PAN AMERICAN JOURNAL OF PUBLIC HEALTH 100 YEARS

Original Research

Perspectives of health practitioners on the challenges to accessing sexual and reproductive health care services for Venezuelan migrant women during the COVID-19 pandemic in Quito, Ecuador

Susana Guijarro[1], Ana Lucia Torres[1], Gonzalo Montero[1], Mónica Garcia[2], Hernán Sabay[2], Sarah Iribarren[3], José Andrés Ocaña[1], Paula Yánez[1], and Patricio Murgueytio[4]

Suggested citation Guijarro S, Torres AL, Montero G, Garcia M, Sabay H, Iribarren S, et al. Perspectives of health practitioners on the challenges to accessing sexual and reproductive health care services for Venezuelan migrant women during the COVID-19 pandemic in Quito, Ecuador. Rev Panam Salud Publica. 2023;47:e58. https://doi.org/10.26633/RPSP.2023.58

ABSTRACT

Objectives. To describe the perspectives of health practitioners on the barriers, gaps, and opportunities that Venezuelan migrant women experienced to accessing sexual and reproductive health (SRH) services during the COVID-19 pandemic and how SRH services were affected in Quito, Ecuador.

Methods. Health practitioners involved in SRH services at nine public health care facilities in three zones of Quito were surveyed. The Minimum Initial Service Package readiness assessment tool survey, available from the Inter-Agency Working Group on Reproductive Health in Crisis, was adapted for use and data collection in Ecuador.

Results. Of 297 respondents, 227 were included in the analysis. Only 16% of the health practitioners agreed that discrimination against migrant Venezuelans women occurred in the health care system. Of those, only 2.3% described specific conditions associated with discrimination, including requiring identification documents (7.5%) and lack of empathy or responsiveness (6.6%). Most (65.2%) respondents reported that the COVID-19 pandemic affected the use of SRH services by women in the general population and by Venezuelan migrant women more so (56.3%) because of more limited access to SRH services, poverty, and vulnerability. There were no differences between perceptions by levels of health care facility, except with regard to the lack of supplies, awareness of discrimination, and the belief that Venezuelan migrant women were affected more negatively than the local population.

Conclusion. The perception among health practitioners in Quito was that discrimination occurred infrequently during the COVID-19 pandemic despite affecting the health care system. However, some level of discrimination toward migrant Venezuelan migrant women seeking SRH services was acknowledged and may be underrepresented.

Keywords Migrant; sexual health; reproductive health; access to health services; social discrimination; Venezuela.

[1] Public Health Institute, School of Medicine, Pontifical Catholic University of Ecuador, Quito, Ecuador. ✉ Susana Guijarro, susanaguijarro@gmail.com

[2] Graduate Program in Gynecology and Obstetrics, School of Medicine, Pontifical Catholic University of Ecuador, Quito, Ecuador.

[3] University of Washington, Seattle, United States of America.

[4] Independent advisor, Gaithersburg, United States of America.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 IGO License, which permits use, distribution, and reproduction in any medium, provided the original work is properly cited. No modifications or commercial use of this article are permitted. In any reproduction of this article there should not be any suggestion that PAHO or this article endorse any specific organization or products. The use of the PAHO logo is not permitted. This notice should be preserved along with the article's original URL. Open access logo and text by PLoS, under the Creative Commons Attribution-Share Alike 3.0 Unported license.

Migration is the process of human mobility owing to factors such as national insecurity and economic or political instability (1). For many years, migration was considered a be a male process; however, modern migratory waves have shown that female migration is a specific phenomenon that must be analyzed (2). In recent years and in the context of political and economic crises, a large portion of the population of Venezuela has been leaving the country. This situation has generated what some call a mass exodus given that as of 2021, approximately 6 million Venezuelans have left their country. Ecuador is among the countries that has received many Venezuelan migrants (3).

In mid-2021 and during the COVID-19 pandemic, there were 430 000 Venezuelan individuals in Ecuador, almost half (46%) of whom were women, 92% of reproductive age and 43% had a secondary education (4). The most recent wave of migration to Ecuador had included mostly people with limited economic resources; urgent needs for health care, education, and housing; limited possibilities for engaging in the country's economy; and a need for legal residence (4-6). Moreover, the COVD-19 pandemic affected social conditions, putting Venezuelan migrant women (henceforth female individuals of all ages) in vulnerable situations and experiencing unintentional pregnancies, gender-based violence, sexual violence, and sexually transmitted infections (STIs), and HIV/AIDS (3,5,7).

Ecuador's Constitution and an integrated framework for health care guarantees the right to universal access to health care, without discrimination at any level of care (9). However, there is international evidence that migrants are less likely to access health care services and to obtain care compared to the local population (9, 10).

According to a global study (5), in 2021 approximately 51% of people experiencing human mobility accessed public health centers and 15% did not seek any type of assistance. Of the latter group, their reasons included lack of knowledge about the availability of free services (56%), lack of health insurance (24%), fear due to immigration status (10%), and health staff behavior (3%) (5). A report by the United Nations Refugee Agency (4) found that care was inadequate or denied (21%) because services were not available (10%) or because there was a lack of resources (36%). In general, Venezuelan women reported a greater utilization rate of public health services (60%) in comparison with their male counterparts (40%) (5). According to the International Organization for Migration (IOM), in 2021, 38% of Venezuelan migrant women reported accessing SRH services compared with only 26% of men. Women who accessed SRH services sought contraception (26%), STI testing (7%), and health education or counseling (7%) (5).

In Ecuador, the national health system includes primary-level health care services, maternal and child health units, and emergency units located in urban areas to provide health promotion and disease prevention services as well as curative care and outpatient palliative care. Additional services include medical and nursing care, dentistry, psychology, obstetrics and gynecology, pediatrics, nutrition, short-stay hospitalization, and emergency maternity care. Tertiary-level health care facilities provide specialized outpatient and inpatient care and are considered to be national referral centers (11). Government health services are the principal source of health care for 52% of the population (12).

To our knowledge, there is currently no published literature available to understand the access of Venezuelan migrant women to SRH services from the perspective of health practitioners in the city of Quito, which is where the greatest number of Venezuelan migrants arrived (5). There is also a lack of understanding of whether there are differences in perspectives across levels of care. We believe that by understanding practitioners' beliefs and attitudes towards migrant populations, we may contribute to providing more humane and better-quality client-oriented care, a common challenge across government services in Ecuador and elsewhere.

To contribute to this gap in knowledge, we conducted a multiphase study to understand access to SRH by Venezuelan women of reproductive age (10-49 years) residing in the city of Quito. This study explores the health practitioners' perspective on: (a) barriers and opportunities in access to SRH services, (b) changes in SRH services during the COVID-19 pandemic, and (c) differences of perceptions among practitioners, by level of health care facility.

MATERIALS AND METHODS

Study design

We conducted a cross-sectional study as part of a broader investigation, using a mixed-methods (i.e., quantitative and qualitative) approach. This article presents the findings from the quantitative survey of health practitioners. The qualitative results from focus groups with Venezuelan women, men, transgender individuals, and youth, and in-depth individual interviews will be published separately.

Study tools

The Minimum Initial Service Package readiness assessment tool from the Inter-Agency Working Group on Reproductive Health in Crisis Situations was adapted for use in Ecuador (13); i.e., a Spanish version developed by Pro-Familia was modified for the culture and language nuances of Ecuador.

The survey examined the health practitioners' perceptions of barriers, discrimination, gaps, and opportunities faced by Venezuelan migrant women when seeking access to SRH services. Questions were added to evaluate the status of SRH services during the COVID-19 pandemic. The survey included 32 questions to evaluate SRH services for Venezuelan migrant women, including perceptions of discrimination against this population, changes in health services due to migration, the relevance of care to a migrant population, and perceptions on the state of SRH for Venezuelan migrant women. Responses used a 5-point Likert scale for rating perceptions, and yes/no and open-ended responses for expanding on examples and providing details. The survey was pilot-tested among the research team and 30 health practitioners at a secondary-level hospital in the Metropolitan District of Quito. The survey was refined based on feedback to ensure that the questions were clear and could be completed independently.

Study location and participants

Participants were recruited from three maternity hospitals and two primary-level health care centers linked to each

hospital in the southern, central, and northern regions of Quito (n=9). All health practitioners, including general and family physicians, obstetrics–gynecology specialists, obstetric midwives, and nurses who were 18 years of age and older and worked in obstetrics–gynecology services at each health care facility were invited to participate. Convenience (self-selection) sampling was used to recruit from a population of approximately 700 health care practitioners from these categories and levels of care. We requested that health directors at each site distribute the survey to all health practitioners in SRH units and services. The surveys were sent by email and administered online and then followed up with three reminders. RedCap (Research Electronic Data Capture) was used to develop the survey and collect the data.

Data analysis

Anonymous response data were aggregated and analyzed using simple frequency distributions with means, standard deviations, and bivariant analyses using Chi-square and Fisher exact tests based on 95% confidence intervals (95% CIs) for the analysis of health care facility by level of care. Open-ended responses were grouped and recoded into categories established by the research team for ease of analysis and interpretation. Statistical significance level was defined as $P < .05$. Data analysis was performed February to March 2021 using STATA, version 15.0 (StataCorp).

Ethics approval

The study protocol was reviewed and approved by the Ethics Committee for Human Research of the Pontificia Universidad Católica, Ecuador (PV-01-2020); the Ministry of Public Health Directorate for Health Information (MSP-SNSG-2020-15725); and the Pan American Health Organization Ethics Committee (No. PAHOERC.0330.02). Participants provided informed consent in writing before the survey was administered.

RESULTS

A total of 297 surveys were submitted. Of those, 70 were excluded because respondents answered fewer than 60% of the survey questions (n=57) or did not provide informed consent (n=13). The final analysis included a study sample of 227 completed surveys. Table 1 summarizes the baseline characteristics of the study participants. Most participants were women (71%), physicians (58.8%), worked in direct service delivery (86.7%), and were from primary-level health care facilities (61.3%). We found no significant differences between the groups included and excluded from the study.

The survey findings of health practitioners' perceptions of discrimination, barriers, gaps, and opportunities among Venezuelan migrant women's access to SRH services in Quito are presented in the tables. Table 2 presents perceptions of and reasons for discrimination against Venezuelan

TABLE 1. Demographic characteristics of health practitioners in Quito, Ecuador, included or excluded from study analysis, 2021

Characteristic	Respondents, No.	Included		Excluded		*P* value
		No.	%	No.	%	
Respondents, total	297	227	76.4	70	23.6	—
Gender	259					
Women	186	161	71.0	25	78.1	0.397[a]
Men	73	66	29.0	7	21.9	
Profession	227					
Generalist	47	47	21.3	0	0	0.538[b]
Midwives	46	45	20.4	1	16.7	
Obstetrics–gynecology specialist	33	32	14.5	1	16.7	
Family physician	20	19	8.6	1	16.7	
Medical graduate trainee/resident	34	32	14.5	2	33.3	
Nurse	47	46	20.8	1	16.7	
Position	232					
Service-level staff	201	196	86.7	5	83.3	0.363[b]
Chief of service	17	17	7.5	0	0	
Team leader	6	6	2.7	0	0	
Resident/graduate trainee	8	7	3.1	1	1 16.7	
Location of facility, three zones[c]	262					
South	64	56	24.7	8	22.9	0.471[a]
Center	111	93	41.0	18	51.4	
North	87	78	34.4	9	25.7	
Level of care	231					
Primary care	140	138	61.3	2	33.3	0.168[b]
Tertiary care	91	87	38.7	4	66.7	

Source: Prepared by the authors from the study results.
[a]Chi-squared test.
[b]Fisher exact test.
[c] South: Nueva Aurora Luz Elena Arismendi Obstetrics–Gynecology/Pediatric Hospital, La Magdalena Health Center (HC), and Guamaní HC. Center: Isidro Ayora Obstetrics–Gynecology Hospital, Colonial Center HC, and Las Casas HC. North: Pablo Arturo Suarez General Hospital, Carapungo HC, and People's Committee HC.

TABLE 2. Practitioners' perceptions of discrimination toward Venezuelan migrant women who sought access to accessing sexual and reproductive health care services in Quito, Ecuador, 2021

Variable (No. of respondents)	Total	%
Perception of discrimination in health care (n=227)		
Yes	36	15.9
No	191	84.1
Request for legal documentation as a form of discrimination (n=227)		
Yes	17	7.5
No	210	91.5
Deferral in care due to prioritization of local patients as a form of discrimination (n=227)		
Yes	5	2.2
No	222	97.8
Mistreatment as a form of discrimination (n=227)		
Yes	15	6.6
No	212	93.4
Xenophobia as a main reason for discrimination (n=227)		
Yes	47	20.7
No	180	79.3
Overcrowded services as a main reason for discrimination (n=227)		
Yes	106	46.7
No	121	53.3
Lack of supplies as a main reason for discrimination (n=227)		
Yes	75	33.0
No	152	67.0
Health staff exhaustion as a main reason for discrimination (n=227)		
Yes	31	13.7
No	196	86.3
Aware of any condition for discrimination (n=174)		
Yes	4	2.3
No	131	75.3
Don't know	39	22.4
Other reasons for discrimination (n=75)		
Is not familiar with services	3	4.0
Cultural differences	7	9.3
Difficulty to set up an appointment	4	5.3
Lack of documents	3	4.0
Lack of a migration policy	2	3.7
Poverty	9	12.0
Personal prejudices among health care providers	5	6.7
Violence against staff	42	56.0
Negative effects on health care due to incoming Venezuelan population (n=174)		
Agree	98	56.3
Disagree	60	43.7

Source: Prepared by the authors from the study results.

migrant women who accessed SRH services. A minority of practitioners (16%) agreed that discrimination against migrant Venezuelans women occurs in the health care system. Of those, only 2.3% described specific conditions under which discrimination may occur; for example, asking to see immigration documents (7.5%) and lacking empathy or responsiveness (6.6%).

Table 3 presents the perceived influence of the COVID-19 pandemic on access to SRH services. Most respondents (65.2%) reported that the COVID-19 pandemic affected the use of SRH by women in the general population. Venezuelan women appeared to be the most affected (56.3%) because of limited access to health services, poverty, and vulnerability owing to a lack of immigration documentation.

Regarding the gaps in SRH problems, most practitioners (75.3%) reported some degree of agreement that Venezuelan migrant women faced greater SRH problems compared with the local population. Similarly, most (94.3%) perceived that

TABLE 3. Perceptions of change in sexual and reproductive health care (SRH) services in Quito, Ecuador, during the COVID-19 pandemic affecting the general population compared with Venezuelan migrant women, 2021

Variable (No. of respondents)	No.	%
Changes in SRH services, by women (n=224)		
Yes	146	65.3
No	68	30.3
Do not know	10	4.4
Changes affect Venezuelan migrant women vs local population (n=224)		
Yes	81	36.2
No	113	50.4
Do not know	30	13.4
Reasons that Venezuelan migrant women are mostly affected (n=26)		
Alterations in support/management of emergency and migration crises	2	7.6
Lack of identification/documents	3	11.5
Lack of health care supplies	3	11.5
Lack of familiarity with health services	2	7.6
Poor access to health services	6	23.0
Poverty and vulnerability due to conditions of illegality	6	23.0
Resources allocated primarily to COVID-19	1	3.8
Crowded services	2	7.6
Difficulties with transportation	1	3.8

Source: Prepared by the authors from the study results.

Venezuelan migrant women were more likely to have STIs than the local population. Furthermore, 199 (68.4%) practitioners perceived that Venezuelan migrant women faced a greater number of SRH problems, including greater risk of acquiring an STI (n=131; 75.3%). Furthermore, regarding the health practitioners' perceptions of opportunities to access SRH services, most (84.9%) agreed or totally agreed that adequate care to Venezuelan migrant women was provided, and 155 (89.1%) agreed on the importance of SRH care provided to Venezuelan migrant women.

Table 4 presents the associations among barriers, discrimination, gaps, and opportunities to accessing health services for Venezuelan migrant women, by level of care (primary- versus tertiary-level services). There were no differences in perceptions by level of health care facility, except with regard to the lack of supplies, awareness of discrimination, and the belief that Venezuelan migrant women are more affected than the local population.

DISCUSSION

To our knowledge, this is the first Regional study exploring the perspectives of public health system practitioners on the challenges that Venezuelan migrant women face regarding discrimination, gaps, and opportunities to accessing SRH services and the changes that affected SRH services during the COVID-19 pandemic. We found that only 16% of respondents reported that during the pandemic, discrimination (for various reasons and in different forms) was a barrier for Venezuelan migrant women seeking to access SRH services. In contrast, a study in Peru found that most (53%) migrant users of health services reported experiencing a high rate of discrimination in the local system during the COVID-19 pandemic (14). Given that we found no other studies of practitioner perspectives in the Region, we could not compare our findings with those of similar studies. We suggest that perspectives between practitioners and users of SRH services differ. These differences may be associated with a reluctance among practitioners to openly acknowledge stigma and/or discrimination, whereas service users may be more willing to share their authentic feelings when asked.

It is important to note that the questions on discrimination did not focus on personal practitioner attitudes, such as xenophobia, but rather on circumstances regarding the lack of resources (e.g., health care supplies, personnel, or overcrowding). Negative perceptions on the lack of resources were more frequent at the primary care level, which experienced more budgetary limitations during the COVID-19 pandemic because hospitals and other specialized centers were given priority over primary care. Similar findings were identified by a study conducted at the Brazil-Venezuela border area regarding maternal health care; 25% of the women surveyed reported dissatisfaction owing to overcrowding within health care facilities (15). In contrast, a qualitative study in Peru and Colombia by Zambrano-Barragán and colleagues (14) reported that Venezuelan migrants perceived discrimination by practitioners as a barrier to access, a finding that differs from the results of the present study.

Other barriers reported by the health practitioners in our study included Venezuelan migrant women's fear of deportation due to a lack of legal documentation and information and/or discrimination by practitioners. These findings have also been reported by Venezuelan migrants in other countries of the Region, such as Colombia, Peru, and Brazil (14,16). In our study, perceptions of verbal violence towards health care staff by migrants and the influence of cultural expectations towards treatment as reasons for discrimination were novel findings and merit further exploration through a qualitative analysis that is not included in this report.

Regarding gaps in access to SRH services during the COVID-19 pandemic, although most practitioners responded that services

TABLE 4. Association of discrimination barriers, gaps, and opportunities in access to sexual and reproductive health care (SRH) services by Venezuelan migrant women, Quito, Ecuador, 2021

Variable (No. of respondents)	Level of care				*P* value
	Primary		Tertiary		
	No.	**%**	**No.**	**%**	
Total (n=225)	138	61.3	73	38.6	—
Perception of discrimination in health care (n=225)					
Yes (n=36)	24	17.4	12	13.8	0.473[a]
No (n=189)	114	82.6	64	86.2	
Demand for legal identification/documents as a form of discrimination (n=227)					
Yes (n=17)	9	6.5	8	9.2	0.460[a]
No (n=208)	129	93.5	79	90.8	
Deferral in care by prioritizing local patients as a form of discrimination (n=227)					
Yes (n=5)	5	3.6	0	0	0.084[b]
No (n=220)	133	96.4	87	100.0	
Mistreatment in care as a form of discrimination (n=227)					
Yes (n=15)	9	6.5	6	6.9	0.558[b]
No (n=210)	129	93.5	81	93.1	
Xenophobia as a main reason for discrimination (n=227)					
Yes (n=46)	26	18.8	20	22.9	0.452[a]
No (n=179)	112	81.2	67	77.0	
Saturation in services as a main reason for discrimination (n=227)					
Yes (n=106)	63	45.6	36	49.3	0.581[a]
No (n=119)	75	54.4	37	50.7	
Lack of supplies as a main reason for discrimination (n=227)					
Yes (n=75)	55	39.9	20	23.0	0.009[a]
No (n=150)	83	60.1	67	77.0	
Exhausted staff as a main reason for discrimination (n=227)					
Yes (n=31)	18	13.0	13	14.9	0.687[a]
No (n=194)	120	87.0	74	85.1	
Aware of any situation for discrimination (n=174)					
Yes (n=4)	0	0	4	5.3	0.034[b]
No (n=131)	79	79.8	52	69.4	
Does not know (n=39)	20	20.2	19	25.3	
Changes in SRH services more greatly affecting Venezuelan migrant women (n=224)					
Yes (n=80)	44	32.1	36	41.9	0.112[a]
No (n=113)	77	56.2	36	41.9	
Does not know (n=30)	16	11.7	14	16.2	
Changes in maternal care services due to COVID-19 pandemic (n=224)					
Yes (n=146)	88	64.3	58	67.4	0.517[b]
No (n=67)	41	30.0	26	30.2	
Does not know (n=10)		5.8	2	2.4	
Changes in maternal services more greatly affecting Venezuelan migrant women (n=224)					
Yes (n=30)	14	9.6	16	18.6	0.203[a]
No (n=168)	107	78.4	61	70.9	
Does not know (n=25)	16	12.0	9	10.5	
Adequate to provide care to migrant populations (n=174)					
Agree (n=147)	87	87.9	60	80.0	0.155
Disagree (n=27)	12	12.1	15	20.0	
Negative changes in SRH services due to incoming of Venezuelan migrant women (n=174)					
Agree (n=98)	46	46.4	52	69.3	0.002
Disagree (n=76)	53	53.6	23	30.7	
Disagree (n=19)	10	10.1	9	12.0	

(*Continued*)

TABLE 4. (Cont.)

Variable (No. of respondents)	Level of care				P value
	Primary		Tertiary		
	No.	%	No.	%	
Venezuelan migrant women face greater SRH problems (n=174)					
Agree (n=119)	56	60.3	63	75.8	0.001
Disagree (n=55)	40	39.7	15	24.2	
Venezuelan women are more prone to sexually transmitted infections (n=174)					
Agree (n=131)	68	68.7	63	84.0	0.02
Disagree (n=43)	31	32.5	12	16.0	

Source: Prepared by the authors from the study results.
[a]Chi-squared test.
[b]Fisher exact test.

were affected during this time, only 36.2% perceived that Venezuelan migrant women were more affected compared with the general population. Practitioners also perceived that Venezuelan migrant women faced more issues with receiving SRH care, especially risk associated with STIs compared with the local population. This perception is supported by epidemiologic findings of a study conducted in Brazil that observed a higher prevalence of STI cases among migrant women compared with the local population (17). We were not able to validate this observation using local epidemiologic data because it is not routinely collected by the public health system in Ecuador.

Lastly, it is important to note that more than 85% of the survey respondents agreed that SRH services should be available to Venezuelan migrant women. This finding is consistent with public sector policy and regulations in Ecuador, which provide free and universal access to health care. However, this finding also underscores that some health practitioners may not agree that these services should be available to migrant women, a perspective that could potentially affect access.

Limitations

Our study reflected the situation at a given point in time and within a defined space; therefore, the findings may not reflect the changing scenario of health services amid COVID-19 nor the different geographic and social contexts in the Region. We selected primary- and tertiary-level health services in three areas of Quito to have a geographically diverse local representation. Initially (pre-pandemic) we planned to evaluate a random sample of all health services in the Metropolitan District of Quito. However, given the restrictions imposed during the pandemic, we had to shift to a convenience sample of nine health facilities, and it became difficult to trace each respondent. Consequently, results cannot be generalized to other health services and other populations. The highest proportion of respondents came from the primary-care level; thus, tertiary-level practitioners may be underrepresented, which may affect the associations among levels of care and barriers to discrimination, gaps, and access opportunities.

Conclusions

Health practitioners reported low rates of perceived gaps in care, discrimination barriers, and opportunities for access to SRH services by Venezuelan migrant women across the three city zones of Quito, Ecuador. The main reasons associated with discrimination were the lack of resources and the excessive demand for services. These findings suggest that health practitioners within the public health facilities in Quito agree with the need to guarantee the right to health care through free and universal care for migrants; however, they also believe that migration has affected health services. Finally, we found no significant differences between practitioners at the primary- and tertiary-levels of care regarding perceptions of a discrimination barrier, gaps, and opportunities to access health services. Two exceptions were the tertiary-level practitioners' perception that the lack of supplies was greater at the primary care level and that the risk of SRH problems among Venezuelan migrant women was greater compared with the local population.

Not surprisingly, health practitioners reported that SRH services were adversely affected by the pandemic, and many considered Venezuelan migrant women to be more affected than women of the local population. Practitioners also perceived that Venezuelan migrant women were at higher risk for SRH problems and STIs compared with women of the local populations; this perception could not be validated by the available epidemiologic data.

Although the perception of health practitioners suggests that discrimination occurred infrequently in the health care system of Quito, some level of discrimination toward migrant Venezuelan women was acknowledged; it may be underreported. Findings highlight the need for awareness and training of health practitioners on SRH needs of migrant Venezuelans to address discrimination and other barriers to access for this population living in vulnerable situations and to ensure that Ecuador's national and international protocols are upheld.

Author Contributions. SG, ALT, MG, SI, GM, and PM participated in the original conception of the study. SI, PY, SG, MG, HS, and JAO supported the preparation of the instrument, its application, and data tabulation. JAO, GM, SG, and SI participated in the analysis of results. All authors participated in the preparation and correction of the manuscript. All authors reviewed and approved the final version.

Conflicts of interest. None declared.

Funding. This work received funding from the UNDP–UNFPA–UNICEF–WHO–World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), and the UNICEF–UNDP–World Bank–WHO Special

Programme for Research and Training in Tropical Diseases (TDR), both cosponsored programmes executed by the WHO. This work also received support from the Alliance for Health Policy and Systems Research, Science Division at the WHO; the Center for Perinatology, Women's Health, and Reproduction (CLAP) at PAHO; and the Centro de Pesquisas em Saúde Reprodutiva de Campinas (CEMICAMP), Brazil. The funders had no role in the study design, data collection or analysis, decision to publish, or preparation of the manuscript.

Disclaimer. Authors hold sole responsibility for the views expressed in the manuscript, which may not necessarily reflect the opinion or policy of the *RPSP/PAJPH* and/or the Pan American Health Organization (PAHO).

REFERENCES

1. Hofmann M, Jolivel A, Huss D, Ambiaux C. International Migration: Drivers, Factors and Megatrends. A Geopolitical Outlook; International Centre for Migration Policy Development. 2020 [cited 2023 Jan 27]. https://www.icmpd.org/file/download/51472/file/Policy%2520Paper%2520-%2520Geopolitical%2520Outlook%2520on%2520International%2520Migration.pdf
2. Courtis C, Pacecca MI. Género y trayectoria migratoria: Mujeres migrantes y trabajo doméstico en el área metropolitana de Buenos Aires. Pap Poblac. 2010 [cited 2021 Dec 13];16(63):155-185. http://www.scielo.org.mx/pdf/pp/v16n63/v16n63a6.pdf>
3. CEPAM, ACNUR, UNFPA, IPPFRHO. Acceso de mujeres migrantes, refugiadas y personas en situación de vulnerabilidad a los servicios de salud sexual y salud reproductiva en Ecuador durante la pandemia por COVID-19. UNFPA en el Ecuador [Internet]. 2021 [cited 2021 Dec 13]. Available from: https://ecuador.unfpa.org/sites/default/files/pub-pdf/fin_resumen_ejecutivo_final_acnur_cepamg_ippfrho_final_1_3.pdf
4. United Nations Refugee Agency. Ecuador: Monitoreo de Protección Q1 2021-24 junio 2021 [Internet]. 2021 [cited 2021 Dec 13]. Available from: https://data2.unhcr.org/en/documents/details/87953#_ga=2.140136179.1901618233.1639434376-485111991.1639434376>
5. International Organization for Migration. Displacement Tracking Matrix. Monitoreo de Flujo de Población Venezolana: Ecuador (March 2021). [Internet]. 2021 [cited 2022 May 2];1–18. Available from: https://dtm.iom.int/reports/ecuador-%E2%80%94-monitoreo-de-flujo-de-poblaci%C3%B3n-venezolana-ronda-10-febrero-marzo-2021
6. United States Agency for International Development. USAID/OFDA brinda asistencia de salud a venezolanos vulnerables en Colombia [Internet]. 2019 [cited 2021 Oct 20]. Available from: https://2017-2020.usaid.gov/sites/default/files/documents/1866/Boletin_OFDA_LAC_Marzo_2019.pdf
7. Robalino Molina AV. Estrategias emprendidas por las mujeres migrantes venezolanas calificadas en Quito para enfrentar los desafíos y dificultades en su inserción laboral. 2019 [cited 2021 Dec 13]. Available from: http://repositorioslatinoamericanos.uchile.cl/handle/2250/2924246
8. Ministerio de Salud Pública del Ecuador. Modelo de Atención Integral Del Sistema Nacional de Salud. MSP; 2012:219.
9. Derose KP, Gresenz CR, Ringel JS. Understanding disparities in health care access--and reducing them--through a focus on public health. Health Aff (Millwood). 2011;30(10):1844-1851. doi:10.1377/hlthaff.2011.0644
10. Lucas JW, Barr-Anderson DJ, Kington RS. Health status, health insurance, and health care utilization patterns of immigrant Black men. Am J Public Health. 2003;93(10):1740-1747. doi:10.2105/ajph.93.10.1740
11. Ministerio de Salud del Ecuador. Suplemento del Registro Oficial No. 428, 30 de enero 2015 Normativa: Vigente (se expide la tipología sustitutiva para homologar los establecimientos de salud por niveles de atención y servicios de apoyo del sistema nacional de salud). 2015 [cited 2021 Dec 28];1–14. Available from: https://www.suinba.com/website/registros%20oficiales/S.R.O%20N%C2%B0%20428,%20VIERNES%2030%20ENE2015.pdf
12. Velasco M, Hurtado F, Tapia J. El acceso geográfico desigual a la salud en Ecuador. Obs Soc del Ecuador [Internet]. 2020 [cited 2022 Apr 11];10. Available from: https://cebes.org.br/el-acceso-geografico-desigual-a-la-salud-en-ecuador/22472
13. United Nations Population Fund. Minimum Initial Service Package (MISP) for SRH in Crisis Situations. United Nations Population Fund [Internet]. 2020 [cited 2023 Feb 6]. Available from: https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations
14. Zambrano-Barragán P, Ramírez Hernández S, Freier LF, Luzes M, Sobczyk R, Rodríguez A, et al. The impact of COVID-19 on Venezuelan migrants' access to health: A qualitative study in Colombian and Peruvian cities. J Migr Health. 2020;3:100029. doi: 10.1016/j.jmh.2020.100029
15. Bahamondes L, Laporte M, Margatho D, et al. Maternal health among Venezuelan women migrants at the border of Brazil. BMC Public Health. 2020;20(1):1771. doi:10.1186/s12889-020-09912-x
16. United Nations Refugee Agency. Regional Refugee and Migrant Response Plan: Venezuela. Rompiendo Barreras, Creando Caminos: Prácticas Y Prioridades Estratégicas Para El Acceso a Los Servicios para Sobrevivientes de Violencia Basada en Género [Internet]. 2019 [cited 2021 Dec 20]. Available from: https://data2.unhcr.org/en/documents/details/71649
17. de Lima MM Junior, Rodrigues GA, de Lima MR. Evaluation of emerging infectious disease and the importance of SINAN for epidemiological surveillance of Venezuelans immigrants in Brazil. Braz J Infect Dis. 2019;23(5):307-312. doi:10.1016/j.bjid.2019.07.006

Manuscript received on 16 November 2022. Revised version accepted for publication on 2 December 2022.

Perspectivas de los prestadores de atención de salud sobre las dificultades de acceso a los servicios de salud sexual y reproductiva de las mujeres migrantes venezolanas durante la pandemia de COVID-19 en Quito (Ecuador)

RESUMEN

Objetivos. Describir las perspectivas de los prestadores de atención de salud sobre los obstáculos, las brechas y las oportunidades que registraron las mujeres migrantes venezolanas para acceder a los servicios de salud sexual y reproductiva (SSR) durante la pandemia de COVID-19 y cómo se vieron afectados estos servicios en Quito (Ecuador).

Métodos. Se encuestó a prestadores de atención de salud que trabajan en servicios de SSR en nueve centros de salud pública de tres zonas de Quito. Se utilizó una adaptación de la encuesta sobre el instrumento de evaluación de la disposición operativa del paquete de servicios iniciales mínimos, disponible en el Grupo de Trabajo Interinstitucional sobre Salud Reproductiva en Situaciones de Crisis, para la recopilación de datos en Ecuador.

Resultados. De las 297 personas encuestadas, 227 quedaron incluidas en el análisis. Solo el 16% de los prestadores de atención de salud estaba de acuerdo en que en el sistema de salud había discriminación contra las mujeres migrantes venezolanas. De estos, solo el 2,3% describió circunstancias específicas asociadas a la discriminación, como la exigencia de documentos de identidad (7,5%) y la falta de empatía o capacidad de respuesta (6,6%). La mayoría (65,2%) de las personas encuestadas manifestó que la pandemia de COVID-19 había impactado en el uso de los servicios de SSR por parte de las mujeres de la población general y, en mayor medida, por parte de las mujeres migrantes venezolanas (56,3%) debido a sus limitaciones para acceder a los servicios de SSR, su pobreza y su vulnerabilidad. No hubo diferencias en las percepciones según el nivel de los centros de salud, excepto con respecto a la falta de insumos, la concientización sobre la discriminación y la creencia de que estas mujeres se vieron más afectadas que la población local.

Conclusión. La percepción en los prestadores de atención de salud en Quito fue que, pese a ser un fenómeno que afectaba al sistema de atención de salud, la discriminación había sido poco frecuente durante la pandemia de COVID-19. Sin embargo, se reconoció cierto nivel de discriminación hacia las mujeres migrantes venezolanas que solicitaban servicios de SSR y que este fenómeno podría estar subrepresentado.

Palabras clave Migrantes; salud sexual; salud reproductiva; accesibilidad a los servicios de salud; discriminación social; Venezuela.

Perspectivas dos profissionais de saúde sobre as dificuldades de acesso aos serviços de saúde sexual e reprodutiva das mulheres migrantes venezuelanas durante a pandemia de COVID-19 em Quito, Equador

RESUMO

Objetivos. Descrever as perspectivas dos profissionais de saúde sobre as barreiras, lacunas e oportunidades que as mulheres migrantes venezuelanas encontraram para acessar serviços de saúde sexual e reprodutiva (SSR) durante a pandemia de COVID-19 e como esses serviços foram afetados em Quito, Equador.

Métodos. Foram entrevistados profissionais de saúde envolvidos nos serviços de SSR de nove unidades públicas de saúde de três zonas de Quito. Adaptou-se o questionário de avaliação da prontidão para oferecer o pacote de serviço inicial mínimo, disponibilizado pelo grupo de trabalho interagencial sobre saúde reprodutiva em situações de crise, a fim de realizar a coleta de dados no Equador.

Resultados. Dos 297 respondentes, 227 foram incluídos na análise. Apenas 16% dos profissionais de saúde concordaram que havia discriminação contra mulheres migrantes venezuelanas no sistema de saúde. Desses, apenas 2,3% descreveram condições específicas associadas à discriminação, como cobrança de documentos de identificação (7,5%) e falta de empatia ou responsividade (6,6%). A maioria (65,2%) dos respondentes relatou que a pandemia de COVID-19 afetou o uso dos serviços de SSR por mulheres na população de modo geral. As mulheres migrantes venezuelanas foram mais afetadas (56,3%) devido ao acesso limitado a serviços de SSR e à pobreza e vulnerabilidade. Não houve diferenças de percepção entre diferentes níveis de atenção à saúde, exceto no que diz respeito à falta de insumos, sensibilização para a discriminação e crença de que as mulheres migrantes venezuelanas foram afetadas de forma mais negativa que a população local.

Conclusão. Para os profissionais de saúde em Quito, a discriminação foi pouco frequente durante a pandemia de COVID-19, embora a pandemia tenha afetado o sistema de saúde. Entretanto, os profissionais reconheceram certo nível de discriminação contra as mulheres migrantes venezuelanas que procuram serviços de SSR, que pode estar sub-representado.

Palavras-chave Migrantes; saúde sexual; saúde reprodutiva; acesso aos serviços de saúde; discriminação social; Venezuela.