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The impact of COVID-19 on Venezuelan migrants' access to health: A qualitative study in Colombian and Peruvian cities

Patricio Zambrano-Barragán[a,*], Sebastián Ramírez Hernández[b], Luisa Feline Freier[c], Marta Luzes[d], Rita Sobczyk[e], Alexander Rodríguez[f], Charles Beach[g]

[a] Inter-American Development Bank, 1300 New York Avenue NW, Washington DC, 20577, United States
[b] Princeton University, 119 Julis Romo Rabinowitz Building, Princeton, NJ, 08540, United States
[c] Political and Social Sciences Department, Universidad del Pacífico, Jr. Gral. Luis Sanchez Cerro, 2141, Jesus Maria, Lima, Peru
[d] Centro de Investigación, Universidad del Pacífico, Jr. Gral. Luis Sanchez Cerro, 2141, Jesus Maria, Lima, Peru
[e] Faculty of Political Science and Sociology, Department of Sociology, University of Granada, C/ Rector López Argüeta s/n, 18071 Granada, Spain
[f] Oraloteca - Universidad del Magdalena, Carrera 32 No 22 – 08 Santa Marta D.T.C.H, Colombia
[g] University College London, 14 Taviton Street, London WC1H 0BW, United Kingdom

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ABSTRACT

This research seeks to understand how COVID-19 has affected access to healthcare among migrants in Latin American cities. Using ethnographic research methods, we engaged with Venezuelans living in conditions of informality in four Colombian cities—Barranquilla, Cucuta, Riohacha, and Soacha—and three Peruvian cities—Lima, Trujillo, and Tumbes. We conducted 130 interviews of both Venezuelan migrants and state and non-governmental actors within the healthcare ecosystems of these cities. We found that forced migrants from Venezuela in both Colombia and Peru face common obstacles along their access trajectories to healthcare, which we summarize as legal, financial, and relating to discrimination and information asymmetry. By limiting effective access to care during the pandemic, these obstacles have also affected migrants' ability to cover the costs of basic needs, particularly food and housing. Our study also found a prevalent reliance on alternative forms of care, such as telemedicine, easy-to-access pharmacies, and extralegal care networks. We conclude that COVID-19 has exacerbated preexisting conditions of informality and health inequities affecting Venezuelan migrants in Colombia and Peru.

Introduction

In recent years, Latin America and the Caribbean (LAC) has experienced an unprecedented rise in intraregional migration flows. Based on data from the United Nations Global Migration Database, the number of migrants in LAC rose by 77% between 2000 and 2019, higher than the increase of global South-South migration (60%).[1] Between 2015 and 2018, countries such as Chile, Colombia, Ecuador, Guyana, Peru, and Trinidad and Tobago have seen the proportion of immigrants rise between 0.5% and 2%—considerably higher than the global average of 0.1%.

Venezuelan migrants are key protagonists of these unprecedented migration trends. As a result of worsening social and economic conditions, close to five million people have left the country since 2015, of whom over four million have stayed within the LAC region (UNHCR, 2020).[2] The primary destinations are Colombia and Peru, followed by Chile and Ecuador; this geographic distribution describes a southbound trajectory along the Andean subregion, from Venezuela to Chile and Argentina. Colombia is now home to over 1.7 million Venezuelans, of whom 55% do not have legal status (Migración Colombia, 2020). Between early 2017 and mid 2020, 1.3 million Venezuelans entered Peru; to date, over 790,000 have stayed and only 350,000 have received formal permits to stay (Migraciones, 2020).

The majority of these" recent migrants have settled in urban areas, typically in large metropolitan areas and border cities. Up to 500,000

[1] The Global Migration Database is available at https://population.un.org/unmigration/index_sql.aspx.

[2] Some researchers have argued that Venezuelan migrants could qualify as refugees under the expanded Cartagena definition; see Freier et al., 2020

* Corresponding author.
E-mail addresses: pzambrano@iadb.org (P. Zambrano-Barragán), srtwo@princeton.edu (S. Ramírez Hernández), lf.freierd@up.edu.pe (L.F. Freier), martaluzes@gmail.com (M. Luzes), rsobczyk@ugr.es (R. Sobczyk), alexanderodriguezcontreras@gmail.com (A. Rodríguez), charles.beach.16@ucl.ac.uk (C. Beach).

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Venezuelans live in just three Colombian cities: Bogota, Cucuta, and Barranquilla. In Peru, close to 300,000 live in the Lima Metropolitan area (Migración Colombia, 2020). As the IOM points out, "migration is essentially an urban affair" (IOM, 2015, 4, p. 2). This has held true for LAC since the first big wave of urbanization in the 1950s, during which large numbers of people migrated from rural areas to cities in search of better socio-economic opportunities.[3] Though the expected correlation between urbanization and economic growth was broadly realized in LAC, arriving migrants all too often lacked access to adequate housing and basic services and settled informally in at-risk, peripheral areas (Ward, 2015). While some of these first informal neighborhoods are now consolidated parts of LAC cities, new growth follows similar settlement patterns: low-income internal and international migrants move into communities characterized by inadequate housing and poor access to services, including health and education.[4]

The COVID-19 pandemic has exacerbated preexisting conditions of informality and inequality in LAC cities. Even before the pandemic, it is estimated that up to 30% of households lived precariously (i.e., in overcrowded homes, without basic services or proper title) (Rojas, 2019). In addition, LAC cities are among the most unequal in the Global South (OECD, 2018). These conditions, coupled with a lack of migrant-focused relief strategies by the state, have made it impossible for communities living informally to observe basic public health guidelines and withstand the pandemic (Fernández-Niño et al., 2020). By October 2020, the region had close to 10 million confirmed cases, equivalent to 27% of cases worldwide, and over 350,000 deaths, equivalent to 34% of deaths worldwide—even though LAC only represents 8% of the world's population (Sullivan et al., 2020).

The pandemic may have further increased health inequities among migrant communities. Research from multiple contexts in both the developed and developing world has shown that migrants, particularly forced migrants, tend to exhibit disparities compared to host populations, both in terms of their state of health and access to quality services (Dookeran et al., 2010; National Academies of Sciences Engineering and Medicine, 2018; Hu et al., 2016; Adiga et al., 2018; WHO, 2010; Luckett et al., 2011; Salinero-Fort et al., 2015; Rodríguez Álvarez et al., 2014). While data on health disparities within LAC are limited, recent data show an association between high inflows of forced migration and a rise in vaccine-preventable diseases (Ibañez and Rozo, 2020). Empirical research on the impacts of the pandemic on health disparities is still nascent, but these inequities will be magnified by a combination of urban informality, top-down policies restricting mobility and barriers to legal status, and on-the-ground discrimination and misinformation (ILO, 2020; Lustig and Tommasi, 2020; Vera Espinoza et al., 2020).

Our research seeks to understand how COVID-19 affects access to health care among migrants in Latin American cities. Through ethnographic and qualitative research methods, we engaged with Venezuelan migrants living in conditions of informality in Colombian and Peruvian cities. First, we sought to understand how Venezuelan migrants living informally access health services in each of these cities and what kind of barriers they face, especially in comparison to host populations. Second, we explored how COVID-19 has affected access to care. Third, we inquired about how migrants have sought alternatives to care when facing barriers to access. Our results highlight future directions for both academic and policy work by identifying barriers to access and potential ways to address them that capitalize on migrants' own resilience strategies.

[3] Urbanization rates soared from 41% in 1950 to 64% in 1980, due to continuous migration from rural areas to cities (UN, 2014).

[4] For example, in Argentina, 49% of households who live in areas formally defined as informal are foreign-born (Vera and Adler, 2020, p. 148).

Material and methods

Information about informal settlements and communities is often difficult to access through traditional quantitative and aggregate data. The COVID-19 pandemic further prevented researchers from carrying out work on the ground. In addition, migrants' access to communication technologies, such as telephones and the internet, is uneven. Finally, both the effects of xenophobia and the lack of legal status make migrants mistrust the presence of strangers inquiring about the intimate details of their lives. Combined, these factors presented considerable challenges when engaging with vulnerable Venezuelan migrants. We therefore designed a remote ethnographic methodology that capitalized on existing research networks in both Colombia and Peru.

The authors used qualitative methods, particularly semi-structured interviews and life histories, to capture a wide variety of voices and experiences from select cities in Colombia and Peru. To complement these ethnographic inquiries, the team also sought to map healthcare options available to migrants through interviews with representatives from national, regional, and municipal agencies, as well as well-established civic organizations. To avoid transmission risks of COVID-19, and in consideration of data privacy concerns of potentially vulnerable populations, interviews were carried out remotely by phone or digital telecommunications platforms that offer end-to-end encryption (e.g., Signal and WhatsApp) and included either signed or oral consent.

The research team completed 96 interviews in Colombia and 34 in Peru between July and September 2020. Interviews lasted between one and two hours. We focused on four Colombian cities—Barranquilla, Cucuta, Riohacha, and Soacha (metropolitan Bogota)—and three Peruvian cities—Lima, Trujillo, and Tumbes. The choice of cities responded to the following criteria. First, the inclusion of cities with large Venezuelan migrant populations (Soacha in metropolitan Bogota and Lima). Second, a focus on rapidly growing secondary cities that are among the top destinations for Venezuelan migrants (Barranquilla, Trujillo). Third, the inclusion of border cities that are among the first points of entry for migrants arriving from Venezuela (Cucuta and Riohacha along the Colombia-Venezuela border and Tumbes along the Ecuador-Peru border). Riohacha represents a special case: the city lies along the Colombia-Venezuela border but is also part of a broader territory home to the Wayúu indigenous peoples, whose struggles with and innovation in healthcare access highlight the need for culturally-appropriate approaches to care.

This work brought together a team of researchers with specific experience in each of the study's cities, each of whom have built a network of relationships with migrant communities and local residents through previous work. City-specific knowledge allowed us to emulate a respondent-driven sampling, whereby initial interviews allowed participants to recruit peers from their social network, thus expanding the sample and describing the contours of the overall size and composition of hard-to-reach populations (Gile and Handcock, 2010; Johnston, 2014). Data collection was time-bound to ensure findings remain relevant to pandemic-focused work while still allowing the team to identify valid descriptive themes. An iterative interpretive approach was used to analyze the data: first, city-specific researchers coded interviews to identify common and emerging themes, and conducted data reduction by focusing on statements most relevant to our research questions (Roulston, 2014). The combined Colombia-Peru research team then further coded results to identify categories and themes across both countries, with the goal of achieving transferability—to develop context-relevant descriptions—and theoretical validity—to establish an effective relationship between our study and existing theoretical frameworks (Roulston, 2014; Ravitch and Carl, 2016). Despite the robustness of the data collected, additional interviews and prolonged participant observation, particularly in some of the select cities, could increase the richness of our findings (See Table 1 for descriptive statistics).

Table 1
Summary statistics from qualitative data collection amongst Venezuelan migrants in Colombia and Peru

Category	Number	Percentage
Gender		
F	88.00	77.19%
M	26.00	22.81%
LGBTIQ+	1.00	0.88%
Age		
18-35	65	57.02%
36-59	47.00	41.23%
60+	3.00	2.63%
No answer	2	1.75%
Status		
Regular	55	48.25%
Irregular	58	50.88%
No answer	4	3.51%
Time in Host Country		
Less than a year	9.00	7.89%
1-2 years	60.00	52.63%
2-3 years	32	28.07%
3+	12.00	10.53%
No answer	4.00	3.51%
Household size		
1-4	30.00	26.32%
5+	80.00	70.18%
No answer	7.00	6.14%

Theory

Tanahashi (1978) describes access to health as a series of stages that must be overcome in a succession. The model tracks a trajectory that includes service availability, accessibility, acceptability, contact, and effectiveness. By understanding migrants' trajectory, we can investigate how the various factors alter or affect access at different instances in their health trajectories. Although this conceptualization is widely recognized as an effective way to evaluate healthcare systems, other models have sought particularly to understand the interaction between the supply of services and the active demand for them. Frenk (1992) seeks to describe the correspondence between the characteristics of the healthcare system and the population demands on it. More recently, Levesque et al. (2013) expanded this view to describe access as "the opportunity to obtain appropriate care in situations in which the need is perceived" (p. 16). By reframing the issue of access in terms of opportunity, Levesque et al. assume trajectories similar to those found in the Tanahashi model, while emphasizing the dynamic and complex nature of the interactions between health systems and populations across time.

Venezuelans migrants can encounter obstacles at virtually each stage of their access trajectory. In Frenk's terms, the institutional supply of healthcare services is uncertain and limited in spaces occupied by forced migrants. However, migrants also face structural barriers and challenges. In a recent review of studies that focus on migrants' access to health in LAC, Piérola and Rodríguez Chatruc (2020) identify four main obstacles: 1) lack of coverage; 2) discrimination, prejudice, and stereotypes; 3) language and cultural barriers; and 4) lack of information and fear of deportation. The authors highlight how structural obstacles, such as lack of coverage, are exacerbated by social barriers. Although discrimination and linguistic and cultural differences are identified as significant barriers, literature on these issues in LAC remains scarce. Similarly, the report describes information asymmetry as a significant problem but focuses somewhat narrowly on migrants, whereas gaps in knowledge and information about health rights of migrants may also be present among providers and other actors on the supply side.

Finally, COVID-19 is an unprecedented crisis that calls for deeper engagement with literature on the impact of health crises on vulnerable populations. In particular, research on the impacts of HIV/AIDS highlights how vulnerability to biological hazards is not equally distributed to all members of society. In a summary of the literature on the distribution of risk, Pellowski et al. (2013) describe HIV/AIDS as a "pandemic of the poor," demonstrating how determining social factors affect both the odds of contracting the virus and health outcomes once infected. Castro and Farmer (2003), reflecting on the prevalence of infectious disease in Haiti, set forth the concept of structural violence and argue that the distribution of disease around the world is not random, but rather centers on populations that historically bear the impacts of social inequality.

Although academic literature on the distribution of effects of the COVID-19 pandemic in Latin America is scarce, analyses carried out in other regions point to the need to observe how social differences frame the progress of the virus. In a recent study focused in the United States, van Dorn, Cooney, and Sabin (2020) conclude that the pandemic exacerbates chronic socio-economic and medical vulnerabilities that disproportionately affect non-white communities, including migrants. For example, non-white people tend to perform jobs that do not allow them to practice social distancing (and that were considered essential during quarantining), exposing themselves to greater risks of contagion. However, these same populations have more difficulties accessing healthcare services and have higher rates of chronic medical conditions, which further exposes them to the most serious effects of COVID-19. Despite the potential for disproportionate impact on vulnerable populations, the differential effects of efforts made to mitigate the spread of COVID-19 have not received sufficient attention. In their review of more than 13,000 publications on the effects of COVID-19, Anderson et al. (2020) identified only 50 empirical studies on the effects of social isolation measures, of which none mention refugees or migrants, and only three discuss effects in countries outside of Europe or Asia, none of which were in Latin America.

Results

Below, we present consolidated results from both Colombia and Peru, highlighting specific findings from individual cities and citing emblematic testimonies. Based on our results, we divide obstacles in four categories: legal, financial, discrimination, and information asymmetry. In addition, we summarize findings about alternative forms of care found by participants. We also include a specific section about the impacts of COVID-19.

Legal obstacles

Over the last five years, due to the unprecedented levels of immigration to Colombia, the government has made important changes and updates to the legal framework governing migrant status. These changes have a direct bearing on migrants' access to services, including healthcare. Broadly, there are two status categories. Legal status can be obtained through the Special Permit of Permanence (*PEP*, in Spanish), a permanent residence card, or through citizenship. Legal status gives migrants access to the same health coverage as native Colombians. Migrants who do not have any of these legal documents—approximately 950,000 by August 2020 (Migración Colombia, 2020)—are eligible for healthcare under specific extraordinary circumstances or if they belong to specific groups, such as: 1) those facing life-threatening emergencies and arriving in emergency rooms at public hospitals; 2) those facing urgent maternity needs and immediate pregnancy needs; 3) children, especially infants, with neonatal, developmental, and immunization needs. Other segments of migrant populations—older adults, men, non-pregnant women—and other categories of health issues—chronic disease, non-life-threatening conditions, mental health, etc.—are not covered. Though there are provisions for emergency care and for specific groups, this free coverage does not include follow-up services and tests. Migrants must pay for these services on their own.

> My husband fell off his bike and fractured his elbow. He was hospitalized for 15 days. Initially they didn't give us any problems; the doctor saw him. But afterwards, they didn't want to perform the surgery because we couldn't pay for it, so I went to look for help at the social security… He had an x-ray done after 10 days. We are waiting for the appointment to remove his stitches, get an x-ray and a tomography. He was discharged [a month ago]. They haven't removed his stitches. But we can't go to a doctor because I don't have any documentation. (Gleydimar, Soacha)

Similarly, in Peru, the biggest barrier to healthcare access for Venezuelan migrants is lack of legal migratory status. To access the public Integrated Health System (*Sistema Integral de Salud*, or SIS, managed by the Ministry of Health), migrants must have a regular residence permit, or at least a temporary residence status (carrying a special permit, the *carné de extranjería*), and must also be eligible under the national social registry, the SISFOH (*Sistema de Focalización de Hogares*). However, those who have requested asylum in Peru, or who hold a temporary permit of residence despite their regular migratory status, do not have access to SIS (except for pregnant women and children five and under). This excludes close to 500,000 asylum seekers as well as migrants without legal status (Migraciones, 2020). In our sample, only 32% of migrants had a *carné* and only 11% had health insurance.

Financial obstacles

The majority of participants interviewed across all cities work in the informal economy, and even those who enjoy formal employment face job insecurity, as they report being targeted for dismissal and abuse and often lack resources for legal defense. This economic uncertainty has significant effects on access to healthcare. Due to their exclusion from the formal economy, most of the migrants interviewed cannot afford health insurance. Migrants interviewed in Colombia overwhelmingly depend on daily work for basic subsistence needs, meaning they cannot afford to spend wages on or miss work seeking healthcare. Additionally, medical conditions represent losses in economic productivity that have significant impacts on the subsistence of large family groups.

> I work all day and didn't have time. I am the only one in my house who works, and in order to get all the paperwork done, they say I need an entire day, and that means no money to eat. (María, Barranquilla)

In Peru, an estimated 87% of migrants had no formal contract in June 2020 (Equilibrium CenDe, 2020a). The lack of social protection for migrants in Peru also means that they often have to incur expenses with no help from the state and therefore have less disposable income for healthcare (Luzes et al., 2020). The inability to access SIS (see Legal Obstacles section) means that most migrants will incur expenses when they need to use health services, often visiting private clinics where their undocumented status is not a barrier but the cost of services is. The cost of regularizing their migratory status also poses a financial challenge in addition to a lack of information about the different migratory statuses and incoherence of requirements experienced by different public institutions and services (Equilibrium CenDe, 2020b). These financial and transactional barriers reinforce each other and make it hard for migrants to bear the financial costs of either.

> To access the SIS, migrants must have a carné de extranjería. My PTP [*Permiso Temporal de Permanencia*] expired a few months ago, and to access the *carné de extranjería*, I must have 300-350 soles to get my criminal record and all the other requirements. (Rosibel, Lima)

The most common way to support the financial costs of private or public healthcare when migrants do not have insurance is through donations, salary advances from their bosses, or loans from relatives, friends, and people they know; 42% of participants had to ask for help to support healthcare expenses. Another common way to finance healthcare costs is through pleas on Venezuelans' social media.

Discrimination

Navigating the bureaucratic requirements to access care represents an important obstacle for migrants in Colombia. Migrants who do not have the PEP and who seek care in hospitals in emergencies face a series of obstacles to being admitted. Determination of what constitutes a vital emergency is often made by non-medical personnel, such as security guards and reception staff. To access medical services in hospitals, migrants must be admitted (they cannot receive outpatient care), which implies procedures within the institution's social work offices for costs to be covered by territorial entities. Once admitted, several migrants have reported being held by the institution's medical staff until hospital fees were collected. For those who leave the hospital with debt, they are threatened with refusal of further medical attention if they do not pay their fees on time.

> I gave birth here at the Niño Jesús Hospital, and that was also a whole process…they had me waiting for almost an entire week, until I got all the documents they demanded…the residence card…some witnesses that can say I live here and so on…I had a normal child birth, without any complications, without any need for them to keep me there… They said "no, you can't leave because they haven't discharged you"… but I knew it was because of the documents. (Andreina, Barranquilla)

Women bear the greatest burden in terms of access to healthcare in the migrant population. Most of the interviewees report that it is the women in the households who are responsible for caring for people during disability or for accompanying patients—even as they simultaneously work to gain income or goods.

In Peru, 53% of participants mentioned situations of discrimination in the health system in Peru. Discriminatory attitudes toward migrants often come from medical staff. When interviewed, one member of an international aid organization shared that doctors and health professionals are not aware of the documentation and migratory statuses that are available to migrants, nor who can and cannot access services. In addition, experiences of discrimination seem to be stronger in bigger hospitals and in health facilities outside of Peru's capital, Lima.

> First, they took a long time with the paperwork and did not want to treat me until all the papers were in order. I asked if they could please treat me while my husband oversaw the paperwork, and they replied that they could not. Second, the doctor that performed the cesarean delivery did not like me because I was Venezuelan, and she made that very clear to all of the doctors in the operating room. I was between life and death, given that once she took the babies out, the doctor left the operating room and told the doctors to find someone else to stitch me up because she had already fulfilled her duty. (Yherineth, Trujillo)

Information asymmetry

Venezuelan migrants in both Colombia and Peru lack sufficient information about the country's healthcare system—its requirements and procedures—as well as about the rights they have and the resources they could tap into for care. Access to healthcare, particularly for people with limited resources, requires the completion of various bureaucratic procedures that are difficult for migrants to navigate. Additionally, these procedures are not consistent over time or across institutions, which means that even those with knowledge may find obstacles. In each of the cities analyzed, the services offered vary enormously, and therefore mobility in national territory implies the need to become familiar with the complex organizational context of each location.

Participants report having developed information networks through both established and new platforms to disseminate information for re-

sources and opportunities. Virtual social networks—especially WhatsApp, Facebook, and Instagram—offer spaces where migrants can request and offer information regarding healthcare services and aid available from governmental and non-governmental institutions. These networks are created and moderated by social leaders, people with technical knowledge who typically are professionals in Venezuela and who do not generally receive income from these services. These networks typically function independently from institutions that offer services to the migrant population, and efforts to coordinate the provision of services or assistance through these networks are very scarce. Naturally, word of mouth remains an important resource for sharing information. Despite these shortcomings, many migrants learn how to navigate the healthcare system in this manner.

> I have a platform through Instagram.... But apart from that, I take individual appointments on my personal phone.... I have more than 2,500 migrants on my WhatsApp, so when I post a status, that is already an information chain...and people also spread whatever information I post. (Wilmer, Barranquilla)

Alternative access to healthcare services

Venezuelan migrants in Colombia and Peru have developed strategies to access healthcare services that respond directly to the obstacles listed above, while also expanding on practices from Venezuela and those used by low-income host populations and informal communities. These alternative forms of care are extralegal or informal, and, per our interviews, may include: pharmacies, healthcare professionals who formally practice in Colombia and Peru but offer their services and knowledge to their neighbors outside of their professional practice, Venezuelan migrant healthcare professionals who offer unofficial services to the migrant population, medical professionals who offer their services through informal telemedicine models, and providers of traditional/magical-religious/spiritual medicine.

Pharmacies. Pharmacies are one of the most common informal healthcare systems used by Venezuelan migrants in Colombia and Peru. Pharmacists offer information on possible treatments and indications regarding the use of medication in and outside of the official medical sphere. The attitude toward prescription medicine in these countries is lax. For example, in Peru, despite a law that prohibits purchase of drugs without prescription, the prevalence of the sale of antibiotics is very high, ranging between 25% and 58% (Rojas-Adrianzén et al., 2018). Most migrants we interviewed have taken advantage of such informal practices of pharmacies in both Colombia and Peru to buy medicine without going to a clinic or hospital. Some participants reported adverse effects, even some that required hospitalization. In all cases, migrants must pay for all of these services, which can represent additional financial burdens. Out of the 19 migrants interviewed in Peru, more than half have resorted to self-medication in pharmacies.

> The informal sector is the most used by the migrants—the pharmacy on the corner. Even without a prescription, they will sell you [medication] because they need to sell. I have seen two or three cases of families who have brought prescriptions from Venezuela and they were sold the medication here. There are people with cases of cancer, HIV, diabetes, hypertension… During the pandemic these services have been used more often, people have self-medicated more. (NGO representative, Trujillo)

Network of Venezuelan Doctors. Participants reported having sought help from Venezuelan doctors or those who practiced as healthcare professionals before emigrating. These providers—from nurses to general practitioners—tend to have qualifications but have not completed the process needed to practice formally in Colombia or Peru. Notably, when assessing whether to pay for healthcare within the formal system or within this known network, many migrants opt to see Venezuelan doctors, since they can thus avoid some of the obstacles present in hospitals and other healthcare institutions. Some of these extralegal practitioners also offer services for free.

> I was studying medicine.... I needed exactly four more months to graduate...but I had to come here, because the situation became too complicated and there were no means of transportation, no food, nothing, so I couldn't finish my major.... My neighbors come to see me quite often when they feel pain.... I guide people quite a bit, at least when they have children, I tell them what to do, also pregnant women.... I don't charge anything, and sometimes they tell me to charge...but I won't. (Deyna, Barranquilla)

> I have used these networks of Venezuelan doctors that I found through Venezuelans' WhatsApp groups The consultations are free and, depending on the case, are carried out in person or virtually. If it's serious, they refer you to a doctor in a health facility. The advantages (…) are that Venezuelans already know how Venezuelan doctors work, there is trust, and we understand each other's dialect. Especially in these times of COVID-19, one can use these services that do not require going out, which means that there is less chance that one will get infected with the virus. (Yherineth, Trujillo)

Due to the difficult and costly process of validating foreign professional titles in both Colombia and Peru, especially in medicine, many Venezuelan migrants cannot exercise their professions in the host country. Additionally, medical professionals need to become collegiate professionals in Peru, a costly and prolonged process few qualified Venezuelan doctors residing in Peru can pursue. Despite this bureaucratic barrier, many still practice medicine through virtual appointments, in parallel to the formal healthcare system.

Telemedicine, Non-governmental Services, and Non-Biomedical Providers. Local Venezuelan civic organizations represent an invaluable resource for newcomers to Colombia. In cities with a long history of migration, such as Riohacha and Cucuta, Venezuelan organizations, local non-government associations, and religious charities have an equally long experience helping migrants and guiding them through local service options. Over the last few years, these organizations have become the first line of assistance to migrants. In Barranquilla, where Venezuelan migration is more recent, there are nonetheless established organizations that are building a strong network of assistance and defense of rights. Similarly, in Soacha, new organizations led by or collaborating with Venezuelans have recently emerged.

> Some neighbors told me... "There is going to be a health campaign at the church...they will hand out medicine; they're going to help us with the SISBEN nonsense...." There I met [the name of an organization leader].... From then on, she added me to the group, and each time they organize health campaigns and all that, I received a message and she also lets me know. (Veronica, Barranquilla)

Migrants have also turned to healthcare professionals outside of Colombia through informal telemedicine models. Some participants report maintaining contact with their healthcare providers in Venezuela through platforms like WhatsApp. In other cases, migrants establish new relationships with healthcare professionals in Venezuela and in other neighboring countries, such as Panama. These healthcare providers are paid through electronic transfers. Telemedicine is often comparatively cheaper, but migrants acknowledge that this option precludes access to ancillary services such as laboratory tests. In some cases, payment is not required. Primarily, virtual healthcare is based on social ties with specialists in Venezuela established prior to emigration.

We also note the reported presence of community centers (*centros comunitarios*) set up by the municipality that organize doctor visits—a common practice in resource-constrained cities. In Tumbes, Peru, the actors we interviewed shared that they started organizing these visits due to the increasing influx of Venezuelan immigrants and the need to have free access to healthcare in their communities.

Non-biomedical service providers, such as healers, massage therapists, medicine men, and other specialists in traditional/magical-religious/spiritual medicine also represent a relied-upon option. Migrants must pay for these services directly, but as is the case with Venezuelan providers, it is a preferable option to potentially bad or discriminatory treatment in the formal system. In some cases, these healthcare providers offer services that respond to cultural concerns and difficulties present in social contexts. Among Wayúu populations in Riohacha, healers act as a comparatively more welcoming and accepting form of care.

Finally, participants also reported using medicine exchange networks, which typically help people with chronic conditions common among older adults, such as hypertension and diabetes. Migrants donate drugs for those who need them and lack the resources to buy them. Medicine may be exchanged for medicine or for other goods. Notably, medicine exchange networks also represent an important platform to build trust and community bonds among participants.

The impacts of COVID-19

Participants report severe economic duress caused by the pandemic, which has increased their chance of contracting the virus, because it forced them to disregard lock-downs in search for income, while limiting their ability to cover basic food and housing expenses. Additionally, the pandemic has taken a heavy toll on participants' mental health. Each of these factors represent significant public health challenges in their own right. In Colombia, participants reported reductions of between 50% and 80% in their daily income. In Peru, after the first two months of lockdown, a large proportion of Venezuelans were reportedly unemployed; 74% of the surveyed migrants could not afford to buy food and basic necessities (Luzes et al., 2020). Combined, they present a constellation of challenges that demand coordinated and decisive care.

> It's horrible, because picture this, we can't work as we used to. Luckily, I have a job, but one must work hidden from the police; they won't let you work... I have to pay rent daily, I mean, also Saturday and Sunday and it is really tough. I have my baby and I leave him with a sitter. (Merlys, Riohacha)

Participants reported a decrease in the number of meals consumed daily, and some report eating only once a day. Access to food is the biggest concern for migrants who often have to borrow money to cover their basic living expenses.

> The impact has been quite strong. My wife previously worked at a restaurant, but lost her job due to the pandemic. I was called back to work and am going 2-3 times a week. For three months, we couldn't pay rent, but luckily we were able to reach an agreement with the owner's family to schedule payments on a monthly basis. Before the pandemic, we had a good income, we ate well, and we even sent money to Venezuela on a weekly basis. Now, we are eating twice a day—we get up late so we are not hungry in the morning and eat lunch and dinner—and we send money to Venezuela every month or month and a half. (Wuinson, Lima)

With regard to housing, the number of evictions rose sharply as migrants could not afford to pay rent; nationally, by June 2020, 37% of migrants in Peru were at risk of eviction (Equilibrium CenDe, 2020a). Despite moratoriums on evictions enacted in Colombia and existing legal protections that prevent immediate removal of tenants, Venezuelan migrants reported being ejected from their homes. In addition, the pandemic has seen rental options reduced, since migrants are perceived to be economically unstable, prone to moving without notice, and prone to living in overcrowded conditions. Difficulties in accessing housing result in other health risks, such as disease and malnutrition. Critically, lack of access to housing decreases access to state aid, as the identification of beneficiaries often takes place through home visits.

Following an emergency health measure at the national level in April 2020, the Peruvian government made the SIS available to every foreigner, irrespective of legal status, in case of showing symptoms of COVID-19 (see Legal Obstacles section). However, we found that migrants believed that the medical staff did not know the Venezuelan population could access the SIS, and that a general ignorance about the national law was commonplace among health staff. Regardless, even the special eligibility granted during the pandemic still excludes the majority of Venezuelans, since many are asylum seekers and irregular migrants (see Financial Obstacles section). Participants report that the quality and attention of municipal health facilities has worsened during the pandemic. At some point in the beginning of the quarantine period, small health posts stopped accepting patients as they were already operating beyond their capacity.

> My friend in Trujillo has COVID-19, and he has been at home for a month having treatment because he went to the hospital and they told him that they were not going to treat him because he was Venezuelan. (Delaskar, Trujillo)

> In general, people have posts close to where they live, although sometimes the hospitals are further away. However, during the pandemic, the health posts do not attend you if you do not have the SIS, no matter how much you pay for your consultation. (Civil Society representative, Lima)

The study could not reliably determine the number of infections or deaths from COVID-19. However, we note results from Peru where, out of the 19 migrants interviewed, a third had contracted the virus. In terms of access to healthcare, participants shared that many Venezuelans who are infected did not disclose their health status so that they could keep working, while others refrained from going to the hospitals because they believed that it would be safer to stay at home to avoid catching the virus. Others shared that they believed they would not be given medical attention at a public or private hospital, or that they would be discriminated against because of their nationality.

Discussion and conclusions

Our qualitative study finds that COVID-19 has disproportionately affected Venezuelan migrants living in informal and precarious conditions. However, beyond this broad observation, we highlight specific lessons gathered from across the four Colombian and three Peruvian cities.

First, we note the complex interactions between national and local policy and actors and how these interactions affect migrants' access to care. The recent introduction of laws and provisions to expand care—such as Peru's inclusion of migrants in care in case of showing symptoms of COVID-19—do not necessarily translate into effective access. Bureaucratic itineraries, per Abadia and Oviedo (2009), still present significant obstacles in terms of cost and time, and often expose migrants to discrimination and even physical danger. Migrants also face unreasonable hurdles at hospitals' points of entry (e.g., guards, clerks), either through ignorance or discrimination, which effectively bar migrants from services. More inclusive migration and health policies often interact ineffectively with other sectors, particularly urban policy—a link most visible in rising evictions in each of the cities we surveyed—which put migrants at higher risk of contagion.

Second, we highlight how COVID-19 impacts the interaction between migrants' health and access to other basic goods and services, particularly housing and food. Since most migrants cannot access a free public health system—by virtue of their status and impossible bureaucratic itineraries—the only way to get medical attention is by having the economic means to cover the treatments. However, as participants in both Colombia and Peru reported, formal jobs are scarce, particularly given quarantine measures, and informal labor puts them at risk. Whatever resources migrants may have are consumed by health needs,

which, in turn, makes it difficult to cover basic needs, further exacerbating their vulnerability. We also note the grave effects these burdens have on migrants' overall mental health.

Third, in a context of increased vulnerability, Venezuelan migrants have come to rely on non-state, often extralegal health services. Migrants turn to loans or charity organizations, as well as to medicine exchange networks, to help manage costs. Technology has also opened up alternative options through telemedicine with doctors abroad and the use of social media to exchange information about care. There is also a strong reliance on Venezuelan doctors who, even when qualified, lack certification to practice in Colombia or Peru. Many migrants similarly prefer non-biomedical health services, which highlights the importance of trust and cultural preferences regarding healthcare.

These findings also provide guidance for specific policy recommendations. Given legal and financial obstacles, it is important to facilitate access to public health services irrespective of migratory status. Access should give special attention to COVID-19 care in the short and medium term but should focus on creating and strengthening systems of access in the long term. Regarding information asymmetry, it is critical to focus on both the 'demand' and 'supply' sides; national and municipal authorities should develop, promote, and consistently disseminate up-to-date information on access options all along the various points of friction in the bureaucratic itineraries of care (this includes hospital security staff, support personnel, secretarial staff, etc.), and must consider preferred digital platforms. Training sessions for public health staff on national migration law and information on access to services is necessary, as this would facilitate the overall usage of public health services amongst migrants and decrease discrimination practices by staff. Alternative purveyors of care should be approached as important resources in these tasks of information dissemination as they already effectively work as intermediaries between migrants and official health providers. Finally, and specifically for resource-constrained public sector agencies, policy should improve procedural and operational options to support and strengthen those alternative sources of care that can be effective and safe, such as telemedicine, especially as they are becoming active parts of the overall system in Colombian and Peruvian cities.

We also note limitations in our study. Digital, qualitative research, particularly given quarantine restrictions, is ideally suited to engage with vulnerable populations. However, given the digital gap amongst migrants and low-income households, participants can be particularly hard to reach. This was especially true in Tumbes and Trujillo (Peru). We recommend complementary work, not only in terms of additional digital and traditional ethnographies, but also through broader quantitative and mixed-methods research that can produce a full and more representative understanding of the impacts of the pandemic, particularly in terms of health and economic outcomes.

Contributions from the authors

Patricio Zambrano-Barragán, in collaboration with Sebastián Ramírez Hernández and Luisa Feline Freier, led the design, methods, research coordination, and validation of analysis and results. Sebastián Ramírez Hernández oversaw the research in Colombia. Luisa Feline Freier and Marta Luzes carried out and supervised primary research in Peru. City-specific studies in Colombia were led by Charles Beach in Cucuta, Sebastián Ramírez Hernández in Soacha, Alexander Rodríguez in Riohacha, and Rita Sobczyk in Barranquilla.

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Declaration of Competing Interest

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Inter-American Development Bank, its Board of Directors, or the countries they represent.

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