MEDWAVE
Peer Reviewed Medical Journal

RESEARCH

# Migration and access to sexual and reproductive health from the perspective of health agents in northern Chile

María Belén Reinoso-Cataldo[a], Mercedes Carrasco-Portiño[a, b]*, Cecilia Bustos-Ibarra[c], Valeria Stuardo-Ávila[d]

*[a]Departamento de Obstetricia y Puericultura, Facultad de Medicina, Universidad de Concepción. Concepción, Chile; [b]Grupo de investigación de Salud Pública. Universidad de Alicante, España; [c]Departamento de Trabajo Social, Facultad de Ciencias Sociales, Universidad de Concepción. Concepción, Chile; [d]Instituto de Salud Pública, Universidad Andrés Bello, Santiago, Chile*

**ABSTRACT**

**INTRODUCTION** Due to the increase and feminization of migration in Chile, and the resulting boost in the demand for sexual and reproductive health consultations, there is a need for analizaing migrants' access to health services from the health agents' perspective.

**OBJECTIVE** To characterize migrants' access to sexual and reproductive healthcare from the health agents' perspective.

**METHODS** Exploratory-descriptive qualitative study with a phenomenological approach. Theoretical sampling included midwives from primary health care (n=4) and staff from NGOs working with migrants (n=7). Data was collected through semi-structured interviews and a focus group, and then analyzed with ATLAS.ti.

**RESULTS** Through healthcare agents, we found that there are gaps in the migrants' access to sexual and reproductive healthcare, which are associated to a lack of information on the Chilean health system, the distance between their living places and the health centers, and health not being migrants' priority, plus other gaps affecting the LGBTQIA+ community. The agents also give suggestions on how to mitigate these gaps, such as increasing information strategies and facilitating cross-sector collaboration. There are positive elements as well, such as the primary healthcare teams' knowledge of health profiles per nationality, ability to fit their speech, and willingness to adapt healthcare to the different cultural practices.

**CONCLUSION** There are gaps in the access of health care and use of sexual and reproductive health services by migrants, which are mainly associated to the lack of information on their rights in Chile and ignorance of sexual and reproductive health services. Information strategies should be expanded towards migrants.

**KEYWORDS** Human Migration, Community Organization, Primary Health Services, Health Services, Sexual Health, Reproductive Health

## INTRODUCTION

In recent years, there has been an increase in migratory movements, both at the international and national levels. The United Nations (UN) projections showed that by mid-2019, there were 271.6 million migrants worldwide, equivalent to 3.5% of the global population. In Chile, according to the latest statistics declared for the same year, there were 1 492 522 foreigners, close to 7.81% of the national population [1]. In 2021, the Tarapacá Region concentrated 4.9% of the migrant population in the national territory, making it the fourth region with the most migrants. The communal distribution residents estimated for 2018, 2019, and 2020 in the Tarapacá Region were led by the commune of Iquique with 63.9% of declared residence, followed by Alto Hospicio with 27.2% [2].

In this sense, when analyzing Census data from 2002 to 2017 and estimates from 2018 to 2021 of migrants in the Tarapacá Region, an increase was observed between 2012 and 2018, followed by an increase of 5.3% in the last year. Bolivia is the country with the highest prevalence, with 46.4% of all migrants

* **Corresponding author** mecarrasco@udec.cl
**Citation** Reinoso-Cataldo MB, Carrasco-Portiño M, Bustos-Ibarra C, Stuardo-Ávila V. Migration and access to sexual and reproductive health from the perspective of health agents in northern Chile. Medwave 2025;25(2):e3009
**DOI** 10.5867/medwave.2025.02.3009
**Submitted** Sep 4, 2024, **Accepted** Jan 23, 2025,
**Published** Mar 27, 2025
**Postal address** Dpto. de Obstetricia y Puericultura, Facultad de Medicina, Universidad de Concepción. Avenida Chacabuco esquina Janequeo s/n, 3er piso, Concepción, Chile

**MAIN MESSAGES**

- Knowledge of the functioning of the health system by the migrant population is essential, as it facilitates the optimal and effective search for the health services offered.
- This study incorporates the perspective of health agents from non-governmental organizations and primary health care, since the scientific evidence focuses on the migrant population.
- The main limitation of the study is related to the lack of time of the population participating in the study.

in the region, followed by Peru and Colombia, which have 23.9% and 7.9%, respectively [2].

Migration a social determinant of health. Every migratory process is dynamic and, as a consequence, causes changes in people's behavior, both at the individual level and in the family and community environment, which has an impact on the health of the migrant [3]. In this sense, the more accurate the approach to the health risk to which migrants are vulnerable, the more their healthcare needs will be understood, and the better the quality of health interventions will be [4].

Knowledge of the functioning of the health system by the migrant population is essential, as it facilitates the optimal and effective search for the health services offered. In this sense, community interventions aimed at informing the migrant about the health system's functioning help ensure effective management of the access and use of health services. This intervention increases the level of satisfaction with the quality of care received by this population, as was observed in a case-control study in Denmark, which concludes that having a certain degree of knowledge of the health system is necessary for effective healthcare-seeking [5].

Another fundamental aspect of access to a comprehensive health system is sexual and reproductive health. Scientific evidence supports the alarming inequities in sexual and reproductive health care for immigrant women in Canada in a systematic review conducted in 2021. The findings showed that while positive experiences with health care providers and social support facilitated access to sexual and reproductive health care for some women, social isolation, precarious immigration status, discrimination, and stigma from the receiving community and health care providers presented significant challenges. This presents a need for a greater understanding of the inequalities faced by immigrant women across the spectrum of services concerning sexual and reproductive health [6].

A study conducted in 2021 focused on Santiago, Chile, showed that almost 70% of migrant participants indicated affiliation with the Chilean healthcare system. Sixty-three percent said they were affiliated with the public system, 6% with the private system, almost 2% said they had another, and 3% did not know if they had health insurance [7].

Of the participants, 78% indicated they had ever received care in the health care system. Of these, 26.5% reported having faced some care obstacles during the COVID-19 pandemic. The most frequently reported was the gap in acceptability of care as people attended but did not feel a respectful attitude toward the treatment received in 40% of the cases. The study also found that 18% of the participants indicated they knew where to go for a consultation. However, they did not find hours available during the pandemic period. In addition, 13% indicated that they went to their scheduled time, but the consultation did not materialize; 12% expressed difficulties with the language to request care; and 11% did not access due to problems related to their documentation, type of visa, Unique Tax Number (RUT, identification number used in the country, which coincides with the National Unique Number, RUN), or affiliation to the health system. Of those interviewed who had ever accessed care, only 15.3% had any notion of the intercultural approach to migrant health, and 6.8% reported having received a consultation mediated by a linguistic or intercultural facilitator at some point [7].

According to the National Institute of Statistics, the distribution of the foreign population from 2018 to 2021, 53.7% of the foreign population in this region were aged between 25 and 44 years. In almost all age ranges, women make up the majority of migrants. The exceptions were the 0 to 19 and 35 to 39 age groups, with more men than women. Considering the latter, the prevalence of these age groups is evidence of the need to access services due to their reproductive age [8].

In Chile, most sexual and reproductive health care is provided by the women's health program, which includes benefits associated with preconception control, gestational control, childbirth, and puerperium care, along with breastfeeding activities. All these issues are incorporated into the Chile Crece Contigo System. They also address the reproductive stage, but also preventive services for gynecological cancer (breast or cervical cancer), care in the climacteric stage, sexual and reproductive health counseling, along with consultations for sexually transmitted infections, including HIV [9]. Access to this program is similar for the autochthonous population as for migrants since the latter can request a provisional identification number if their migratory situation has not yet been regularized. In Chile, the National Health Fund is in charge of creating and validating the provisional identification number so that migrants can receive primary care, regardless of their status in the country. The provisional identification number is valid for one year, after which it must be re-registered. This is an attempt to support the regularization of migratory status, seeking their inclusion in the country [10,11].

In view of the above, the health experience of mobile populations is also highly influenced by their experiences in their country of origin, during their journey, at their destination, and when they

migrate again. The regulatory framework governing the health system, the political environment, and the economic and social situation of the country of origin are not only determining factors that could explain the cause of the decision to migrate but also factors of protection and exposure to health risks before and during the migration process. For this reason, exposure to risk and vulnerability situations related to the movement of people should be considered and evaluated comprehensively, taking into account all stages of the migration process [12].

This study aims to identify the gaps faced by the migrant population in accessing sexual and reproductive health, mediated by health agents as key actors in the access and use of health services in Chile [13].

## METHODS

This is a qualitative study with an exploratory-descriptive design and a phenomenological perspective. The accounts of health agents who perform functions in the Province of Iquique are analyzed. The fieldwork was carried out between October and December 2023.

The study population was determined using a theoretical purposive snowball sampling. Seven people who provided services as non-governmental organization (NGO) staff were interviewed (three individual interviews and one focus group with four participants) and four individual interviews with primary health care (PHC) midwives. The inclusion criterion for primary health care personnel was to have a midwifery degree, at least two years of experience in primary health care, and attend migrants. For NGO community agents, it was required that they participate directly in the sexual and reproductive health care of the migrant population. For both profiles, people with severe cognitive dysfunction and/or communication or hearing difficulties, which could affect the communication exchange process, preventing the development of the information collection method, were excluded. Midwifery professionals of foreign nationality performing functions in the study territory were also excluded.

The approach with participants was carried out in three NGOs that provide services to the migrant population and in three primary health centers in the Province of Iquique. Contact was established by the researcher responsible for the mayor's office of Alto Hospicio, considering that the health centers are under municipal administration and with the directors of the three NGOs. The study's objectives were described to them, and letters of approval for participation were sent. Once they had agreed to participate, the interview schedules were coordinated. The study's objectives and the confidentiality of the information were explained to all interviewees. Those who agreed to participate signed the informed consent form.

The information-gathering technique was carried out through an in-depth interview based on a guideline that, in turn, was based on a logical framework. In addition, the focus group technique was also used as an adjustment to the initial methodological design, which contemplated only individual interviews. This was in response to the difficulties of the NGO staff's available schedules.

The first author conducted all the interviews and the focus group in person, and a quality control sheet was used to record observations. They were conducted at the NGO headquarters and health facilities in spaces that guaranteed confidentiality. Each session was recorded and later transcribed. The duration fluctuated between 40 and 60 minutes until saturation of the discourse was achieved. An effort was made to anonymize the audio interventions of the people involved after the transcription of each one of them. The team read, organized, and grouped the content according to the subject treated. The qualitative analysis software ATLAS Ti was used to analyze the data collection and organize it following the objectives.

Express authorization was requested from each of the participants in the study after a favorable report from the Scientific Ethical Committee of both the Faculty of Medicine of the Universidad de Concepción (CEC4/2023) and the Ethics, Bioethics, and Biosafety Committee of the Vice-Rectory of Research and Development of the Universidad de Concepción (CEBB1523/2023). Subsequently, an information sheet and informed consent were given to each of the study participants.

## RESULTS

In characterizing access to sexual and reproductive health care for the migrant population from the perspective of health agents, categories emerged associated with non-priority health among migrant groups, knowledge about access and autonomy in sexual and reproductive health, and appreciation of the scientific-technical quality of consultations. In addition to these categories, current migration policies such as the provisional identification number, user treatment, and access of the LGTBIQA+ (lesbian, gay, bisexual, transgender, queer, intersex, and asexual, +) migrant population to the health system are also considered. In addition to highlighting the importance of the facilitators and barriers to access to the health system recognized by this study group, they suggest proposals to close the gaps identified (Table 1).

### Knowledge about access to the health system

From the perspective of health agents regarding knowledge of migrants' access to the health system, in all the experiences, this knowledge is scarce or non-existent. Upon entry, considering their migratory status, migrants mistakenly assume that they will not be able to access services because of their irregular entry. They also express fear since the fact of accessing services could be an instance of risk of deportation.

### Sexual and reproductive health benefits

Regarding sexual and reproductive health, they consider that migrants arrive unaware of the range of services available. This generates a significant gap in using and enjoying the full range of services offered. On the other hand, attention is focused on prenatal care, and misinformation minimizes the need to

**Table 1.** Characteristics of access to sexual and reproductive health care for the migrant population.

| Categories | PHC midwives | NGO officials |
|---|---|---|
| Knowledge about access to the health system | • Lack of access information.<br>• Fear of deportation. | • Lack of information regarding access to health services.<br>• Association between irregular migratory status and not having the right to access health services.<br>• Fear of deportation.<br>• Lack of information network among compatriots. |
| Sexual and reproductive health benefits | • Low awareness of the availability of sexual and reproductive health services.<br>• Perception of limited supply of family planning methods in the public health system.<br>• Late admissions for prenatal care.<br>• Continuity of HIV treatment. | • Lack of knowledge of sexual and reproductive health services.<br>• Services focused on prenatal care.<br>• Access to benefits according to referrals indicated by health professionals. |
| Non-priority health | They come on the recommendation of peers rather than because of their need for care. | • Migration for economic, labor, quality of life, political or armed conflicts.<br>• Less relevance of practices associated with access to and use of health services mediated by cultural practices of the context of origin.<br>• Non-priority sexual and reproductive health services. |
| Lack of autonomy on the part of clients | • Perception of fear and inferiority on the part of the consulting migrant.<br>• Perception of self-hierarchization in an inferior position and of lesser possibilities compared to the national population.<br>• They are subordinated to the professional's indications. | No information available. |
| Facilitators of access | • Common language.<br>• Adequacy of language by the professional. | Community organizations facilitate access to care by providing information. |
| Appreciation of the scientific-technical quality of healthcare | • Very short consult times.<br>• Professional knowledge of a profile by nationality.<br>• Adaptation of sexual and reproductive health care according to diverse cultural practices. | No information available. |
| Access barriers | • Scarce human resources versus demand for care.<br>• Geographic distance [1]. | • Constant change in immigration policies, such as the request for more documentation.<br>• Increasing misinformation regarding immigration policies.<br>• Lack of information on how to obtain the PIN. |

(Continued)

seek services. This is much more invisible for the sex-diverse community.

(Continued)

| Categories | PHC midwives | NGO officials |
|---|---|---|
| LGTBIQA+ | • Guaranteed access and equal health.<br>• Lack of training for health professionals on the subject.<br>• Perception of self-marginalization added to non-regular migratory status.<br>• Lack of knowledge or invisibilization of sexual and reproductive health services for this population. | • Closeness among peers from the sexually diverse community.<br>• Perception of Chile as a more prejudice-free country than their countries of origin.<br>• Internalization of stigma[4].<br>• Lack of training for health professionals on the subject. |
| Suggestions for improvement | Strengthening the work with the intersector to massify the supply of health services. | • Greater initiative on the part of the local government to provide information on access to health care in the mass media.<br>• More information on access to the health care system for the migrant community directly from the health facility itself.<br>• Information work on access to health care in the field.<br>• Raise awareness among the migrant population about the importance of the basic right of access to health care and regular health check-ups.<br>• Strengthen PHC-NGO links to carry out articulated work that allows access to health care for the migrant population. |

HIV: human immunodeficiency virus. LGTBIQA+: lesbian, gay, bisexual, transgender, queer, intersex and asexual, +. NGOs: non-governmental organizations.PHC: primary health care. PIN: Provisional Identification Number.
[1]Population mainly living in squatter settlements, far from health centers, do not have good road access or nearby locomotion, connectivity is not adequate.
[2] Illegal occupations.
[3]Non-formal employment.
[4]Self-marginalization from care centers for fear of discrimination.
Analysis carried out from the perspective of health agents in the Province of Iquique, Chile.
Source: Prepared by the authors based on interviews with four primary health care midwives and seven people who provide services as employees of non-governmental organizations.

**Non-priority health**

Migrants do so due to economic, labor, quality of life, or even to flee political or armed conflicts. For these reasons, health is subordinated to a later level, preventing access to the health system. From this perspective, the failure to prioritize sexual and reproductive health is closely linked to the supply of preventive services in the countries of origin. People who come from countries with similar services (for example, cervical cancer preventive control through the Papanicolaou test) demand such services in Chile.

**Appreciation of scientific-technical quality**

This category is only identified by primary health care midwives. Although there is a generalized perception of satisfaction with the scientific-technical quality of the Chilean health care system by the migrant population, they consider that the time performance of the consultations is low. In other words, they perceive that not all their needs are attended to in the consultation, which generates a certain degree of user dissatisfaction. The same occurs with medical consultations since they report that short attention times are insufficient for professionals to give complete and understandable diagnoses. This also leads to a decrease in the degree of compliance with the expectations of the user population.

**Facilitators of access**

Among the facilitators of access to the health system, community agents highlight the community organization itself. In general, they emphasize their role in orienting and supporting migrants, highlighting the importance of their initiatives to promote access to the health system for migrants. For primary health care professionals, having a profile differentiated by nationality and adapting health care considering cultural preferences and roots favors users' adherence to the health system.

**Access barriers**

One of the common access barriers for health workers is geographic distance. This is given explicitly by squatter settlements far from the central points of the commune, with poor road access and poor connectivity. In addition, primary healthcare professionals recognize insufficient human resources to respond to the demand for care.

Other barriers identified by the NGOs are related to structural aspects linked to the migration policy in Chile (for example, modification of these policies, increase of requirements for regularization, and lack of information on the procedure to obtain the provisional identification number, among others).

**LGTBIQA+ population**

Regarding the LGTBIQA+ population, there is a perception on the part of health agents that recognizes what has been called "internalization of stigma". This is expressed in self-marginalization from health care centers for fear of discrimination. In addition, the findings show the intersection between their migrant status and belonging to the sex-diverse community, placing people in a position of unique vulnerability.

Regarding the competencies of health professionals, both health workers perceive little training in topics such as the treatment and management of people belonging to the LGTBIQA+ community. This limits the access of this community to sexual and reproductive health services.

Another finding identified by the NGOs is that the migrant population perceives Chile as a country with fewer gender prejudices and stereotypes than their countries of origin.

## DISCUSSION

In the access to the health system of migrants under the experience of civil society organizations and primary health care professionals, common elements are identified. We found that, in their eyes, health care is not a priority issue for the migrant population; the time designated for care due to the performance established by the Ministry of Health is scarce; and illegal settlements are far from health care centers. Regarding the LGTBIQA+ population, self-marginalization and the lack of professional training for their care are the main obstacles to access.

However, the health component acquires special relevance in the case of mobile populations. This is because their behaviors, demographic disposition, health needs, and access to and use of the health system differ from those of the native population [14]. According to data from the Socioeconomic Characterization Survey (CASEN) of 2017, these account for a better level of self-perceived health by the migrant population compared to the Chilean population [15]. This is related to what the literature has described as the so-called "healthy migrant effect", which correlates with better health indicators in the migrant population compared to the national population. That is, the healthy population of reproductive age migrates. Thus, people who have not accessed health services do so because they say they are not sick or do not feel sick. Consequently, they would not represent a real need for assistance and access [16].

On the other hand, when faced with the same health needs as the local population, they do not have access to care, which is known under the concept of "horizontal inequity" in health services. This consists of differentiated access to or use of the health system for the same needs. In other words, migrants underuse health services due to the barriers to access and use, which are also discussed in this study [16].

On the other hand, it should be remembered that the current legislation associated with entry and exit movements to and from Chile establishes that access to health care is independent of the migratory status of individuals. Decree No. 67, which incorporates immigrants in an irregular situation, without visas or documents, as beneficiaries of the National Health Fund, reinforces the importance of disseminating information about their rights among health agents and users [16].

Concerning the lack of information regarding access to care, this research shows that migrants are unaware of the functioning of health services in their destination country. In addition, it was found that the information provided by their migrant peers is not adequate. In this sense, the role of NGO community agents is highlighted as a guide and facilitator to inform, sensitize, and raise awareness among the migrant population regarding access to services, mainly access to the basic right to health.

These findings are consistent with international literature in a study investigating why Canadians and immigrants do not seek health services even when they report needing them. Compared to the Canadian population, a higher proportion of immigrants related their lack of effective access to the health care system to not knowing how to access it, language difficulties and health care services might be inadequate for them [17].

Regarding the health personnel's appreciation of the scientific-technical quality, the study groups consider that care yields are very limited in the primary health system. The Ministry of Health defines this measure of human resources management. One of its main criticisms is the standardization in the time of care, assuming that each person requires a different time according to the reason for consultation [18]. This is one aspect that determines the degree of satisfaction of both the user population and those who make up the health teams. The short attention time is detrimental to user satisfaction, reduces the preventive scope, determines an incorrect prescription of drugs, and increases the chances of clinical malpractice [19]. In this sense, the findings of this research position this element as a barrier in primary care, which would provide information that can guide health management to improve patient satisfaction.

Another barrier to access identified by the health agents is geographical distance, contrary to what would be expected in facilities located in urban areas, where this gap is not generally present. In the province of Iquique, there was an exponential increase in the formation of camps and squatter settlements, which can be explained by the enormous migratory pressure

that this border region is experiencing, which is associated with the social and health crisis. In the Tarapacá Region, there were 3935 homes in camps by 2018, increasing to 11 328 by 2023. Alto Hospicio displaced other communes as the municipality with the most camps in Chile. This would explain the incidence of migratory movements in irregular housing far from the central points of the commune, segregating migrants socio-spatially and making access to health services difficult. These conditions, associated with the socioeconomic level, poor road access, and the monetary cost of transportation as described in this research, would constitute a gap in access to health services for this group in particular [20].

Regarding the LGTBIQA+ population, there is a perception of self-marginalization associated with the fear of discrimination or distrust generated by the institutional health system itself. According to the findings obtained, when any person belonging to the sex-gender diversity migrates, they are placed in a situation of special vulnerability and are often discriminated against for reasons of sexual orientation and gender identity. Fear of discrimination is positioned as an important barrier that generates reluctance to access health services, both in terms of linkage and in terms of adherence and continuity of care. This is a consequence of patterns of marginalization and submission rooted in Chilean culture [21]. In addition, it could be attributed to the concept of internalized sexual stigma. This is based on the self-acceptance of stigma and discriminatory acts by people who recognize themselves as part of a sexual minority, incorporating it into their value formation. This would affect their adequacy and conformity to social prejudices [22].

In this sense, this fear and self-marginalization are positioned as gaps in access in a preponderant way in the general context of the people who participated in the research, not only segregating gender diversity. Perception of discrimination is a complex variable, considering that it is one of the social determinants of mental health [23,24].

There is also a significant lack of information regarding gender and sex diversity issues on the part of professionals working in health facilities. Thus, there is a certain degree of invisibilization of LGTBIQA+ people due to lack of training, use of non-inclusive language, and stigmatization. According to the people interviewed, staff training is a priority and should be implemented in care, findings that agree with research conducted in Concepción, Chile [17]. Training health personnel on gender issues should be an important part of undergraduate and technical training. The incorporation of constant and updated knowledge on gender issues will ensure that users receive care from a gender perspective, free of prejudice and stigmatization, thus ensuring compliance with the ethical aspects related to health care [25].

The study's main limitation is related to the lack of time of the study participant population, both NGO and primary health care people. This was faced through methodological adjustment, from an initial design considering only semi-structured interviews to incorporating the focus group technique.

The results show an important finding in the structural barrier linked to migration policies. Even so, the lack of information is particularly relevant, which, together with other variables intrinsically associated with migrating, makes the link between foreigners and the health system even more difficult. Generally, foreigners encounter greater obstacles than the local population in accessing and using the health system.

## CONCLUSIONS

The present investigation confirms that there are gaps associated mainly with the lack of knowledge of the functioning of the health system in general, as well as of the access and use of this system by the migrant population. In this context, administrative barriers such as unregulated entry and stay, fear of discrimination, and insufficient time for care by health personnel stand out.

Based on these findings, it is possible to recommend, in the first instance, the strengthening of information strategies on the health system for the migrant population, especially for those who are in their first period of settlement in the country.

It is also necessary to strengthen actions to bring the offer of sexual and reproductive health services of the Chilean primary health system closer to the migrant population through operations and field trips.

Along the same lines, it is necessary to establish and/or reinforce formal links between the health system and civil society to achieve an effective intersectoral articulation that will favor the access of the migrant population to the health system.

In addition, it is essential to strengthen good treatment and the cultural relevance of care, rejecting any form of discrimination or any action that restricts the free exercise of sexual and reproductive rights.

Finally, it is suggested to reinforce training strategies in gender-focused care for women and sex-gender diversities.

**Contributor roles** MBRC participated in the conception of the idea, design of the study, data collection, data analysis, drafting, writing - revision and editing of the final paper submitted to the journal. MCP, CBI and VSA participated in the conception of the idea, design of the study, data analysis, drafting, writing - reviewing and editing of the final paper submitted to the journal.

**Competing interests** The authors declare that there are no conflicts of interest.

**Funding** Community surveillance of socio-epidemiological aspects linked to sexual health and related communicable diseases in migrant population in Chile. National Agency for Research and Development of Chile, National Fund for Scientific and Technological Development (Fondecyt Regular No 1220371).

**Language of submission** Spanish.

**Peer review and provenance** Not requested. With external review by three peer reviewers, double-blind.

## REFERENCES


1. Diaz Tolosa R. In: Contexto social y estatuto de los migrantes en Chile [Internet]. 2020. https://intranet.academiajudicial.cl/Imagenes/Temp/BOC_AJ_Libro%20MD2_Contexto%20social%20y%20Migrantes_2020-08-18_Imprimible%20(1).pdf
2. Servicio de Migraciones. Minuta población migrante en la Región de Tarapacá. In: Serviciomigraciones.cl [Internet]. https://serviciomigraciones.cl/wp-content/uploads/estudios/Minutas-Region/Tarapaca.pdf
3. Copelli G. La globalización económica del siglo XXI. Entre la mundialización y la desglobalización. Revista de estudios internacionales Universidad de Chile. https://doi.org/10.5354/0719-3769.2019.52048
4. Silva C. In: Globalización: Dimensiones y Políticas Públicas [Internet]. https://www.cienciared.com.ar/ra/usr/3/770/hologramatica_n10_vol1pp3_25.pdf
5. Arenas P, Urzúa M. A. ESTRATEGIAS DE ACULTURACIÓN E IDENTIDAD ÉTNICA. UN ESTUDIO EN MIGRANTES SUR-SUR EN EL NORTE DE CHILE. Univ Psychol. 2016;15: 15–25. https://doi.org/10.11144/Javeriana.upsy15-1.eaie
6. Majid S, Douglas R, Lee V, Stacy E, Garg AK, Ho K. Facilitators of and barriers to accessing clinical prevention services for the South Asian population in Surrey, British Columbia: a qualitative study. CMAJ Open. 2016;4: E390–E397. https://doi.org/10.9778/cmajo.20150142
7. Cabieses B, Obach A, Blukacz A, Vicuña JT, Carreño A, Stefoni C. In: Vulnerabilidades y recursos de comunidades migrantes internacionales en Chile para enfrentar la pandemia SARS-CoV-2: Construyendo estrategias diferenciadas desde la interculturalidad [Internet]. Santiago, Chile: Universidad del Desarrollo; 2021. https://saludinmigrantes.cl/wp-content/uploads/2021/05/Reporte-final-Vulnerabilidades-y-recursos-de-migrantes-en-pandemia-09abril.pdf
8. Instituto Nacional de Estadística de Chile. Informe de resultados de la estimación de personas extranjeras residentes en Chile al 31 de diciembre de 2021, desagregación nacional, regional y principales comunas. Santiago, Chile: INE; 2022. https://www.ine.gob.cl/docs/default-source/demografia-y-migracion/publicaciones-y-anuarios/migraci%C3%B3n-internacional/estimaci%C3%B3n-poblaci%C3%B3n-extranjera-en-chile-2018/estimaci%C3%B3n-poblaci%C3%B3n-extranjera-en-chile-2021-resultados.pdf?sfvrsn=d4fd5706_6#:~:text=En%202021%20se%20estimaron%20un,con%20ligera%20mayor%C3%ADa%20de%20hombres
9. Gobierno de Chile, Ministerio de Salud. In: Programa de Salud de la Mujer [Internet]. https://diprece.minsal.cl/programas-de-salud/programas-ciclo-vital/informacion-al-profesional-salud-de-la-mujer/
10. Organización Internacional de Migraciones, UNICEF, Gobierno de Chile. In: Lo que debes saber sobre acceso a salud [Internet]. https://chile.iom.int/sites/g/files/tmzbdl906/files/documents/2024-08/folletooim-derechosaludeducacion.pdf
11. Gobierno de Chile, Ministerio de Salud. In: Salud del inmigrante [Internet]. https://www.minsal.cl/salud-del inmigrante/
12. Cabieses B, Bernales M, McIntyre A. In: La migración internacional como determinante social de la salud en Chile: evidencia y propuestas para políticas públicas Universidad del Desarrollo [Internet]. Santiago, Chile: Universidad del Desarrollo; https://www.udd.cl/dircom/pdfs/Libro_La_migracion_internacional.pdf
13. FONASA. In: Estudio de migración en Fonasa: caracterización de la población migrante 2018 [Internet]. http://www.fonasa.cl/sites/fonasa>/adjuntos
14. Gobierno de Chile, Ministerio de Desarrollo Social y Familia. Encuesta de Caracterización Socioeconómica Nacional (CASEN) 2017. In: observatorio.ministeriodesarrollosocial.gob.cl [Internet]. https://observatorio.ministeriodesarrollosocial.gob.cl/encuesta-casen-2017
15. Cabieses B, Libuy M, Dabanch J. In: Hacia una comprensión integral de la relación entre migración internacional y enfermedades infecciosas [Internet]. https://www.colegiomedico.cl/wp-content/uploads/2019/10/documentos-migrantes_final_compressed.pdf
16. Gobierno de Chile. Decreto 67 – Modifica Decreto N° 110 de 2004, del Ministerio de Salud, que fija circunstancias y mecanismos para acreditar a las personas como carentes de recursos o indigentes. 2004.
17. Wu Z, Penning MJ, Schimmele CM. Immigrant status and unmet health care needs. Can J Public Health. 2005;96: 369–73. https://doi.org/10.1007/BF03404035
18. Gobierno de Chile, Superintendencia de Salud. In: Estudio sobre Trato Digno en Usuarios del Sistema de Salud (nacionales y migrantes internacionales) [Internet]. https://obtienearchivo.bcn.cl/obtienearchivo?id=documentos/10221.1/83090/1/Informe_Final_Trato_Digno_V2.pdf
19. Lin CT, Albertson GA, Schilling LM, Cyran EM, Anderson SN, Ware L, et al. Is patients' perception of time spent with the physician a determinant of ambulatory patient satisfaction? Arch Intern Med. 2001;161: 1437–42. https://doi.org/10.1001/archinte.161.11.1437
20. Poduje I, Vergara J, Mieres E, Iribarne C. Incidencia de Tomas Organizadas con Recursos y Logística [TORL]. In: Atisba.cl [Internet]. https://www.atisba.cl/wp-content/uploads/2023/03/Reporte-Atisba-Monitor-Campamentos.pdf
21. El Otro inmigrante "negro" y el Nosotros chileno.Un lazo cotidiano pleno de significaciones. The International Encyclopedia of Human Sexuality. http://onteaiken.com.ar/ver/boletin17/art-tijoux.pdf22.Bockting https://doi.org/10.1002/9781118896877
22. World Health Organization. In: Plan de Acción sobre Salud Mental 2015-2020 [Internet]. 2014. https://www.paho.org/es/documentos/plan-accion-sobre-salud-mental-2015-2020

23. Estay G. F, Valenzuela V. A, Cartes V. R. Atención en salud de personas LGBT+: Perspectivas desde la comunidad local penquista. Rev chil obstet ginecol. 2020;85: 351–357. https://doi.org/10.4067/S0717-75262020000400351
24. Valenzuela A, Cartes R. Perspectiva de género en la educación médica: Incorporación, intervenciones y desafíos por superar. Rev chil obstet ginecol [Internet]. 2019;84: 82–88. https://doi.org/10.4067/S0717-75262019000100082.26
25. McCann E, Brown M. The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. Nurse Educ Today. 2018;64: 204–214. https://doi.org/10.1016/j.nedt.2018.02.028

# Migración y acceso a la atención en salud sexual y reproductiva desde la perspectiva de los agentes de salud en el norte de Chile

**RESUMEN**

**INTRODUCCIÓN** Considerando el incremento de la migración y su feminización, con el consiguiente aumento en la demanda de consultas en salud sexual y reproductiva, es importante describir el acceso que tienen las personas migrantes a los servicios de salud desde la perspectiva de los agentes de salud.
**OBJETIVO** Identificar las características del acceso a la atención en salud sexual y reproductiva de la población migrante desde la perspectiva de agentes de salud.
**MÉTODOS** Estudio cualitativo, exploratorio-descriptivo con perspectiva fenomenológica. Se efectuó un muestreo teórico intencionado que incluyó a matronas de atención primaria de salud (n = 4) y a personal de organizaciones no gubernamentales (n = 7) que atienden a población migrante. Se realizaron entrevistas en profundidad y un grupo focal. Cada entrevista fue grabada y transcrita. Se realizó análisis de contenido con apoyo del software ATLAS.ti.
**RESULTADOS** Las agentes de salud identificaron brechas en el acceso a la atención en salud sexual y reproductiva para las personas migrantes, asociadas a falta de información sobre el sistema de salud chileno, distancia geográfica de su lugar de residencia y los centros sanitarios, y a que la salud no es prioritaria para las personas migrantes, teniendo en cuenta sus condiciones de vida y otras brechas específicas que afectan a la población LGBTIQA+. Se aportan sugerencias que podrían mitigarlas, como aumentar estrategias informativas a la comunidad y favorecer la articulación intersectorial. Destacan elementos positivos como el conocimiento de los equipos de atención primaria de salud de los perfiles según nacionalidad, adecuación del lenguaje y disposición de adaptación de la atención según las distintas prácticas culturales.
**CONCLUSIÓN** Se reconocen brechas asociadas al acceso y uso de servicios en salud sexual y reproductiva de la población migrante, cuyo eje central se asocia a la falta de información sobre el derecho a la salud de esta en Chile y al desconocimiento a las prestaciones en salud sexual y reproductiva. Se sugiere ampliar las estrategias informativas.