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Access to health services: the perspective of migrants from Chocó to Medellín

Acceder a los servicios de salud: la mirada de migrantes del Chocó a Medellín

Acesso aos serviços de saúde: a perspectiva dos migrantes de Chocó em Medellín

RESEARCH ARTICLE

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Keyra Liseth Asprilla Córdoba
https://orcid.org/0000-0002-2275-2276.
Magister en Salud Pública. Universidad CES, Medellín- Colombia. Correo electrónico: asprilla.keyra©uces.edu.co.

Gino Montenegro Martínez
https://orcid.org/0000-0001-9090-6209.
Doctor en Salud Pública. Universidad CES, Medellín- Colombia. Correo electrónico: gmontenegro@ces.edu.co.

Abstract

Introduction: Internal migration implies facing a series of conditions that prevent or delay the use of health services; **ii) objective:** Understand barriers to health services access from the perspective of Chocó migrants living in Medellín.; **iii) methodology:** Qualitative study, two focus groups were carried out in which 13 people with migratory experience from the department of Chocó to Medellín participated-; **iv) results:** Afro-Colombian migrant population experiences barriers to entry due to not being insured by the general social security system in health, denial of service provision, lack of information, and unfavorable geographical accessibility. In health services, the barriers are associated with the color of skin and barriers due to delay or denial of authorization for procedures; **v) conclusions:** Migrant population experiences barriers to access to health services. An intersectoral approach to this problem is required, considering the particularities of the migratory context in the country where issues such as employment, education, and violence by armed actors, among others, are mainstreamed.

Keywords: Barriers to access of health services; Ethnic group; Internal migration; Personal Narrative.

Resumen

Introducción: Migrar internamente implica afrontar una serie de condiciones que impiden o retrasan la utilización de los servicios relacionados con el bienestar, entre ellos, los servicios de salud; **ii) objetivo:** Comprender las barreras de acceso a los servicios de salud desde la perspectiva de migrantes del Chocó residentes en Medellín.; **iii) metodología:** Estudio cualitativo, se realizaron dos grupos focales en donde participaron 13 personas con experiencia migratoria del departamento del Chocó a Medellín-; **iv) resultados:** La población migrante afrocolombiana experimenta barreras a la entrada por no encontrarse asegurados al sistema general de seguridad social en salud, por negación en la prestación del servicio, por falta de información y por accesibilidad geográfica desfavorable. Al interior de los servicios de salud, las barreras están asociadas al color de piel y por retraso o negación de autorización para procedimientos; **v) conclusiones:** La población migrante experimenta barreras en el acceso a los servicios de salud. Se requiere el abordaje intersectorial de este problema, teniendo en cuenta las particularidades del contexto migratorio en el país en donde se transversalizan asuntos como empleo, educación y la violencia por actores armados, entre otros.

Palabras clave: Barreras de acceso a los servicios de salud; Grupo étnico; Migración interna; Narrativa Personal[1].

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1 Los términos clave han sido recuperados a partir del Tesauro [DECS (Ciencias de la Salud)].

RESEARCH ARTICLE

Resumo

Introdução: Migrar internamente implica enfrentar uma série de condições que impedem ou atrasam a utilização de serviços relacionados com o bem-estar, incluindo serviços de saúde; **(ii) objectivo:** compreender as barreiras ao acesso aos serviços de saúde da perspectiva dos migrantes de Chocó residentes em Medellín; **(iii) metodologia:** estudo qualitativo, foram realizados dois grupos focais com a participação de 13 pessoas com experiência de migração do departamento de Chocó para Medellín; **(iv) resultados:** população migrante afro-colombiana do departamento de Chocó para Medellín. **v) conclusões:** A população migrante experimenta barreiras no acesso aos serviços de saúde. É necessária uma abordagem intersectorial a este problema, tendo em conta as particularidades do contexto migratório no país onde questões como o emprego, a educação e a violência por parte de actores armados, entre outras, são transversais.

Palavras-chave: Barreiras ao acesso aos serviços de saúde, Grupo étnico, Migração interna, Narrativa pessoal.

Introduction

Internal migration is the movement of people that occurs when they decide to permanently or eventually change their place of residence to other cities, municipalities or towns in the same country. Displacement, on the other hand, is the forced or obligatory movement of people who must flee their territory and who have abandoned their homes or habitual residence to escape the effects of armed conflict or environmental disasters, among others (International Organization for Migration, 2006a, 2006b).

Migration is established as a resource that people resort to in order to achieve their objectives, face financial crises or improve their quality of life (Granados, 2010; Rojas et al., 2011); a decision that, in parallel, involves experiencing a series of changes in economic, employment, work and lifestyle conditions. In the Colombian context, international and internal migration is a selective process related to socioeconomic status and educational level (Ministerio de Salud y Protección Social y Profa- milia, 2015).

In the country, the two reasons for migration for all wealth quintiles are for family and economic issues. However, the third cause for the highest income quintile is education and for the poorest quintile is violence by armed groups (Ministry of Health and Social Protection and Profamilia, 2015). The majority of internal migrants in the country are women, which reflects the feminization of the migratory phenomenon. The migrant population is relatively young, six out of ten are under 29 years of age (Ministry of Health and Social Protection and Profamilia, 2015).

The department of Chocó is one of the departments of Colombia considered as an expeller, it is co- noce that 75 people out of every 1000 have migrated and in Medellin reside approximately 32,855 people coming from that department (Departamento Administrativo Nacional de Estadística, 2018). As part of the argument to explain this dynamic, Medellin's labor and economic offer behave as pull factors.

Migrants may face difficulties in accessing housing, work, social services and health care upon arrival at their destination. Because of its consequences, it has been conceptualized that this can be configured as a social determinant of health (Cabieses et al., 2017). Phenomena such as the socioeconomic residential segregation faced by migrants reveal the ways in which these difficulties in accessing basic services arise (Rodríguez and Martínez, 2021).

In relation to the obstacles to accessing health services, delays have been documented in accessing care and being able to reconcile work issues in order to attend consultations with the health professional (Búron, 2012). On the other hand, given the administrative procedures that must be carried out, according to the characteristics and dynamics of the health systems, health care is delayed (Obach et al., 2020). Additionally, it has been described that there is little or no information that allows people to know where to go, what to do and how to do it, which is related to poor access to health care for the migrant population (Dzúrová et al., 2014; Woodward et al., 2014).

Access to health services is understood as the ability of the individual to use them when and where they are needed, which occurs within the framework of a delivery system, which contains a series of peculiarities depending on the health policies of each context (Aday & Andersen, 1974). Understanding access to health services requires examining the barriers to access, i.e., the factors that impede access to health services.

access to health care. In terms of their classification, barriers can be experienced from the supply or demand side. The former refer to the resources of the delivery system (volume and distribution) and its organization (conditions for entry and structure). The latter are related to predispositions, capacity and need for care (Aday & An- dersen, 1974).

Access to health services can be affected by several social and demographic characteristics, such as: level of education, gender, age, type of employment, affiliation to the general social security system, place of residence, and procedures within the health system, among others (Aday & Andersen, 1974). In Colombia, despite having coverage greater than 95% in health social security affiliation, there are still barriers to access to health services (Restrepo et al., 2018). Among others, there are challenges to implement optimal models to achieve, in addition to universal coverage, access to health services and thus achieve equity in health (Bejarano, 2019).

In the specific case of internal migration, it has been pointed out that information on the needs of internal migrants, as well as the difficulties and abuses they face, is necessary to develop public policy strategies (Duarte and Montoya, 2020). Previous research conducted in the city has investigated the barriers to access for women to prenatal check-ups (Hoyos and Muñoz, 2019), and for older adults (Agudelo et al., 2014; Peña et al., 2016). For the above reasons, this research exercise is necessary because it allows us to approach how internal migration is linked to access or not to health services and places migrants as central elements in the analysis.

We are not aware of a study oriented to analyze the access barriers of internal migrants in Medellin, particularly those coming from Chocó. In this sense, the objective is to explore the barriers to access to health services of the Afro-Colombian population from the department of Chocó to Medellín.

THEORETICAL REFERENCES

MIGRATION

Migration processes have generated interest among researchers, as the globalization process has made it possible to change the place of residence within the same country of birth, since internal migration has established itself as a growing social reality and as an economic strategy, since it allows solving unsatisfied basic needs, obtaining new job opportunities, improving income and achieving a greater offer for access to the higher education system (Asprilla, 2016).

Migration is not only a change of place of residence, it implies leaving a common place to reach another, with new social dynamics and trying to maintain yours and gradually gain a new place (Granados, 2010). Two geographical zones are involved in the migratory process, one where migration begins, called the zone of origin, and the zone where migration ends, called the zone of destination (Welti, 1997 cited in Franco, 2012). Upon arrival in the destination community, migrants may face numerous difficulties related to access to housing, work, health care and other social services. Thus, migrants may face numerous difficulties related to access to housing, work, health care and other social services.

as they are exposed to the social determinants of the new space in which they find themselves which, in some cases, is aggravated by greater conditions of inequality, marginalization, xenophobia and discrimination (Cabieses et al., 2017).

Migration is considered an important event that forces people to maximize their ability to adapt to the new environment, which can affect their health (Rojas et al., 2011). Migrating can result in a development chain that can be reflected by individuals, passes through families and communities, and subsequently reaches countries (International Organization for Migration, 2013).

For its part, there is consensus in the scientific community on the recognition of migration as a social determinant of health, being a dynamic process that goes beyond biological variables and includes changes in lifestyle, social and socio-environmental conditions, socioeconomic, political and structural changes. These changes can mean difficulty in integrating into new ways of life and environments, as well as greater vulnerability and health risks for migrants, their families and the communities that host them (Cabieses et al., 2017). There are different causes and types of existing migration; there is contrast between the areas of attraction and rejection, this affects the direction and intensity of migration, which in turn exacerbates their differences by changing the size of the area of origin and the destination population (Franco, 2012).

ACCESS TO HEALTH SERVICES

One of the dimensions where greater inequality has been observed is access to health services, since many times the process of seeking care is not completed or even not initiated due to supply or demand barriers (Mejía et al., 2007). The most vulnerable are those who face the greatest barriers: those living in socioeconomic poverty, minority groups, women and others who face stigma and discrimination (Cabieses and Bird, 2014).

Growing inequalities around the world mean that approximately 100 mi- lion people are pushed into poverty when paying out-of-pocket for health services. Currently, more than 1 billion people are unable to obtain the health services they need because those services are inaccessible, unavailable, unaffordable, or of poor quality (World Health Organization, 2018). Thus, access to health services turns out to be the final expression of the schemes implemented to guarantee the financing and provision of services in a given context (Cabieses et al., 2017), which can mainly improve the health of individuals and populations by providing high-quality interventions to those who can benefit from them (Shengelia et al., 2005).

Access to health services is a concept that seeks to explain operationally how the gateway to the health system functions, regardless of its type (public, private or mixed), as well as the relationship between patients demanding health care and the different services that make up such health structures (Valencia et al., 2007). On the other hand, it is inextricably linked to the type of health system available, the general level of development of the country, its demography and geography, and broader issues such as the population's beliefs and values about health and ill health. For this reason, access to health care can vary widely across populations, depending on many social, economic and cultural factors (Cabieses and Bird, 2014).

Ensuring equal access to health care is an important goal for all countries,

but it is especially difficult in low- and middle-income countries (LMICs). Despite the wide use of the concept of access, it continues to be defined and measured in very different ways (Cabieses and Bird, 2014).

In a critical review of international literature (Cabieses and Bird, 2014), the following components of access are identified as important: i) physical or geographic access refers to the availability of health services, which reflects whether the right health care provider/service is available in the right place at the right time to meet the health needs of the population; ii) financial access, which refers to affordability, including the total cost of using the service for the individual and the individual's ability to pay in relation to the family budget.ii) Financial access, which refers to affordability, including the total cost of using the service to the individual and the individual's ability to pay in relation to the family budget. iii) Socio-cultural access, which refers to the population's acceptability of the health service provision.

ADAY AND ANDERSEN THEORETICAL MODEL

The theoretical model proposed by Aday and Andersen was selected to explore the barriers to access to health services of the Afro-Colombian migrant population from the department of Chocó to Medellín since it allowed understanding access to health services as a whole, that is, the study of access to health services follows the logic of multi-causality: factors and levels as explanatory axes that allow responding to the objective of this research. The purpose of the model is to discover the conditions that facilitate or impede utilization (Rodriguez, 2010b).

In relation to the characteristics of the delivery system, reference is made to the way in which the delivery of services is organized for the potential care of consumers. Two essential elements are located in this area: resources and organization. In relation to the former, this includes personnel, the structure in which care is provided and the equipment and materials used. Regarding the second, it corresponds to the process of entry into the system, i.e., travel and waiting times; and the characteristics of the system that determine what happens to the patient after entry, who they consult and what treatment they receive (Aday & Andersen, 1974).

According to the characteristics of high-risk groups, reference is made to predispositions, capabilities and needs, which act as individual determinants for the use of the service. The predispositions category includes: age, sex, race, religion and the individual's assessment of health and disease. Capabilities account for all the means that people have to use health services, including income level, health insurance coverage and the characteristics of the community in which the individual lives. Finally, need is related to the severity of illness, which in turn is a direct reason for using health services (Aday & Andersen, 1974).

In relation to the use of health services, this can be characterized in terms of type, place, reason and time interval. Type refers to the type of services received and the health agent providing them (hospital, physician, dentist, pharmacist, etc.). Place refers to whether it is a medical center, hospital outpatient department, emergency room, etc., where the care occurs. The reason for the visit refers to whether the visit is a preventive, therapeutic or personal care visit in a non-medical setting. And finally, the time interval can be expressed in terms of contact, volume or continuity (Aday & Andersen, 1974).

METHODOLOGY

A qualitative approach was used to the extent that, given the nature of the research question to be addressed, this type of approach enables inquiry into relational dynamics in a local and contextualized manner and is characterized mainly by being emergent, inductive, rather than strongly configured (Vasilachis et al., 2006). Considering that, according to the literature review that accompanied the development of this study, the scope of this research is exploratory.

The technique for the collection of research information was developed within the framework of the health emergency declared by Covid-19. Thus, it was necessary to make adjustments in the procedure so that the modality of face-to-face focus groups was changed to remote virtual focus groups, due to the fact that it was not possible to establish personal contact with the research subjects. Regarding the development of this collection technique, some recommendations already mentioned previously (Archibald et al., 2019) were followed.

The participants were contacted by telephone based on information provided by the ethnic groups team of the Mayor's Office of Medellin. In total, two focus groups were formed with a total participation of 13 people with migration experience from the department of Chocó to Medellín. The focus groups were conducted by the first and second author of this article and a third person who acted as facilitator.

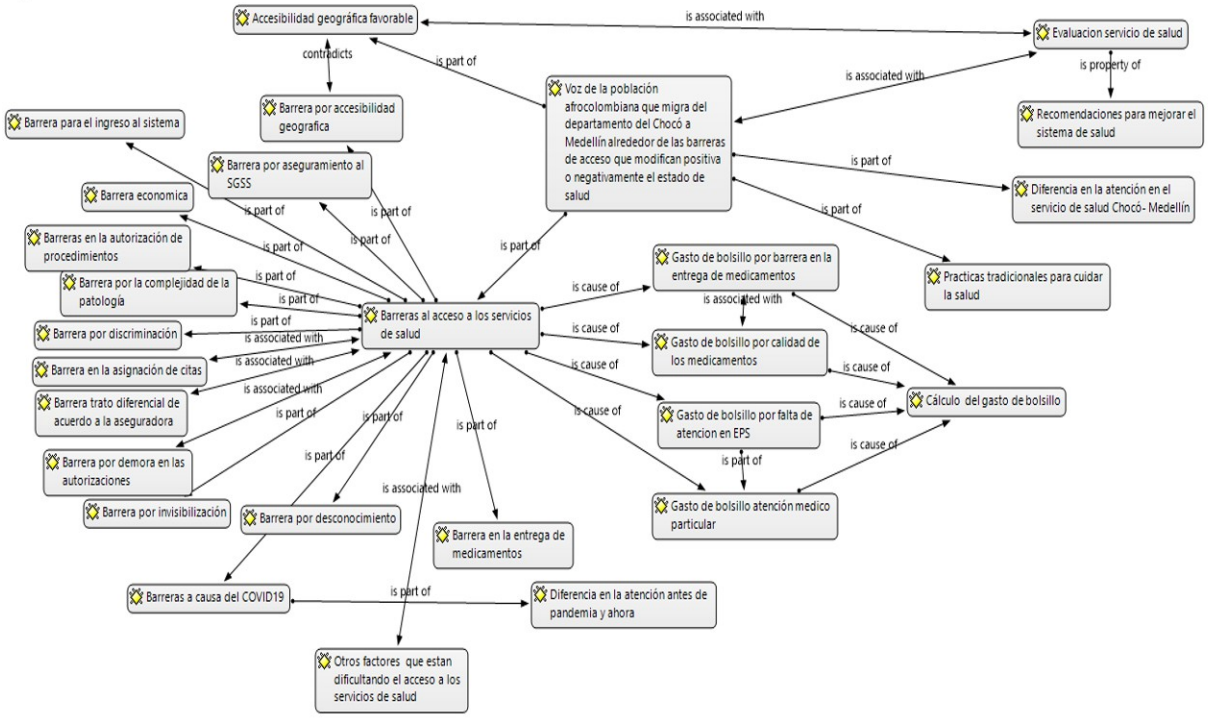
The focus group guide was developed with the purpose of going deeper into some relevant aspects to understand the barriers to access to health services and was based on some questions that guided the meetings: How has your experience been in relation to access to health services in the city of Medellin, what type of barriers do you encounter most when you go to the health services, what factors do you think are hindering access to health services for the migrant population, and what factors do you think are hindering access to health services for the migrant population, and what factors do you think are hindering access to health services for the migrant population?

For the analysis of the data, the discourses were interpreted using narrative content analysis (Ruiz, 2012). For this purpose, the narratives were segmented by type of barriers, a first coding of the data was carried out, and then they were grouped into categories based on the questions posed. Finally, a synthesis of these categories and subcategories was made from the domains of interest discovered, oriented to account for the barriers to access to health services of the Afro-Colombian migrant population from the department of Chocó to Medellín.

The virtual focus groups were transcribed verbatim, being faithful to what was expressed by the participants, then the data were coded in the data processor Atlas-Ti© version 8 (CES University License). All the categories were the result of the analysis of the data that emerged from the remote virtual focus groups with the participants.

Figura 1

Codificaciones barreras de acceso a los servicios de salud desde las narrativas de la población afrocolombiana



Fuente: Elaboración propia

The criteria for participation in the research were: a) Afro-Colombian migrants from the department of Chocó who at the time of the research resided in the city of Medellín. b) Afro-Colombian migrants who agreed to participate and signed the informed consent form. c) Afro-Colombian migrants of legal age (18 years of age). The exclusion criteria were: a) Persons with some cognitive or other type of limitation.

The research was classified as minimal risk according to Resolution 8430 of 1993 (Ministry of Health, 1993). This article is part of the doctoral thesis work entitled "Barriers to access to health services and health status of Afro-Colombian migrants from the department of Chocó to Medellín 2020", approved by the Human Ethics Committee of Universidad CES, registered in minute No. 125 of August 8, 2018.

RESULTS

Socio-demographic characterization

Persons between 19-29 years of age accounted for 7.7%, 30-59 years of age 69.2%, older adults aged 60 years and over accounted for 23.1%. According to marital status, 53.8% do not have a partner and 46.2% have a partner. According to the municipality of birth, 30.8% migrated from Quibdó, 23.1% migrated from Alto Baudó, 23.1% from Quibdó and 46.2% from Alto Baudó.

15.4% migrated from Tadó and 7.7% migrated from Bahía Solano, Condoto, Carmen del Atrato and Medio Baudó, respectively.

According to the migration period, the highest proportion of migration is from 1997-2006 migrated 46.2% of people, before 1996 migrated 7.7%, from 2007 to 2016 38.5% and from 2017 onwards 7.7%. According to the causes of migration, 46.2% migrated because of violence due to armed groups, 15.4% in search of economic improvement and 38.5% for other causes.

Regarding educational level, 7.7% of people do not read and do not write, 7.7% have primary education, 69.2% have secondary education and 15.4% have higher or university education. Finally, 46.2% of people participated in focus group 1 and 53.8% of people participated in focus group 2 (See Table 1).

Table 1.
Characteristics of the population participating in the focus groups

Variable	n	%
Age		
19-29	1	7,7
30-59	9	69,2
60-85	3	23,1
Sex		
Man	7	53,8
Woman	6	46,2
Marital Status		
No partner	7	53,8
With partner	6	46,2
Municipality Nacimiento		
Upper Baudó	3	23,1
Solano Bay	1	7,7
Condoto	1	7,7
Carmen de Atrato	1	7,7
Middle Baudó	1	7,7
Quibdó	4	30,8
Tadó	2	15,4
Year of arrival Medellín		
Prior to 1996	1	7,7
1997- 2006	6	46,2
2007 -2016	5	38,5
2017 onwards	1	7,7
Reason for migration		
Violence caused by armed groups	6	46,2
Search for better economic	2	15,4
Other causes* Other causes* Other causes* Other causes* Other causes* Other causes* Other causes* Other causes* Other causes	5	38,5
Educational level		
Does not read, does not write	1	7,7
Primary	1	7,7
Secondary	9	69,2
College or University	2	15,4
Focus group participation		
Group 1	6	46,2
Group 2	7	53,8

Note: *Other causes: Education, family reasons, health, natural phenomena Source:

Barriers to entry to health services

Although the Colombian state must guarantee access to health services, Colombian internal migrants report having barriers to access services due to lack of insurance. This implies experiencing difficulties in receiving care from health care providers and the denial of the opportunity to receive the care they require because they do not have the capacity to pay. This situation is expressed by migrants as a deprivation of the right to enjoy a good state of physical and mental health.

35-year-old female; Citation 2:29

"They ask you if you have insurance, you say: 'I don't have insurance! just for the heck of it, they take care of you [...] even the medicine they don't give you properly because you don't have money... I do think that's a bad thing".

They also report presenting barriers due to delays in the provision of health services. The population transits unsuccessfully in the city's health institutions where they are not attended. Consequently, they incur out-of-pocket expenses, i.e., affecting the economic capacity of the families for private health spending and limiting the recovery of their health condition.

40-year-old male; Citation 2:107

"When it comes to cases that require special attention, go to such and such a place, go from one place to another, what we call the millionaire's walk and the walk of death, we can't attend to them here [...] Finally, you have to take money from where you don't have it, to pay for private doctors.

They also identify barriers to access to health services due to the lack of information to guide the migrant population on providers and on how health services are provided (rights, portability of services, places of care, prevention and promotion programs, delivery of medication and others). This implies the completion of a greater number of procedures by a population that is ultimately unaware of its duties and rights in the use of services.

40 year old male; Citation 2:87

"I would believe that one of the main barriers when arriving here in the city has basically to do with the lack of knowledge of the spaces or how the health system is managed here in Medellín [...] for no one it is a secret that the health centers [...] are in almost every community, but not having clear information on where to go to request an appointment and not knowing the city plays against it."

Moreover, they express barriers to access to health services due to the non-recognition by municipal institutions of these people's settlements in some sectors of the city, which is expressed in the scarcity of health services, little data on ethnic-racial composition, and unequal access to care.

47-year-old male; Citation 2:112

"The health secretary has failed to make these territories visible to high-risk, high-risk people.

vulnerability where black communities are, so it is a shortcoming where it was identified that in the health system there are no variables of black communities, there are no data of black communities, but that has to do with the issue that they did not take into account that most of the population has a context and we are stigmatized as subjects of displacement".

At the same time, they refer to barriers to access to health services due to unfavorable geographic accessibility. It is evident that the Afro-Colombian migrant population from the department of Chocó to Medellín is settled in part of the periphery of the city of Medellín, which makes it difficult to travel to health care sites.

47 year old male; Quote: 2:13

"A lot of us live isolated in the peripheries and it turns out that the system does not go to the peripheries, so for example in the rooftop park, at the time they take the comprehensive health program, but it turns out that they do not take into account the black communities that live in the peripheries and that it is difficult for them to go down."

Barriers within the health services

The Afro-Colombian population identifies barriers within the health services related to discrimination, i.e., they experience differential treatment due to their skin color and culture. Prejudice based on racial-ethnic status can have negative consequences on health status, inequity in access to health services and discourage the use of services.

60-year-old woman; Citation 2:24

"And as far as racism is concerned, it is noticeable how the attention to those of us who are Afro is different from the mestizo people, we cannot deny it because some manage their racism in a hidden way or a micro racism and they do it in a very disguised way that you do not notice, or if they say something to you because of your skin color, they conceal it with something that you are left believing that the first part that was said has nothing to do with it or is not bad, so it is noticeable in the officials, in the attention and also in some doctors who are also inclined when the user or client is from an ethnic minority".

In addition to the above, the internal migrant population experiences barriers due to delays or denial of self-certification for health procedures, which fragments care, complicates recovery processes, increases paperwork and forces the user to resort to private health services. These structural barriers in the service network increase health care costs and delay diagnosis.

35-year-old female; Citation 2:18

"I have needed an ultrasound for two years, because I had surgery to avoid having more children and this is the height [...] I have never received the paper, they have never called me to explain why or when they are going to do it, they never authorize it".

40-year-old male; Citation 2:140

"They usually take a month, two months or up to six months to authorize procedures sometimes,

The sooner the case is diagnosed or attended to, the more likely it is to get better.

DISCUSSION

The results of this research revealed contextual conditioning factors and the dynamics of health care in the Colombian health system, which generate obstacles to access to health services for the migrant population from the department of Chocó to Medellín.

The barriers experienced by migrants from Chocó to Medellín are at the entrance of health services because they are not insured in the SGSSS and the consequent denial of the service, lack of information for timely access to health services, lack of recognition of settlements of this population in the city and unfavorable geographic accessibility. Within the health services, they recognize barriers associated with the color of their skin and barriers due to delays in authorization for procedures. In agreement with this research, Sznajder et al. (2020) identified that migrants face a series of challenges that negatively affect their health.

Barriers are caused by factors such as segregation and stigma, which are linked to gender inequality, living conditions and socioeconomic disadvantage (Pan American Health Orga- nization, 2021). According to the National Population and Housing Census (Departamento Administrativo Nacional De Estadística, 2018) the deprivation indicator of households with at least one person who self-recognizes as belonging to the Black, Afro-Colombian, Raizal and Palenquera population presents more ba- rriers to access to health services with 8.9% compared to the rest of the Colombian population which presents 6.2%.

At the global level, the Pan American Health Organization estimates that at least half of the world's inhabitants still do not have comprehensive coverage of basic health services (Pan American Health Organization and PAHO/WHO, 2021). At the national level, the Ministry of Health and Social Protection states that 1% of Colombians do not have health insurance, which is an important determinant of the disparities in access to health among ethnic groups (Viáfara et al., 2021).

Another relevant issue that reflects the context in which the migration process takes place is around its causes. Almost half of those interviewed stated that this was due to violence by armed groups, an issue that, according to previous research, corresponds to the third motivation of internal migrants from the lowest income quintile (Ministry of Health and Social Protection and Profamilia, 2015). On the above, Afro-descendants began and ended the last decade with higher poverty rates than whites and mestizos; they are also less socially mobile than their compatriots. Mobility analysis shows that Afro-descendant families are 2.5 times more likely to live in chronic poverty than non-Afro-descendant households (World Bank, 2018).

The lack of visibility of the internal Afro-Colombian migrant population is another important factor to be addressed. The lack of knowledge of the size of the population is expressed in barriers to access to opportunities for the improvement of their quality of life. Official data regarding the Afro-Colombian population are precarious in terms of conditions, marginalization, poverty and exclusion (Ingleby, 2012).

The limitation of specific statistics that explain the existence, characteristics and of the Afro-Colombian population is considered one of the most visible forms of structural racism (Rodriguez, 2010a). The lack of information does not allow for measuring and understanding the complexity of the social reality; this means delays, socioeconomic segregation and lack of institutionalization in the provision of services, especially health services, which can negatively impact the experience of internal migration (Sun & Yang, 2021). Statistical data and the characterization of the Afro-Colombian population are essential for the distribution of services and economic resources, as well as the formulation of public policies that positively impact this population.

Another recurrent barrier expressed by the research participants was the differential treatment they received in health care, related to their skin color and belonging to an ethnic minority. In terms of health services, there are large disparities between white and mestizo populations and Afro-Colombian communities (Tovar et al., 2020). It is clear that the greatest difference between the health indicators of the majority and minority groups is in the quality of care they receive (Torres, 2001), and there are unfavorable attitudes of health professionals towards the ethnic population.

On the other hand, power and domination relations mediated by race, racism and ethnicity have been documented in societies and cultures of different times and places (Lamus, 2012). Such relations are based on negative racial stereotypes rooted in the dominant culture and act as a configu- ration of the institutional structures of society, exacerbating health inequalities (Williams & Mohammed, 2009). Discriminatory treatment of the internal migrant Afro-Colombian population implies deficits in terms of coverage and quality of care, disincentives the user to use the services, fear or shame when attending a health service, resulting in lags in access, lower quality of life and low health indicators. Discrimination also exacerbates inequalities in health care, and exclusion has negative consequences (Hurtado et al., 2013).

On the other hand, it was possible to point out the barriers due to lack of information to access health services on the part of the migrant population. They experienced a lack of knowledge about the functioning of the health system, points of care, health promotion and disease prevention programs, as well as a lack of knowledge about the supply of medium and high complexity services. This situation implies more paperwork on the part of the users, lack of knowledge of their rights in health and, finally, people who drop out of access to services. In accordance with the above (Hernández et al., 2015) observe in their study that users' lack of knowledge of the regulations has become an obstacle to real access to health care.

However, portability of health services could be another reason why barriers to access to health services among the Afro-Colombian migrant population could be being created due to a lack of knowledge. Portability applies when an affiliate changes his/her place of residence on an occasional or temporary basis, for a period of more than one month and less than twelve months. Therefore, the person must inform the EPS (Ministry of Health and Social Protection, 2022), when a person does not make such a request, he/she will only be able to receive care in emergency services, this situation implies difficulties for effective access to health services.

To reduce access barriers due to lack of information, the Danish Refugee Council (2021) proposes to carry out promotion and publicity activities with information for migrants and refugees.

The Afro-Colombian population is not only disadvantaged in terms of access to health care centers, but also in terms of the time it takes to travel to the health care center for a consultation, which takes more than 31 minutes, and some socioeconomic characteristics of the Afro-Colombian population. As for unfavorable geographic accessibility to health care centers, this is related, on the one hand, to the time required to travel for a consultation of more than 31 minutes and, on the other hand, to some socioeconomic characteristics of the Afro-Colombian population that make it difficult to access health services.

Having a low level of economic income prevents people from being able to defray the cost of travel to places of care, obtain co-payment services, which translates into unequal access to health care. In line with this finding, Vargas (Vargas, 2009) points out that financial barriers are more related to transportation costs to perform procedures and receive care due to the geographic inaccessibility of services, and co-payments for services. In addition to the above, another barrier to access to health services in the participating population was the discontinuity of health services due to denial of authorization for procedures. The interruption of health treatments and services not only affects the users and the management of their treatment, but also has family, work, economic, social and other consequences (Rodriguez et al., 2015). In addition to the increase in the cost of medical services due to the fact that people have to consult many times to try to solve the health situation. The lack of continuity of care was described as a result of the structure or development of the system itself (Rodriguez, 2010b).

Finally, it is essential to adapt cultural strategies when it comes to the provision of health services to recognize the current needs of Afro-Colombian internal migrants, which should be part of a comprehensive approach to internal migration, given that it intersects with issues such as education, employment, and armed violence.

Limitations

Study participants may have omitted, not remembered, or modified the experience of access to health services. On the other hand, the study was conducted under a SARS Covid-19 pandemic scenario characterized by high unemployment rates, informal economy and restructuring of health services, so it is possible that the results of the research were influenced.

CONCLUSIONS

The barriers identified by the Afro-Colombian migrant population from the department of Chocó to Medellin include obstacles at the entrance to and within the health services. This implies health inequities exacerbated by the interruption of health services and treatments, increased economic costs due to multiple displacements to try to access health services and the payment of private health services.

An intersectoral approach is required in order to guarantee an efficient and effective social impact on health services, taking into account the characteristics of the internal migrant population in the country where issues such as employment, education and violence by armed actors, among others, are cross-cutting.

This study allows decision-makers to guide policies, programs and strategies that will improve the quality of their products and services.

The study also aims to improve access to health services for Afro-Colombian internal migrants. On the other hand, it encourages public health and social science researchers to delve deeper into internal migration and its impact on access to health services for Afro-Colombian populations.

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