http://revistas.unheval.edu.pe/index.php/repis/
https://doi.org/10.35839/repis.5.4.1150

Migration and health, a look from the 2018 Census in Colombia

Migración y salud, una mirada desde el Censo 2018 en Colombia

Jaime Martínez-Santa[1], Julieth Andrea-Castañeda[2], José I. Alfonso-Mantilla[3,a]

Abstract

Introduction. The human being is characterized by having specific development spheres such as social, physical, family, spiritual and emotional. People known as migrants because they are outside their cultural, family and community sphere, and under atypical conditions they adopt new practices and styles of life , which causes risks to their own health and to the community by which they have been welcomed. **Methodology.** A descriptive study was carried out with the following variables from the 2018 Colombian census: five-year ages, sex, year of arrival in the country, any health problem in the last 30 days, main treatment of the health problem, attention to the health problem, quality of health service provision, any difficulty in their daily life, health insurance, barriers to access to health services, barriers to early childhood care services. **Results.** Health care for the migrant population in Colombia is not on the fringes of e the one that had its own population and there is no major difference in terms of quality and coverage, gender and access barriers, which are equal to the general population without differences with respect to the child population. Although health insurance is lower than the general population, only half of the migrants give formal treatment to their health problems. **Conclusion.** Specific policies should be established to promote health care for migrants, as this is a challenge for public health due to access policies and the care provided. which are equal to the general population without differences with respect to the child population. Although health insurance is lower than the general population, only half of the migrants give formal treatment to their health problems.

Keyword: migration, health condition, policies, quality, perception, access.

Resumen

Introducción. El ser humano se caracteriza por tener esferas de desarrollo especifico tales como social, física, familia, espiritual y emocional, Las personas conocidas como migrantes al estar fuera de su esfera cultural, familiar y comunitaria, y bajo condiciones atípicas adoptan nuevas prácticas y estilos de vida, lo que ocasiona riesgos para la salud propia y de la comunidad por la cual han sido acogidos. **Metodología.** Se realizó un estudio de tipo descriptivo con las siguientes variables del censo de Colombia de 2018: edades quinquenales, sexo, año de llegada al país, algún problema de salud en los últimos 30 días, tratamiento principal del problema de salud, atención del problema en salud, calidad de la prestación del servicio de salud, alguna dificultad en su vida diaria, aseguramiento en salud, barreras de acceso a los servicios de salud, barreras a servicios para cuidado de la primera infancia. **Resultados.** La atención en salud de la población migrante en Colombia no está al margen de la que tenía la población propia y no hay mayor diferencia en cuanto a calidad y cobertura, género y las barreras de acceso las cuales son iguales a la población en general sin diferencias con respecto a la población infantil. Aunque el aseguramiento en salud es menor que la población general solo la mitad de los migrantes dan un tratamiento formal a sus problemas de salud. **Conclusión.** Se deben establecer políticas específicas para promover el cuidado en salud de las personas migrantes al ser esto un desafío para la salud pública por las políticas de acceso y la atención brindada.

Palabras clave: migración, condición de salud, políticas, calidad, percepción, acceso.

[1]Physiotherapist Universidad Nacional de Colombia, Specialist in Epidemiology Universidad del Rosario, Specialist in Statistics Universidad Nacional de Colombia, Specialist in Forensic Anthropology Universidad Nacional de Colombia, Specialist in Physiotherapy in Critical Adult Universidad del Rosario, specialist in Demographic Analysis Methods Universidad Externado de Colombia, Colombia.
[2]Statistician Universidad Santo Tomas, Demographic Analysis Methods Specialist Universidad Externado de Colombia, Colombia.
[3]Physiotherapist, Universidad del Rosario, Colombia.

ORCID:
[a]https://orcid.org/0000-0003-2597-1826

Corresponding author:
José Iván Alfonso Mantilla

Postal Address: Universidad del Rosario, Colombia.

Email: josealfonso25@hotmail.com

Reception date: august 04, 2021

Approval date: october 22, 2021

Quote as: Martínez-Santa J, Andrea-Castañeda J, Alfonso-Mantilla JI. Migración y salud, una mirada desde el Censo 2018 en Colombia. Rev. Peru. Investig. Salud. [Internet]; 5(4): 305-310. Recuperado de: http://revistas.unheval.edu.pe/index.php/repis/article/view/1150

Introduction

Currently, the concept of migration has been defined and developed according to authors as specific structural events that have been increasing in developing countries, where people's health has been a focus of attention for public entities in places of destination and origin, prioritizing health care for this population, highlighting the causal relationship between migration and health as challenges at the organizational and operational level of the provision of health services (1, 2).

The human being is characterized by having specific development spheres such as social, physical, family, spiritual and emotional. People known as migrants when outside of their cultural, family and community spheres adopt new living conditions, which causes risks to their own health and to the community by which they have been welcomed. This new lifestyle is related to an alteration in development at an economic level due to the inability to access formal jobs due to social and contractual conditions caused a precariousness in the condition and quality of life of primary care services, altering the health of migrants (3-5).

The disease patterns of migrants are influenced by the external conditions of the places of origin and destination, being categorized by the lifestyle of the countries, migration itself determines the health conditions of the people, intervening main factors as sequential causes of migration. specifies such as the migration zone (rural-urban) (6, 7), environmental characteristics and family situation (8). This implies risks for health care such as exposure to diseases, social and economic adjustment influenced by educational level and the perception of the state of health (4, 9), this situation is aggravated by factors such as the high cost of living in developing countries(10-12).

Access to health services,it is a factor of vulnerability for this population leading to changes in public health; Health vulnerability is understood as the lack of protection of specific population groups that present particular health problems, as well as the disadvantages they face in solving them, compared to other population groups (13, 14). Health care for these population groups is not at the margin of that of the own population and there is no major difference in terms of quality and coverage(4, 15, 16). Inside this group is important highlighting the women and children, who underuse the services available mainly due to ignorance or fear of being deported if they are in an irregular situation. One of the challenges is treating diseases that were under control again (17) generating a public health problem for this population (18).

This situation in general produces an important change in other demographic variables such as fertility and mortality. This translates into a wide range of health needs ranging from reproductive health care, maternal and child health, contagious diseases, emergency interventions, chronic diseases, mental and behavioral disorders (19). In some states only prioritize care in emergencies where the life of the person is altered, leading to public health risk (20). This is how the importance of the evaluation and analysis of this process is made visible where it is proposed specific analysis models for the migration and health binomial with 3 components: the individual (community and family microenvironment, socioeconomic macroenvironment), the determining factors of health conditions (lifestyle, family structure and dynamics, community organization, production-employment) and the production areas of health services (self-care, conventional and non-conventional services) (21).

The organizations in charge affirm that the obligations of the States is to provide equity and equality in access and care to health services to all people, including migrants at all levels of health care(22, 23). For example, Colombia is experiencing an important migration phenomenon, formulating access policies and plans and information strategies. This has led to regulatory developments in health originating from the migratory phenomenon because to date it is estimated that in Colombia the number of international migrants settled is from1,772,919, of which approximately 56% are irregular (5, 24). The country does not have a law that is consistent with reality or with the demands generated by the current migratory reality, unlike other countries in the Latin American and Caribbean region that have initiatives at the level of laws or policies that seek to grant benefits in health to international migrants (25-27).

Due to the situation exposed to the growing increase in migration in Colombia and being considered a public health problem that directly impacts demographic and health indicators, this article aims to analyze the health status of the migrant population based on the 2018 Population Census to find possible interrelationships that support the close relationship of the migration / health binomial.

Materials and methods

In order to establish the context on the issue of migration and health, the following antecedent sources were examined from: (i) refereed and indexed scientific publications, using the following keywords consulted in DeCs: Migration, health condition, policies, quality, perception, access; The following databases were used: Pubmed, Science Direct, ElSevier, Springer Link, Scielo. The inclusion criteria were: descriptive and analytical studies in the last 20 years and that were in the English or Spanish language; (ii) secondary sources of the microdata bases corresponding to the 2018 National Population Census carried out in Colombia whose access is free and available to the general public.

A descriptive research was carried out with the following census variables: five-year ages, sex, year of arrival in the country, any health problem in the last 30 days, main treatment of the health problem, quality of health service provision, any difficulties in their daily life, health insurance, and barriers to accessing health services

The variables were processed in Redatam registered in a database designed in Excel 2016. A univariate analysis of the variables was carried out and measures of frequency and proportion only will be used. The following study hypotheses were established:
Hypothesis 1: The health of migrants and their families is determined by the access and opportunity to obtain basic health services.
Hypothesis 2: The Health care for migrants is equal to that of the native population and there is no major difference in terms of quality and coverage.

Results

Table 1 shows that the main migrant population in Colombia in the last 6 years corresponded to Venezuelans who represent 87.18% of the migrant population

Regarding the health insurance, the 35% of migrants lack health insurance, this percentage is slightly higher than that of the general population with 20% of the general population.

The 6.98% of the migrants presented some health problem in the last 30 days, of these 56% were female and with an age range between 15 and 59 years, which corresponds to the productive age (76.77%).

Regarding treatment, it is found that only half of the migrant population goes to the social security entity to which it is affiliated, which contrasts with 74.86% of the general population, the migrant population resorts to pharmacies, private doctor or self-medicates in a higher proportion than the rest of the population

In general, when the migrant population is asked about whether they received care for their health problem, there are not very marked differences with respect to the general population. 94% of migrants received care for their health

Table 1. Country of origin migrant population in Colombia

País	2013	2014	2015	2016	2017	2018	Does not inform	Total	%
Argentina	934	1 644	1 493	1 431	1 378	694	14	7 588	0,81%
Brazil	353	714	889	1 018	1 089	607	29	4 699	0,50%
Chile	414	855	986	1 050	1 165	827	10	5 307	0,57%
Ecuador	836	1 757	2 329	3 289	2 744	1 631	129	12 715	1,36%
Mexico	522	819	835	947	1 048	715	16	4 902	0,53%
Panama	380	705	825	978	1 162	601	21	4 672	0,50%
Spain	3 043	4 282	3 209	2 586	2 448	1 345	22	16 935	1,82%
USA	2 528	3 461	3 452	4 007	4 672	2 938	45	21 103	2,26%
Venezuela	6 856	26 580	63 085	136 184	296 290	281 208	2 879	813 082	87,18%
Does not inform	166	18	39	67	139	136	7 498	8 063	0,86%
Other countries	4 091	6 033	5 732	6 143	7 176	4 095	291	33 561	3,60%
Total	20 123	46 868	82 874	157 700	319 311	294 797	10 954	932 627	100,00%

Source Own elaboration based on DANE data 2018 National Population and Housing Census

Table 2. Health insurance

Health insurance				
	General population		**Migrant population**	
		%		%
Without deprivation	34 992 935	80%	605 346	65%
With deprivation	8 842 389	20%	327 281	35%
Total	43 835 324		932 627	

Source Own elaboration based on DANE data 2018 National Population and Housing Census

Table 3. Some health problem

Any health problem in the last 30 days, without hospitalization				
	General population		**Migrant population**	
Yes	4 528 062	10,33%	65 081	6,98%
No	38 844 425	88,61%	866 863	92,95%
Does not inform	462 837	1,06%	683	0,07%
Total	43 835 324		932 627	

Source Own elaboration based on DANE data 2018 National Population and Housing Census

Table 4. Main treatment

Main treatment for health problems				
	General population		**Migrant population**	
He went to the health social security entity of which he is affiliated	3 383 667	74,86%	33 055	50,86%
You went to a private doctor (general, specialist, dentist, therapist or other)	316 709	7,01%	7 218	11,11%
He went to an apothecary, pharmacist, alternative therapies, healers, etc.	183 024	4,06%	6 373	9.81%
He used home remedies	316 085	6,99%	6 412	9,87%
Self-prescribed	193 668	4,28%	7 720	11,88%
Did nothing	126 167	2,79%	4 217	6,49%
Total	4 520 120	100,00%	64 995	100,00%

Source Own elaboration based on DANE data 2018 National Population and Housing Census

problems and 16% of this group perceives a poor-quality health service provision compared to 21% of the general population.

Regarding the existence of barriers to health services, this difference is only slightly higher compared to the general population (8% and 5% respectively), in early childhood the behavior is similar to other age groups in the 2 groups population studied.

Table 5. Quality provision of health services

Quality provision of health services				
	General population		**Migrant population**	
	Total	%		%
Very good	377 451	11%	4 496	15%
Well	2 224 811	68%	21 352	69%
Bad	541 240	16%	3 847	12%
Very bad	148 846	5%	1 253	4%
Total	3 292 348		30 948	

Source Own elaboration based on DANE data 2018 National Population and Housing Census

Table 6. Access barriers

Barriers to access to health services				
	General population		**Migrant population**	
		%		%
Without deprivation	41 569 652	95%	860 122	92%
With deprivation	2 265 672	5%	72 505	8%
Total	43 835 324		932 627	

Source Own elaboration based on DANE data 2018 National Population and Housing Census

Discussion

Migrant health care represents “a challenge for public health, not only considering access and information policies, but above all because of care based on humanized treatment respecting beliefs, values and expectations. A dignified care requires a real commitment from the states and the sensitivity of health care providers, if it is intended to provide comprehensive services based on respect for human rights to this population " (28) The present discussion gives theoretical support to the hypotheses raised. In relation to Migration and gender56% of the migrants who presented a health problem were women, but regarding the differential behavior with men, no major differences were found in terms of access, quality, coverage and attention to the health problem. These results do not coincide with what is reported in the literature where gender inequity is a common element as an explanatory concept of differential access to health services(12, 29, 30) due to the potential risks arising from your situation (31-35). Migration and perception of the state of health. In the results, it was found that the migrant population reported presenting only 6.98% compared to 10.33% of the general population, this may be related to the fact that the migrant may not declare their health conditions upon arrival in the country, and when it elapses. the time of residence may declare worse health states due to the increase in the number of diagnoses of pre-existing health conditions (36, 37) The "influence of culture influences the participation and commitment of the person in health, helping to reduce the incidence and impact of avoidable adverse events in health care" (38, 39) In the present research it was possible to show that the migrant, although 65% has health insurability, only half treats their health problem and Migration and quality of health service provision, the findings of this study show that the migrant population reports a quality of health service provision of 84%, much higher than that reported in the general population (79%), which is in line with migration policies that promote "providing health benefits in a climate friendly to migrants, respecting and considering their identity, cultural, social and religious heritage ".

At the level of Migration and barriers to access to health services is different in each country and although Colombia has some regulations, migrants in a situation of irregularity, since they tend to evade formal mechanisms of attention due to fear of being deported, resorting to self-medication, consultation in the pharmacy or going to a private doctor (25, 40), This coincides with the findings regarding what is the form of treatment of the health problem. However, according to the results obtained from the census, the barriers are similar to those shown by the general population and, finally, in terms of *Migration and barriers to early childhood care services* due to the higher infant mortality rates in our country, the subject was investigated, the literature reports that the infant population that “the migrant leaves behind as and the children who migrate, added to the loss of affective references -fathers, mothers, grandparents or others- increases the probability that they will not receive the same health care, food and adequate protection against all forms of violence. The absences caused by family disintegration carry a significant psychosocial effect that can translate into feelings of abandonment and vulnerability "(41, 42). International migrant children and youth face different health challenges compared to the local population, particularly if they face unsafe environments or adverse social conditions (11, 43). In the data analysis, no major differences were found in terms of barriers with respect to the other age groups. Subsequent analytical studies are recommended to deepen the relationships between the study variables and to model the health condition of migrants.

Conclusions

Health care for the migrant population in Colombia is not at the margin of that of the population itself and there is no major difference in terms of quality and coverage, gender and access barriers, without differences with respect to the child population. Although health insurance is lower than the general population, only half of the migrants give formal treatment to their health problems. Specific policies should be established to promote health care for migrants as this is a challenge for public health by access policies and care provided.

Funding Source

The present study had no source of funding

Authors' contribution

All authors made contributions from their area of expertise to this article.

Conflict of interests

The authors declare that there are no conflicts of interest.

References

1. Caballero M, Leyva-Flores R, Ochoa-Marín SC, Zarco Á, Guerrero C. Las mujeres que se quedan: migración e implicación en los procesos de búsqueda de atención de servicios de salud. Salud pública de México. 2008;50(3):241-50.
2. Stefoni C. Ley y política migratoria en Chile. La ambivalencia en la comprensión del migrante. La construcción social del sujeto migrante en América Latina Prácticas, representaciones y categorías. 2011:79-110.
3. Miguélez F, Recio A. Spain: large-scale regularisation and its impacts on labour market and social policy. Transfer: European Review of Labour and Research. 2008;14(4):589-606.
4. Fernández JA, Orozco KL. Migración venezolana en Colombia: retos en salud pública. Salud UIS. 2018;50(1):6-7.
5. Fernández-Niño JA, Vásquez-Rodríguez AB, Flórez-García VA, Rojas-Botero ML, Luna-Orozco K, Navarro-Lechuga E, et al. Modos de vida y estado de salud de migrantes en un asentamiento de Barranquilla, 2018. Revista de Salud Pública. 2018;20:530-8.
6. Rangel TR. La crisis del sector rural y el coste migratorio en México. Iberóforum Revista de Ciencias Sociales de la Universidad Iberoamericana. 2009;4(8):40-81.
7. Andersen LE. Migración rural-urbana en Bolivia: ventajas y desventajas. Documento de Trabajo; 2002.
8. Agudelo S, Romero I. El concepto de determinates de la salud y su estudio. Universidad de Antioquia. 2010.
9. Meñaca A. Familias rotas y problemas de salud. La medicalización de las familias migrantes ecuatorianas. Quaderns de l'Institut Català d'Antropologia. 2006(22):161-78.
10. Cabieses B, Bernales M, McIntyre AM. La migración internacional como determinante social de la salud en Chile: evidencia y propuestas para políticas públicas. 2017.
11. Cabieses B, Chepo M, Oyarte M, Markkula N, Bustos P, Pedrero V, et al. Brechas de desigualdad en salud en niños migrantes versus locales en Chile. Revista chilena de pediatría. 2017;88(6):707-16.
12. Chepo M, Astorga-Pinto S, Cabieses B. Atención inicial de migrantes en Chile: iniciativa en atención primaria de salud a un año de su implementación. Revista Panamericana de Salud Pública. 2019;43.
13. Yi H, Mantell JE, Wu R, Lu Z, Zeng J, Wan Y. A profile of HIV risk factors in the context of sex work environments among migrant female sex workers in Beijing, China. Psychology, health & medicine. 2010;15(2):172-87.
14. Juárez-Ramírez C, Márquez-Serrano M, Salgado de Snyder N, Pelcastre-Villafuerte BE, Ruelas-González MG, Reyes-Morales H. La desigualdad en salud de grupos vulnerables de México: adultos mayores, indígenas y migrantes. Revista Panamericana de Salud Pública. 2014;35:284-90.
15. Mendoza W, Miranda JJ. La inmigración venezolana en el Perú: desafíos y oportunidades desde la perspectiva de la salud. Revista Peruana de Medicina Experimental y Salud Publica. 2019;36(3):497-503.
16. Caggiano S, Segura R. Migración, fronteras y desplazamientos en la ciudad. Dinámicas de la alteridad urbana en Buenos Aires. Revista de Estudios Sociales. 2014(48):29-42.
17. González Pizarro JA, González Tello PM. Migración latinoamericana en situación de marginalidad. Campamentos y educación en Antofagasta, 2012-2018. Estudios pedagógicos (Valdivia). 2020; 46(2):359-79.
18. Ruiz Sánchez JL, Mendoza Parra YL. ¿ Cuáles son las dificultades que trajo la inmigración venezolana al sistema de salud en Colombia (2015–Junio 2018)? 2018.
19. Moya J, Finkelman J. La migración México-Estados Unidos en el contexto de la salud global. Salud pública de México. 2007;49:4-7.
20. Amon J, Todrys K. Acceso a tratamiento antirretroviral para las poblaciones migrantes del sur Global. Sur Revista Internacional de Direitos Humanos. 2009; 6: 162-87.
21. Frenk J, Garnica ME, Zambrana M. Migración y salud: notas sobre un campo interdisciplinario de investigación. Salud pública de México. 1987;29(4):276 a 87- a 87.
22. Reboiras Finardi LD, Rivera Polo F, Canales Cerón AI, Martínez Pizarro J. Migración y salud en zonas fronterizas: informe comparativo sobre cinco fronteras seleccionadas. 2010.
23. Tamagno C. Situación de los Migrantes Extranjeros en el Perú y su Acceso a Servicios Sociales, Servicios de Salud y Educación. 2017.
24. Ortega Gómez AM, Mejía Turizo J. La salud de los migrantes venezolanos en el Departamento del Atlántico. 2019.
25. Cabieses B, Alarcón A, Bernales M, Astorga S, Martinez F. Informe Final Estudio Licitación Sistematización y Evaluación del Piloto Nacional de Salud de Inmigrantes. Santiago: Ministerio de Salud de Chile En colaboración con Organización Internacional para las Migraciones y Universidad del Desarrollo. 2018.
26. Cabieses B, Gálvez P, Ajraz N. Migración internacional y salud: el aporte de las teorías sociales migratorias a las decisiones en salud pública. Revista Peruana de Medicina Experimental y Salud Pública. 2018;35:285-91.
27. Córdova Muñoz AI, Sierra Baeza RG, Ahumada Cabello R. Percepción de la comunidad peruana respecto del acceso a los servicios básicos de salud, educación y acceso al trabajo: Universidad Academia de Humanismo Cristiano; 2008.
28. Moreno MB, Klijn TP. Atención en salud para migrantes: un desafío ético. Revista Brasileira de Enfermagem. 2011;64:587-91.
29. Castro RP, Bronfman MP. Teoría feminista y sociología médica: bases para una discusión. Cadernos de Saúde Pública. 1993;9(3):375-94.

30. Vega ALB, Ugalde SV. Mujer y migración: alcances de un fenómeno nacional y regional: Editorial Abya Yala; 1995.
31. Sorensen N. Migración, género y desarrollo: el caso dominicano. La migración: un camino entre el desarrollo y la cooperación. 2005:163-82.
32. Ochoa-Marín SC, Cristancho-Marulanda S, González-López JR. Mujeres compañeras de migrantes: imagen social y búsqueda de servicios de salud sexual y reproductiva. Revista de salud pública. 2011;13:183-95.
33. Martine G, Hakkert R, Guzmán JM. Aspectos sociales de la migración internacional: consideraciones preliminares. Revista Notas de Población. 2000; 73: 163-93.
34. Baeza B, Aizenberg L, Barría Oyarzo C. Cultura y salud migratoria: miradas comparativas entre profesionales sanitarios y mujeres migrantes bolivianas. Si somos americanos. 2019;19(1):43-66.
35. Benito MJR, Girón MÁ, Gil CG, Parés AS. Las mujeres inmigrantes en Sevilla: salud y condiciones de trabajo. Una revisión desde la medicina social. Reis. 2003:123-44.
36. Rivera B, Casal B, Currais L. Healthy immigrant effect: trayectoria de salud de la población inmigrante a partir de la ENSE 2011-2012. Estudios de Economía Aplicada. 2013;31(2):339-57.
37. McDonald JT, Kennedy S. Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada. Social science & medicine. 2004;59(8):1613-27.
38. Johnstone M-J, Kanitsaki O. Culture, language, and patient safety: making the link. International journal for quality in health care. 2006;18(5):383-8.
39. Charles C, Gafni A, Whelan T, O'Brien MA. Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. Patient Educ Couns. 2006;63(3):262-7.
40. Salgado de Snyder N, González-Vázquez T, Infante-Xibille C, Márquez-Serrano M, Pelcastre-Villafuerte B, Serván-Mori EE. [Health services in the Mixteca: use and conditions of affiliation in US-migrant and non-migrant households]. Salud Publica Mex. 2010; 52(5):424-31.
41. Bernales M, Cabieses B, McIntyre AM, Chepo M, Flaño J, Obach A. Determinantes sociales de la salud de niños migrantes internacionales en Chile: evidencia cualitativa. Salud pública de México. 2019;60:566-78.
42. Cernadas PC, García L, Salas AG. Niñez y adolescencia en el contexto de la migración: principios, avances y desafíos en la protección de sus derechos en América Latina y el Caribe. REMHU: Revista Interdisciplinar da Mobilidade Humana. 2014;22:9-28.
43. Poveda Rodríguez ST, Villate Niño MP. Derecho a la salud en población infantil migrante venezolana residente en Suacha. 2020.