are the basis for policies that aim at lowering financial barriers, eliminating discrimination, and enhancing the inclusive delivery of healthcare services within healthcare systems. Healthcare access thus goes beyond simply being able to access healthcare services and involves broader notions of fairness, human rights and social inclusion. Access to healthcare services in good health systems and achieving social justice in today's societies cannot be separated from access to healthcare services for all populations including migrants.

The Concept of Migrant Health

Migrant health is defined as the physical, mental and social health of people who migrate across the borders or within countries for various purposes including employment, education, family reuniting, asylum, and refuge. Migration can present a variety of health risks to migrants that are specific to the migration process, such as exposure to unsafe travel conditions, legal insecurity, absence of access to health services due to language barriers, discrimination, and so on. These factors result in a spectrum of vulnerability which can have a negative impact on health.

Vulnerability of migrants is not just about individual characteristics; it is also a product of structural and institutional conditions in host societies. Studies indicate that migrants also have higher levels of psychological distress, risk of unemployment and social exclusion than do the native population (Marmot, Allen, Bell, Bloomer & Goldblatt, 2012; Rechel, Mladovsky & Devillé, 2012). Refugees and asylum seekers are especially vulnerable due to their experiences of conflict, persecution, displacement and the uncertainty of their legal status for an extended period (Ingleby, 2012). Given this, migrant health has become a key public health issue that must be addressed and social and environmental determinants of health and wellbeing need to be considered across the entire migration journey.

Social determinants of health (SDoH) are conditions in which people are born, grow, live, work, and age, and significantly impact the health status of migrants. The health of migrants is influenced by social determinants of health, including income, housing, education, employment opportunities, social support networks, and access to health care. Many migrants work in low-paid and precarious positions which put them at risk of exposure to occupational hazards and lack social protection (Benach et al., 2011). The poor housing conditions, overcrowding and lack of sanitation can make people more vulnerable to communicable diseases and have a negative impact on their mental health (World Health Organization, 2018). Language barriers and cultural differences may also limit access to health care services and the effectiveness of health communication between healthcare providers and migrants (Norredam, Nielsen & Krasnik, 2009).

Discrimination and restrictive migration policies can also increase inequalities in health by reducing access to healthcare and social support services (Solar & Irwin, 2010). These determinants are interrelated and migrant health is a multi-dimensional problem that goes beyond providing healthcare and involves the wider social, economic and political environment.

The health needs of migrants across the EU are diverse and varied, and depend on the migration status, country of origin, socio-economic situation and length of time in the country. Some

migrants may arrive in the region with relatively good health (the 'healthy migrant effect') but this benefit may wane over time due to socioeconomic disadvantages, stress and difficulties accessing health services (Kennedy, Kidd, McDonald & Biddle, 2015). The mental health needs of refugees and asylum seekers are especially important as they often suffer from depression, anxiety and post-traumatic stress disorder due to their pre-migration and post-migration experiences (Priebe, Giacco & El-Nagib, 2016). Additionally, migrants in Europe need better access to maternal and child health services, preventive health services, vaccination programmes and management of chronic diseases. Legal, financial and administrative challenges have been shown to impede migrants' access to timely and appropriate healthcare services (Rechel et al, 2011).

Given the observance of increasing migratory flows of populations to Europe, particularly countries within the EU, and its impact on the nature of European societies, health needs of migrants would undoubtedly inform societal evolution in the long run, with a recognizable need for adequate attention to inclusively promoting public healthcare policies, reducing health inequalities and ensuring equitable access to health services for all population groups.

Theoretical Framework

Andersen's Behavioral Model of Health Service Utilization

There are several theories that have helped to illuminate the understanding of migrants' healthcare access, which take into account the influence of individual factors, social factors, and institutional factors on health-seeking behaviour. One of the most important theories in health services research is Andersen's Behavioral Model of Health Service Utilization. The model was first developed by Andersen (1968) and updated over the years to account for various aspects of the problem of why people use health services and what factors are helpful or unhelpful in accessing services. The theory is based on three general groups of factors that influence the use of health services: predisposing, enabling and need factors. Predisposing characteristics include socio-demographic and social factors like age, sex, education, cultural beliefs, migration status, which affect the likelihood of an individual seeking healthcare.

Personal, family, community and institutional resources include income, health insurance coverage, language ability, transportation and access to health facilities. Need factors are both perceived and appraised health states that require medical intervention (Andersen, 1995). The model also highlights the importance of healthcare utilization not just being a result of health status, but as a product of the relationship between people and the health system. Later revisions added on the importance of environmental and contextual factors, acknowledging that the context of wider social and policy worlds influence health service use (Andersen, Davidson & Baumeister, 2013). The theory is one of the most widely used models in public health and migration research as it offers a broad understanding of patterns of healthcare access and utilization across different population subgroups.

The relevance of Andersen's Behavioral Model to migrant healthcare access is that it can be used to understand various barriers and facilitators that affect the migrant health care experience in interacting with health systems. Migrants have several characteristics that can also predispose them to health-seeking behaviour, including cultural norms, language differences, experiences of migration, and legal status. Norredam et al (2009) found that migrants may be reluctant to seek care because of the non-understanding of the health services in the host country or because of a lack of cultural understanding of disease and treatment. Enabling resources are of particular

importance in the understanding of migrants' access to health care because employment opportunities, income, eligibility for health insurance schemes, language skills and social support networks are all determinant factors in migrants' access to health services (Rechel, Mladovsky & Devillé, 2012).

Across many European countries migrants face administrative and legal restrictions on access to public health services, particularly for undocumented migrants (Cuadra, 2012). Need factors are also important because migrants are likely to suffer from health problems related to migration stress, substandard living conditions, occupational risks, and inadequate preventive health. However, many migrants do not receive adequate healthcare services as a result of structural barriers and socioeconomic disadvantages (Priebe, Giacco & El-Nagib, 2016). This model is thus a valuable basis for conceptualizing the role of individual, social, and health care system influences in determining health care use by migrants.

Social Exclusion Theory is another theoretical approach that has been useful in understanding access to healthcare services among migrants. It grew out of the sociological and policy discussions about inequality, marginalization, and the lack of full participation of some groups in social, economic, political and cultural life. According to Social Exclusion Theory, social exclusion is a multi-dimensional process in which individuals or groups are systematically disadvantaged due to poverty, discrimination, legal status, ethnicity, race, language, or social identity (Silver, 1994). The Social Exclusion Theory has brought a different outlook on poverty that places an increased emphasis on the structural and institutional mechanisms which prevent people from having access to resources, opportunities and rights which are considered to be available to the rest of society (Levitas, Pantazis, Fahmy, Gordon, Lloyd & Patsios, 2007). In this framework, the theory rests on the notion that exclusion is a result of the interconnections of various mechanisms across different levels of the labour market, education, politics, and social welfare systems.

These mechanisms tend to perpetuate inequalities and long-term disadvantages for vulnerable groups. Social exclusion is thus not only considered as a personal experience, but as a process, which has its roots in the institutional structures and power dynamics. Exclusion has been discussed by scholars both in terms of material deprivation and social participation and as a consequence, this impacts on opportunities for personal development and access to critical services, such as healthcare (Burchardt, Le Grand & Piachaud, 2002).

The main theoretical framework used in paper is Andersen's Behavioral Model of Health Service Utilization, which has been well developed to explain the variation in healthcare use among migrants. While Social Exclusion Theory is useful for understanding the structural inequalities and social marginalization, Andersen's model directly provides an analytical framework to analyze the factors that influence the use of health services. The model combines individual characteristics, socio-economic resources, and health needs in a comprehensible explanatory framework, which is very much in line with the aims of this study. The framework acknowledges that personal and contextual factors influence access to healthcare and thus is well suited to explore the experience of West African migrants in the EU. Demographic, educational, cultural beliefs and migration experiences are important predisposing factors for migrants. Enabling resources include their incomes, job situation, legal status, health insurance, language skills and social resources. Need factors associated with health service utilization are health conditions, perceived illness severity

and medical needs. These dimensions enable a thorough analysis of factors that affect healthcare access by migrants and enable an analysis of individual and institutional factors.

Applying Andersen's Behavioral Model to this study gives a logical foundation for the relationships between the variables being studied. The study posits that predisposing, enabling and need factors affect migrants' access to healthcare services. Attitudes towards healthcare are influenced by predisposing factors like age, sex, educational status, cultural orientation, migration history etc., which affect the decision to seek treatment. Access to medical services when they are needed depends on enabling factors such as the existence of documentation, employment status, financial resources, language abilities, and availability of health facilities. Need factors are those conditions of health and self-assessment which drive health-seeking behaviour. These variables interact and, ultimately, influence migrants' health and access to and use of healthcare services.

The conceptual connection between the independent variables and the dependent variables is thus based on the assumption that migrants who have favorable enabling resources and fewer structural barriers to accessing health services will be more likely to access services than those who have socioeconomic disadvantages and structural barriers. These relationships can be analysed within Andersen's model, and it is an adequate theoretical approach to investigate the access to healthcare services of West African migrants in Europe.

Findings and Discussion

There is empirical evidence across different regions of the world that migrants face higher barriers to healthcare services than do citizens who were born in the country. Migration from abroad can present people with unique social, economic, legal and cultural challenges that affect their access to timely and appropriate healthcare services. Research in Europe, North America and elsewhere in the countries show that migrants often experience problems with language, access to health systems, lack of health insurance, discrimination and financial difficulties.

Research has also shown that migration status has a significant impact on healthcare utilization, and that undocumented migrants and asylum seekers tend to have the highest barriers to healthcare access (Winters, Rechel, de Jong & Pavlova, 2018). While many countries have embraced the principles of universal health coverage, there are still significant gaps in access to healthcare among migrant populations, as legal coverage does not necessarily equate to access. Despite having a relatively high level of healthcare systems, migrants are frequently reporting their unmet healthcare needs (Lebano, Hamed, Bradby, Gil-Salmerón, Durá-Ferrandis and Garcés-Ferrer 2020). These results show how much the needs of migrants for healthcare services differ from the goals of healthcare policies.

In the EU, the health of migrants is an important field of empirical research, given the rising number of migrants and the increasing diversity of migrant populations. Systematic reviews indicate that migrants generally tend to use health services differently from the native population, with a tendency to underuse preventive and primary healthcare services and overuse emergency healthcare services when ill health occurs. However, Graetz (2017) found that migrants in several European countries had lower rates of use of specialist outpatient services and preventive screening programmes than non-migrants. Likewise, Norredam, Nielsen and Krasnik noted that migrants often face structural obstacles that postpone use of health services and that negatively affect health over time. A detailed study of migrant health access in Europe found that there were widespread disparities in the use of healthcare services in many countries, such as Germany, France, Italy,

Spain, Greece, Sweden and the UK. Overall, the review revealed that migrants tended to have poorer access to healthcare services than their native counterparts, and migrants often reported problems with communication, information about services, insurance coverage, and administrative difficulties within the health system (Galanis, Spyros, Siskou, Konstantakopoulou, Angelopoulos & Kaitelidou, 2022). It has also been found that undocumented migrants have even greater barriers to accessing care, as legal barriers can restrict access to care beyond emergency care. Even when healthcare is available, fear of deportation, uncertainty about rights, and concerns about administrative reporting discourage health care utilization (Winters, Rechel, de Jong & Pavlova, 2018).

Empirical research also shows that there are many social determinants that interact to influence healthcare access for migrants in the EU. One of the most common reported barriers is language, which hinders communication between healthcare professionals and patients and ultimately affects the quality of the healthcare received. Health-seeking behaviour, perceptions of illness and confidence in health facilities may also be culturally influenced. Lebano, Hamed, Bradby, Gil-Salmerón and Durá-Ferrandis (2020) found that discrimination and institutional barriers play a significant role in unequal access, especially for refugees and undocumented migrants.

Recent research also has shown the impact of racial and ethnic discrimination in healthcare settings on discouraging migrants from seeking healthcare services and on the quality of healthcare received (Pattillo et al., 2023). These are further complicated by socio-economic disadvantages, with migrants being over-represented in low-paid jobs and possibly without secure housing or social networks. Limited access to healthcare for migrants has been found in many studies throughout Europe, which points to difficulties with education, health literacy, and awareness of health care entitlements among migrants (Galanis et al., 2022).

Although the national healthcare and migration systems in Europe differ significantly from one country to another, empirical evidence shows that migrants are still facing significant restrictions to accessing health care in Europe. Thus, inequalities in the health care status between migrants and host populations continue to be a public health problem and a subject of ongoing research.

Institutional and Policy Responses to Migrant Health Care in Europe

European institutional and policy answers to migrant healthcare have shifted significantly over time with the growth in migration, shifts in demographics and international human rights commitments. The European institutions, notably European Union (EU), have been trying to encourage equitable access to health services via various legislative and policy frameworks that embrace health as a basic human right. International instruments including the International Covenant on Economic, Social and Cultural Rights and the Universal Declaration of Human Rights, both of which recognise the right to the highest attainable standard of health irrespective of nationality or migration status, inform the EU approach. Internationally, efforts to improve migrant health have been mirrored within the European context through processes of tackling health inequalities, developing cultural competence in health systems and bolstering provision of preventive and curative services for migrants. The European Commission has funded member states to tackle the unique health needs of migrants through research projects, policy guidance and funding programmes (Rechel, Mladovsky, Deville, Rijks, Petrova-Benedict & McKee, 2011). In the same way, the World Health Organization (WHO) Regional Office for Europe has recommended migrant-sensitive health systems that are able to address language, cultural and socioeconomic challenges faced by migrants (Jakab, Severoni & Ostlin, 2015). Even with these

efforts, however, implementation differs from country to country, due to the national level control of healthcare. In some countries, health services are available to all persons, including undocumented migrants, and in others, the health services are only available to persons in need of emergency care (Norredam, Mygind & Krasnik, 2006). As a result, the services provided to migrants vary significantly across Europe and migrants' health is not equally well protected.

West African migrants face a range of obstacles when trying to access healthcare in Europe, which stem from structural, socioeconomic, cultural and legal factors. Limited knowledge of host-country institutions, language barriers and unfamiliarity with administrative procedures are identified as problems faced by many West African migrants in navigating complex health systems.

These barriers often cause health-seeking to be postponed and utilization of preventive services to be low (Ingleby, 2012). These are further complicated by the fact that many migrants are employed in low-paying jobs, have unstable housing, and are socially excluded, which has a negative impact on their physical and mental health, and are also often affected by socioeconomic disadvantage. It has been documented that migrants are sometimes met with discrimination and stigma in the health system, which can deter them from accessing health services when they are available (Malmusi, Borrell & Benach, 2010). The West African migrants are also at risk as a significant proportion of migrants come via irregular migration channels and may not have legal documents required for access to full healthcare coverage. Undocumented migrants may be hesitant to seek health services at health centers due to fear of deportation or encountering immigration officials, leading to higher utilization of the emergency room and informal care systems (Cuadra, 2012). In addition, cultural differences in the perception of illness, treatment, and health-seeking behavior can lead to miscommunication between patients and healthcare providers. Research has shown that poor interpretation services and lack of intercultural training among healthcare professionals can lead to poor communication, diagnosis and treatment results with migrants (Priebe et al 2011). All these factors add to ongoing disparities in health services access and health outcomes of migrants from West Africa in Europe.

While European institutions are working on policies to ensure migrants' health, there are considerable policy-practice discrepancies. In some European countries, austerity measures have at times had a negative impact on public investment in health and social services, particularly for vulnerable groups such as migrants (Legido-Quigley, Urdaneta, Gonzalez & La Parra, 2013). Furthermore, the politicisation of migration has percolated through to national debates about welfare entitlement and the provision of health care, which has resulted in some governments applying restrictive policies to limit access for groups of migrants. Exclusion from health care services will reduce public health objectives and can result in delayed diagnosis, an increase in disease burden and higher long-term healthcare costs (Marmot, Allen, Bell, Bloomer & Goldblatt, 2012). There is also evidence that mental health issues of migrants, such as trauma, anxiety and depression resulting from migration experiences, are often poorly addressed within the current healthcare system (Lindert, Schouler-Ocak, Heinz & Priebe, 2008). West African migrants might face these challenges exacerbated by racism, labour market marginalisation and enduring uncertainty over their status. As a result, Europe has a variety of institutional and policy arrangements designed to foster migrant health, but significant obstacles remain to ensuring access to effective healthcare for migrants.

Emerging Trends in Migrant Health Care Utilization

Comparative research on access to healthcare services for migrants across European countries shows that access and use of healthcare services varies greatly between countries. Much of this variation is affected by national health system structures, migration policies, welfare policies and legislation on access to care. Several Southern and Eastern European states offer less health coverage and more restrictive health policies for documented migrants in general, and even for asylum seekers and undocumented migrants in particular. Norredam, Nielsen and Krasnik (2010) showed that across Europe migrants make use of healthcare to different extents than native inhabitants, with differences in entitlement and health needs, and in the responsiveness of institutions. Likewise, Nielsen, Krasnik and Rosano (2009) found that the lack of harmonisation between EU member states in the collection of health data on migrants hinders cross-country comparisons, but all the evidence available suggests differences in access to healthcare.

Comparative evidence also indicates that, despite the national context, migrants face linguistic difficulties, cultural misunderstandings, discrimination and administrative obstacles, to varying degrees, depending on the national integration policies. Researches that have been carried out in Germany, Spain, Italy, Greece, France and Sweden suggest that countries with robust social protection are more likely to have favourable healthcare utilization outcomes for migrants than countries with fragmented healthcare systems (Lebano, Hamed, Bradby, Gil-Salmerón, Durá-Ferrandis, Garcés-Ferrer, Azzedine, Riza, Karnaki, Zota & Linos, 2020). The results provide evidence that the health access to migrants is not only related to their health needs but also to the wider political, legal and institutional context that affects migrants' engagement with health systems.

Comparisons have also been made between migrants and non-migrants on each of a series of different healthcare service categories; and it has been found that the patterns of utilization vary by service type. However, migrants tend to make more use of hospital services, particularly of the emergency department and preventive services, and less use of specialist consultations and health screening programmes than non-migrants in many European countries, according to Graetz, Rechel, Groot, Norredam and Pavlova (2017). These patterns are frequently blamed on delayed health care seeking, lack of knowledge about the health care system, and difficulties accessing primary care. Also, Fares, Pinilla Domínguez and Puig-Junoy (2023) found that migrants in different European countries reported higher rates of unmet health needs compared to their native counterparts, with affordability, administrative procedures and service access being significant issues. This is in line with a comparison of other countries like Italy and Greece, showing that legal constraints and administrative hurdles can deter migrants from accessing health services, while countries with regulations that are more welcoming to migrants have shown improved continuity of care and increased use of preventive services. There are also significant differences between documented and undocumented migrants, as documented migrants have the broadest access to health care services, while undocumented migrants have the narrowest access to such services, across all countries. Thus, while there was a considerable improvement towards achieving universal health coverage in Europe, there is still a lack of equal access to health care services for migrants, and disparities remain across national contexts and health care systems.

A related dimension in the discourse of migrant healthcare across countries in West Africa relates to patterns of healthcare utilization. West African countries largely categorized as origin, transit and destination countries, witnessed increased mobility under regional integration frameworks, and intensified interaction between migrants and national health systems. Evidence from across Africa shows that migrants often face common barriers to healthcare access, including

affordability constraints, limited insurance coverage, documentation requirements, language barriers, discrimination, and difficulties navigating health systems. These challenges have been documented in several West African countries, reflecting a broader continental pattern of unequal access to healthcare among migrant populations.

Many migrants also experience overcrowded health facilities, inadequate public health resources, and socioeconomic disadvantages that limit access to quality care, particularly in rapidly urbanizing settings. As a result, migrants frequently rely on informal providers, traditional medicine, or self-medication to meet their healthcare needs. These utilization patterns highlight broader structural weaknesses across many West African health systems, including underinvestment, health workforce shortages, and inequitable distribution of services, which disproportionately affect mobile and vulnerable populations.

Conclusion and Recommendations

Across the EU, countries have introduced migrant healthcare sensitive policies. This includes countries such as Belgium which supports access to healthcare for vulnerable migrant groups through targeted inclusion and health-equity measures, Netherlands which has also introduced migrant-responsive approaches focusing on health literacy, interpretation, and culturally sensitive care, and Italy that operates provisions to enable undocumented migrants access essential healthcare and has implemented cultural mediation initiatives within health services.

In the context of mixed migratory trends such as regional and internal displacement crises, refugee movements, and public health emergencies, the discourse around updated evidence and progressive requirements for healthcare access and services becomes pertinent for inclusive health policies for mobile and vulnerable populations across both regional migratory corridors examined.

Health programs have been scaled up by international and government organizations for maternal health, infectious diseases, vaccination and mental health services for IDPs and migrants. Innovative solutions such as digital health technologies, mobile clinics and community-based health care programs are also gaining traction in accessing migrant populations in areas with limited access. Concurrently, the rise of migration-related research at the global stage is contributing to the understanding of the patterns of healthcare access of migrants and returnees, especially those arriving in Europe and other parts of the world. These developments indicate a gradual shift to the acceptance of migration as an important determinant of health in the health policy discourse. However, issues of financing, health system capacity, social exclusion and continuity of care are still important barriers to the access to healthcare for West African migrants. Comparative evidence from Europe thus provides valuable lessons on the significance of inclusive policies, culturally competent healthcare services and healthcare information systems to increase the use of healthcare services among migrants and to reduce health inequalities.

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