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ORIGINAL PAPER

Human Mobility and Health: Exploring the Health Conditions of Venezuelan Migrants and Refugees in Colombia

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Abstract

Médecins sans Frontières (MSF) conducted a study to identify health needs and access barriers of Venezuelan migrants and refugees at La Guajira and Norte de Santander Colombian border states. The Migration History tool was used to gather information that included various health-related issues such as referred morbidity, exposure to violence, mental health, and access to health care services. A group migration profile with long-term permanence plans was identified. Was evidenced an important share of young population (50% under 20), indigenous people (20%), and returnees (11%). The respondents referred to a mixed pattern of chronic and acute diseases, for which the main difficulty was accessing diagnosis and continuous treatment. Health-seeking behavior was identified as the main barrier to access health care services. The article compiles main findings on the Venezuelan migrants and refugees' health conditions, contributing important evidence for the humanitarian responses in migration contexts.

Keywords Migration · Medical services · Venezuela · Humanitarian aid

Background

The political, institutional, and economic instability in Venezuela has unchained an unprecedented humanitarian crisis in the country. Venezuelans have faced over the past years shortages of food and medicines, violence, hyperinflation, and other situations that force them to leave their country. Consequently, the migratory dynamics in the region have suffered an enormous transformation sharpened during the last 5 years, from being a country that historically attracted population (mainly from neighbouring Colombia) [1, 2] to one that, up to March 2021, registered about 5.5 million migrants, refugees, and asylum-seekers [3]. By January 2021, the official immigration statistics reported that a total of 1.742.927 Venezuelans reside in Colombia being many of them in an irregular situation (57%). The reported gender distribution among this population correspond to 51% male vs. 49% female and with a 24% of people under 18 years old. [4].

As a reception country, Colombia faces serious security problems related to the internal conflict, which are particularly aggravated by the abandonment of the state to the border areas. Under these conditions, the migrants and refugees deal with the bearings that motivated their departure from Venezuela and face structural and historical difficulties present in the regions where they arrive in Colombia. Migrants find themselves in constant competition with the unmet needs that overload locals such as internally displaced people, poor communities, and indigenous populations [1, 2].

This study highlights the importance of exploring and getting to understand the bidirectionality of the relationship between migration and health. Intending to answer the

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questions on how different forms of migration influence health, both individual and collective, and how migration trajectories can positively or negatively impact health outcomes.

Conceptual Framework

Given the current situation of migrants at Colombian border areas; Médecins sans Frontières (MSF) has set up medical care projects in three departments of the country (Guajira, Norte de Santander, and Arauca) since November 2018. The medical activities cover two fronts with institutionalized primary health care services and mobile teams with points of care for long-distance walkers. Along with the medical activities, an operational research study with Venezuelan migrants and refugees was designed seeking to explore health conditions, migration patterns and access to health services of Venezuelan migrants present in Colombian border areas.

Data capitalization regarding Venezuelan migrants and refugees' health conditions and their access to health care was motivated by MSF operational discussions on the challenges it poses to collect health information from people on the move and how it constitutes a key element to identifying critical health services gaps. It is crucial to make available detailed data on the migrant and refugee population's characteristics in the Colombian territory to adapt the response interventions to their needs and circumstances.

The Venezuelan migration phenomenon in Colombia, as in many other migration contexts in the world, has been shaped and is continuously redefined by numerous highly volatile aspects; Venezuelan forced migration have had a disproportionate impact at the bordering states, making particularly evident the neediness for consistent context analysis and information availability on their current health conditions and access to medical care [5, 6] as during migratory processes and in humanitarian contexts in general, inequalities in the use of health services can exacerbate [7]. More vulnerable groups (women, children, people with disabilities, elderly individuals, indigenous groups, among others) are particularly exposed to risk situations, infectious diseases and multiple forms of violence due mainly to discrimination, lack of information and low access to primary care [8].

Methods

Participants

The study areas in Colombia included the two states with the highest influx of migrants to the country. The two selected municipalities, Riohacha (La Guajira) at the extreme North of the country and Tibú (Norte de Santander) at the Middle East; correspond to main points on the migratory routes that flow from Venezuela to Colombia and other destinations. The community food distribution centres (commonly known as *comedores*) were, among places where humanitarian assistance services are provided; the most diverse spaces found for data collection purposes. As the study refers to various modules related to access to health care, health conditions and needs, it was clear that services other than MSF would be preferable to avoid selection bias.

Independent, statistically significant samples were drawn based on total venue capacity and daily new arrival figures of people over 18 years old, using a 95% confidence interval and a 5% margin of error. The final sample size was proportionally distributed among the municipalities, representing Riohacha 66% and Tibú 34% of the sampled population.

Data Collection

MSF has faced the challenge of collecting health information for mobile populations in different contexts. In the search for a methodology "as flexible as the migration itself" the literature review led towards the Life History Calendar (LHC) methodology [9, 10]. Referencing the main aspects of the LHC, a quantitative data collection instrument called Migration History Tool (MHT) was assembled by the social and medical professionals of the Brazilian Medical Unit (BRAMU), to register information on three different dimensions of a person's history: lifetime migration experiences; recent migration experience; and plans and destinations. Data collection domains for migration and related information groups are described in Fig. 1.

Eight senior nursing students from the University Francisco de Paula Santander; were trained over a period of 2 weeks to apply the survey. Training sessions included topics such as migration context, development of the tool, specificities of the research activities, research ethics and methodology. Based on the premise of not associating participation to obtaining social assistance and food services at the *comedores*; the potential participants were randomly approached in areas other than eating zones where migrants and refugees were expected to gather (entry, exit, registration and waiting points, for example). The time–space/location sampling was chosen as is commonly used in hard-to-reach population that tend to gather in defined urban locations. Once a prospective participant was approached, details on the research activity were shared seeking to stablish their will to participate of the survey [11]. Research field implementation activities in Colombia were carried out between February and March 2020.

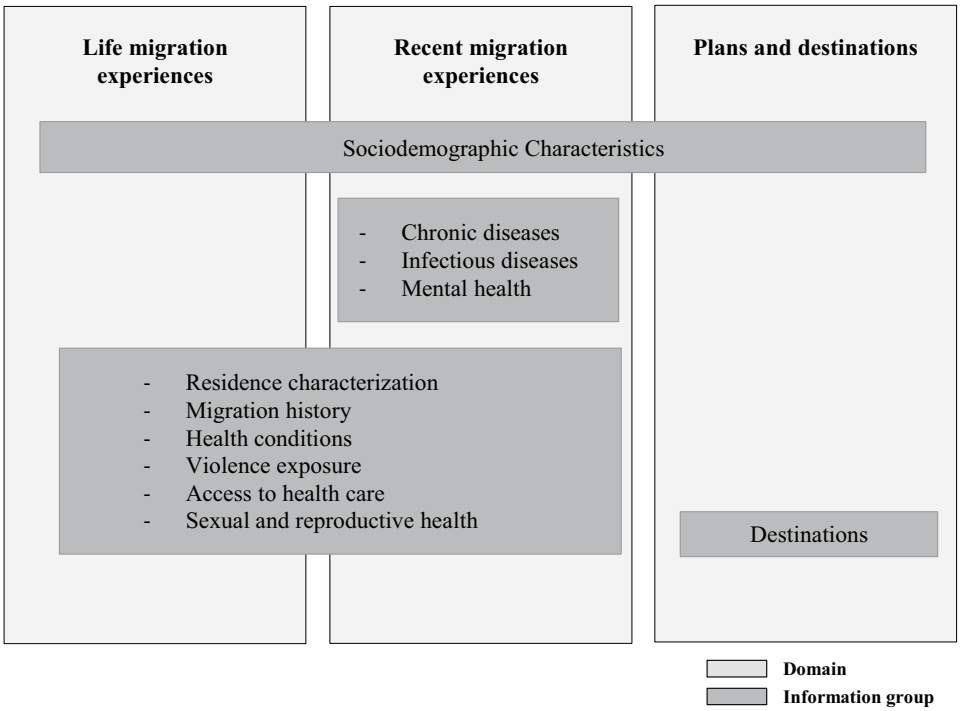

Fig. 1 Data collection tool domains and information groups

Measures

The final tool, adapted to the specific information needs; comprised 211 questions classified in 14 modules according to demographic, time, location, and health-related information groups. The questionnaire corresponded to a series of subordinate tables used according to each participant's migration and life experiences. To ease data registration, a new software link to a georeferencing component as well as audio questions for inquiring sensitive information; was explicitly created for the implementation of the methodology.

Analysis

Information was verified in its quality, consolidated and analyzed using descriptive statistics and bivariate analyses. STATA programming was used for cleaning, debugging, exploring and analyzing data.

The study was approved by the MSF International Ethics Review Board (ID 1948). The *Fundación Guajira Naciente* [12] and the *Diócesis Pastoral de Victimas* [13] afforded local authorizations and participation consents. All participants signed an informed consent form, which was thoroughly explained, highlighting the uses of the information collected, risks, benefits, and confidentiality terms.

Results

Population Description

516 people answered the questionnaire. The average age of participants was 37.1 years old (SD 14.3); being half of them in the age group of 20 to 39 years old. The majority of the sample was female (58%). Indirect information on age, gender, and kinship of 769 the participant's travelling companions was collected, contributing to draw a broader characterization of the migratory influx. The description on the general characteristics of the participants stratified by gender is shown in Table 1.

A group migration profile with long-term permanence plans was identified; Venezuelan migrant population at the research sites correspond to people with a low mobility profile in constant influx towards Colombia during the evaluated period. Calculated mean time of stay in the Colombia was 4 months.

Migrants travelled mostly accompanied (78% of the cases), with approximately three more people (ranging from 2 to 7 individuals). The companions were family members, being that a half of them reported having travelled with their children. The global sociodemographic characteristics pointed out that 50% of the people migrating were individuals under 20 years old, counting among them a striking 20% of children under five. Relevant to highlight that 11% of the participants were classified as Colombian returnees and

Table 1 General characteristics of the participants by gender

Variable	Category	Gender		Total sample
		Male	Female	
Total participants (%)	–	216 (42%)	300 (58%)	516 (100%)
Average age in years (SD)	–	40.6 (15.4)	34.6 (12.9)	37.1 (14.3)
Indigenous population (%)	Yes	42 (41%)	61 (59%)	103 (40%)
	No	174 (42%)	239 (58%)	413 (80%)
Education level (%)	Primary complete/secondary incomplete	95 (41%)	138 (59%)	233 (45%)
	Secondary complete/superior incomplete	55 (42%)	77 (58%)	132 (26%)
	Primary incomplete	33 (49%)	35 (51%)	68 (13%)
	Superior completed	20 (42%)	28 (58%)	48 (9%)
	Illiterate	8 (38%)	13 (62%)	21 (4%)
	Literate without formal education	5 (36%)	9 (64%)	14 (3%)
Marital status (%)	Married/consensual union	109 (37%)	187 (63%)	296 (57%)
	Single	90 (48%)	96 (52%)	186 (36%)
	Divorced/separated	11 (55%)	9 (45%)	20 (4%)
	Widowed	6 (43%)	8 (57%)	14 (3%)

20% of the overall participants described being part of an indigenous community, mainly corresponding to the Wayuu ethnic group.

Reasons to Migrate

The "desire for better living conditions" was undoubtedly the most common motivation referred by the respondents (65%). The second most predominant reason was "job search" (16%), that was more frequently mentioned by men ($\chi^2 = 31.7191$ $p = 0.007$). Motivations such as "family reunion" (6%) and "medical reasons" (4%) appear in third and fourth place respectively. Despite the situation in the country, with documented political prosecution, none of our participants listed political-related factors among their motivations to migrate.

General Health Conditions

Almost half of the respondents reported having had a health problem over the year before the survey. No significant differences were found in the distribution of health issues regarding sociodemographic characteristics. Approximately 32% of the participants recounted being afflicted by a chronic illness (most likely associated with hypertension in 60% of the cases, diabetes 15% and heart disease 10%). On the other hand, 18% reported having had a diagnosis of an infectious disease (being Chikungunya the most mentioned in 45% of the cases; followed by common Flu 26%, Malaria/Paludismo 14%, Dengue 10%, and Zika 5%. The main identified difficulty when having a health problem was accessing proper diagnosis and continuous further treatment according to the respondents' experiences. Noticeable is the high number of people with chronic diseases that were out of treatment (49%) with an average time of no medication of 4 years approximately. Either for being totally out of treatment or not taking medications according to prescription, the main reason was not to have the money to buy the medicines.

Violence Exposure

19% of the individuals reported having experienced physical violence while in Colombia; among them, 1 in every 10 individuals referred to having suffered sexual harassment (being 75% of them women). Was evidenced a low rate of health assistance search after physical aggression (only12% sought medical care). Among the reasons for not searching medical care, the most common ones were not considering

that the experienced violent event was severe enough (59% of the cases) and merely thinking that going to a medical service was not an option (15%). Many of the respondents referred discrimination (4 in every 10 people), in most cases, the discrimination was not an evident reason to search for psychological help.

Sexually Transmitted Infections

HIV testing was explored as an indicator for specific access sexual and reproductive basic health services. About half of the participants (251 individuals) had undergone a specific test for the diagnosis of HIV, presenting a similar distribution per gender and age. Of them, only 34% were done within the last year. 15% of those who had a diagnostic test performed obtained a positive result being that only one person was having access to treatment.

Mental Health

The general anxiety disorder (GAD-7) and the patient health questionnaire (PHQ-9) screening tools were used to identifying general traits of depression and anxiety during the 2 weeks before the survey. The results evidence that approximately 10 in every 100 participants showed severe generalized anxiety, also 15 in every 100 participants exhibited severe signs of depression. These traits did not present a particular distribution according to sociodemographic characteristics. The overall results leave us with approximately 37% of the participants needing further evaluation, follow-up and support for mild and severe anxiety-related issues and major depressive episodes.

Access to Health Care

Health-seeking behaviour was identified as an essential first barrier to access services in Colombia. From the people that referred needing medical services due to a general health problem or an event of physical violence, sexual abuse, or discrimination, only 67% sought medical care. The respondents expressed 'lack of information' as the leading cause of not looking for health services. Also, 28% did not search for medical attention because of rumours of no service or mistreatment to Venezuelans, 16% did not attend a health facility due to their lack of health insurance and 15% because did not consider the health problem severe enough.

Participants had a good perception of the health services offered in the area once they accessed them. 83% of users rated them as good and excellent; 13% found it of indifferent quality, and the other only 4% of users consider it bad or extremely bad, respectively. People who gave a negative concept of medical services pointed out mainly to the lack of procedures for triaging and establishing priorities in providing care services.

17% of the individuals who sought attention did not manage to receive it being that half of them reported that the health centre they visited refused to treat them due to their migrant status. The other share stated various causes mainly related to their health problem being of a more complex level than the primary health care provided in the health centres.

Discussion

Although there is a general belief that needs are diverse and severe [14, 15], there is still a lack of structured analyzes on the sociodemographic characteristics, particular health conditions and access to essential health services of Venezuelan migrants and refugees at the Colombian border areas. The characterized migratory profile corresponds mainly to family groups with long-term stay plans in the search for better living conditions. A significant share of vulnerable population such as women, youth population indigenous people, and returnees were found in the study. Organizations present at Colombian border areas are then called to implement solutions that support the requirement of longer-term access to health care services in general, calling particular attention to the need for care strategies and differentiated approaches targeting specifically the above-mentioned segments of the population.

The results are consistent with the profile described in the literature as 'in a context of crisis' [1, 16–19], showing an increased number of people under 20 years old and among them a relevant share of children under five. For the following years, migration surveys point out the necessity of verifying whether the previously described ratios will be balancing due to family reunification processes that would mean greater stability of Venezuelan emigration in different destinations [17]. This situation points out the need for a broader integration of the migrants and refugees into the Colombian social and economic structure besides the basic assistance of sheltering and food provision currently provided by diverse international organizations.

The continuous provision of health care, treatment, and medical follow up; always arises as a main difficulty when it comes to populations on the move and has been documented by several authors in their academic studies [20–23]. It concerns the high number of Venezuelan migrants and refugees found as "out of treatment" for chronic diseases such as hypertension, diabetes, and HIV. The specific situation of people with and HIV positive status without ARV treatment; has been a constant concern, increasingly referred to in the literature over the last years [24, 25]. Access to diagnosis and treatment must become part of a broader, longer-term activity, including epidemiological surveillance of infectious

diseases and meaningful strategies to support the provision of free medication for various chronic diseases.

The main barrier to access medical care in our study was associated with the health-seeking behaviour. Not searching for medical services, usually relates to significant extend, to lack of information. Contrasting to what is evidenced in the publications on the topic, only a small portion of the study participants reported that they did not seek medical help when they needed it due to fear, discrimination and xenophobia. The highly volatile aspects that define the contexts of migration, makes it necessary for messages about medical services to be disseminated regularly. Besides, gathering places represent great spots for surveillance, triage, and health promotion activities. Additional mobile points of medical attention in those venues can contribute to bringing care near to migrants and refugee's populations.

Proper access and good care services were reported by those that searched for medical services. This study documented that only 17% of those searching for medical care did not have access to it, because their health problem was more complex and required a level of attention higher than the basic health care provided in the health centres. On one side, this situation reflects the need of stablishing a clearer path of referral for higher complexity cases exceeding the capacity of primary health care, including a proper mapping and identification of institutions that could cover second and third level health services for Venezuelan migrants in the region. In addition to liaising with the network of hospitals and clinics in the area for patients' referral, the agreement with the institutions could include a training component and sensitization sessions for health care professionals on the provision of services to this particular population.

Diverse situations such as family separation, violence, unemployment, food scarcity, health problems, barriers to access health care, among others, are all aspects that can have a high toll on the mental health wellness of migrants and refugees' populations. MSF has been caring for patients' mental health for more than 20 years, as a component of all medical interventions such as HIV/AIDS, tuberculosis, nutrition, sexual violence, and during disease outbreaks and disasters. It concerns that the findings in this study point out gaps in the diagnosis and follow up of patients in need of this service; being worrying that the demand rates are even lower when it comes to searching for psychological assistance after a violent event. Due to the vulnerabilities faced by migrants and refugees in general and by Venezuelans and in this context [23, 26], a robust mental health component is core to developing other medical project activities even if currently to guarantee continuity of care in unstable contexts and mobile populations remains as a challenge.

Lastly, it is important to state that the use of the Migration History Tool as any other research tool has inherent limitations. In our study the chosen locations as mentioned in the methodology; correspond to a selection based on MSF activities and operational criteria; reason why the results cannot be applied to the Venezuelan migrants and refugees' situation on a population scale. Additionally, the information was gathered right before the Covid emergency was declared in Colombia with the consequent restriction of border crossings and internal movements and this activity did not capture the impacts that the epidemic certainly had on the Venezuelan migrants and refugees' populations in the study areas.

New Contribution to the Literature

Health as a core human right of migrants and refugees represent a moral and equity issue that must be placed at the centre of the discussion on the humanitarian agenda. Documentation and evidence-based decision-making regarding health interventions for people on the move are reasons that motivated the development of this analysis. In like manner, we highlight the need of making available detailed health information as part of the provision of medical care; that guide the humanitarian response interventions of the various organizations working at the border areas. In its core purpose, this article seeks to make available information about the health needs and access to services of Venezuelan migrants and refugees, pointing out areas where the provision of health services can be strengthened.

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References

1. Koechlin J, Eguren J. El éxodo venezolano: entre el exilio y la emigración. Volumen N. Colección OBIMID. 2018; p. 369.
2. Acosta D, Blouin C, Freier LF. La emigración venezolana: respuestas latinoamericanas (Internet). [cited 2021 Feb 15]. Available from: www.diegoacosta.eu
3. UNHCR. R4V coordination platform (Internet). [cited 2021 Feb 15]. Available from: https://data2.unhcr.org/es/situations/platform
4. Distribución de Venezolanos en Colombia - Corte 31 de Enero de 2021 – Migración Colombia. https://www.migracioncolombia.gov.co/infografias/distribucion-de-venezolanos-en-colombia-corte-31-de-enero-de-2021 Accessed: 03 Oct 2021.
5. A Staggering exodus: millions of Venezuelans are leaving the country, on foot—The New York Times [Internet]. [cited 2020 Sep 16]. Available from: https://www.nytimes.com/2019/02/20/world/americas/venezuela-refugees-colombia.html
6. Arteada PA, Carvajal AF, Guerrero RM. Vista de La migración venezolana y su impacto socio económico en el municipio de Pamplona Norte de Santander. Revista Científica Profundidad Construyendo Futuro ISSN: 2422-2518 (En línea). Vol. 6. Mes Enero -Junio. [cited 13 apr 2021] Available from: https://revistas.ufps.edu.co/index.php/profundidad/article/view/2292/2524
7. PAHO and IOM sign agreement to improve the health of 70 million migrants in the Americas International Organization for Migration (Internet). [cited 2021 Apr 8]. Available from: https://

www.iom.int/news/paho-and-iom-sign-agreement-improve-health-70-million-migrants-americas
8. Becker SO, Ferrara A. Consequences of forced migration: a survey of recent findings. Labour Econ. 2019;1(59):1–16.
9. Freedman D, Thornton A, Camburn D, Alwin D, Young-demarco L. The life history calendar: a technique for collecting retrospective data. Sociol Methodol. 1988;18:37–68.
10. Axinn WG, Pearce LD, Ghimire D. Innovations in life history calendar applications. Soc Sci Res. 1999;28(3):243–64.
11. Semaan S. Time-space sampling and respondent-driven sampling with hard-to-reach populations. Methodol Innov Online. 2010;5(2):60–75.
12. Fundación guajira naciente (Internet). [cited 2021 Apr 8]. Available from: https://guajiranaciente.wixsite.com
13. Diócesis de Tibú Conferencia Episcopal de Colombia. (Internet). [cited 2021 Apr 6]. Available from: https://www.cec.org.co/jurisdicciones/diócesis/diócesis-de-tibú
14. Páez T. La voz de la diáspora venezolana. Madrid: Catarata; 2015.
15. Arellano Á. Florecer lejos de casa Testimonios de la Diáspora Latinoamericana. Fundación Konrad-Adenauer: Montevideo; 2018.
16. Encuesta Nacional de Condiciones de Vida | ENCOVI. Available from: https://www.proyectoencovi.com/. Accessed 14 Apr 2021.
17. Encovi 2018 | Encuesta Nacional de Condiciones de Vida Copy. Available from: https://www.proyectoencovi.com/encovi-2018-encuesta-nacional-de-condiciones-de-vida-copy. Accessed 14 Apr 2021.
18. Encovi 2019 | Encuesta Nacional de Condiciones. Available from: https://www.proyectoencovi.com/encovi-2019. Accessed 14 Apr 2021.
19. Encovi 2017 | Encuesta Nacional de Condiciones de Vida. Available from: https://www.proyectoencovi.com/encovi-2017. Accessed 14 Apr 2021.
20. Fernández-Nino JA, Bojorquez-Chapela I. Migration of Venezuelans to Colombia. Lancet. 2018;392(10152):1013–4.
21. Tuite AR, Thomas-Bachli A, et al. Infectious disease implications of large-scale migration of Venezuelan nationals. J Travel Med. 2018. https://doi.org/10.1093/jtm/tay077.
22. Doocy S, Page KR, et al. Venezuelan migration and the border health crisis in Colombia and Brazil. J Migr Hum Secur. 2019;7(3):79–91.
23. Carroll H, Luzes M, et al. The migration journey and mental health: evidence from Venezuelan forced migration. SSM Popul Health. 2020;10:4.
24. Gómez SA. Increasing cases of HIV/AIDS in the northern region of the Colombia-Venezuela border: The impact of high scale migration in recent years. Travel Med Infect Dis. 2018;25:9.
25. Rebolledo-Ponietsky K, Munayco CV, et al. Migration crisis in Venezuela: impact on HIV in Peru. J Travel Med. 2019;26(2):tay155.
26. Mougenot B, Amaya E, et al. Immigration, perceived discrimination and mental health: evidence from Venezuelan population living in Peru. Glob Health. 2021. https://doi.org/10.1186/s12992-020-00655-3.