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ESSAYS

The health of migrants and Family Medicine Health services in Iberoamerica

La salud de los migrantes y los servicios de salud en Medicina Familiar en Iberoamérica

A saúde dos migrantes e os serviços de saúde de Medicina Familiar na Iberoamerica

Miguel Ángel Fernández Ortega[a]
Jacqueline Beatriz Roo Prato[b]
Rocío Dávila Mendoza[c]
Johanna Montalvo Vázquez[d]
María Cristina Da Costa Dias[e]
Andrea De Angulo Losada[f]
Alan Edward Barrell[g]
Daniel Abidán Alarcón Lerín[h]

Workgroup:
Almeida Magda (Brasil); Borges Carina (Uruguay); Caballé María del Rosario (Argentina); Cabral Diana Ines (Argentina); Da Costa María Cristina (Venezuela), de Angulo Andrea (Colombia); Deza Castro Luis Alberto (Chile); Díaz Brito Ysabel María (República Dominicana); Fernández Maria (España); Fernández Ortega Miguel Ángel (México); Leyns B. Christine (Bolivia); Lezcano Portillo Federico (Paraguay); Luna Téllez Yossadara (México); Meyer Ana Lucía (República Dominicana); Meza Luna Elena Patricia (México); Montalvo Vázquez Johanna (Ecuador); Nadal Carmen (Chile); Ortiz Montalvo Armando (México); Perozo Juan Carlos (Venezuela); Polentinos Elena (España); Quintero Daymé (Panamá); Sánchez Núñez Flor Mariana (México); Suárez Cuba Miguel Ángel (Bolivia); Ulloa Jorge (Nicaragua); Zavala Cru Gad Gamed (México).

Abstract

This is an exploratory, transverse, Qualitative-Quantitative descriptive research, whose objective is to determine the Primary Access and Family Medicine Healthcare conditions for the migrant population in Ibero-America. With the support of University Professors from the Mexico, Colombia and Ecuador Universities, a validated 22 question questionnaire was prepared with items related to the migration phenomenon and healthcare services in Primary Care access and Family Medicine. Subsequently it was responded by the involved researchers of the 13 countries in the region. The conclusions and proposed recommendations from the Work Group on Migration and Healthcare of the VII Iberoamerican Family Medicine Summit were: a) It is necessary to recognize the migrants and their family rights to proper healthcare b) Include in the undergraduate, postgraduate and continuous educational programs the needed capabilities and skills towards an integral healthcare of the migrant populations and their families and c) create a Migrant Health Observatory entity.

Keywords: Health Services; Healthcare; Health; Migration; Family Medicine; Primary Care; Vulnerability

[a] Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM); Confederación Iberoamericana de Medicina Familiar (WONCA-Iberoamericana-CIMF). Mexico. miguelaf03@live.com *(Corresponding author)*

[b] Fondo de Pensiones del Sistema Banrural (FOPESIBAN). Mexico. jroop3@gmail.com

[c] Facultad de Medicina, Universidad Nacional Autónoma de México (UNAM). Mexico. rociodavilam@yahoo.com.mx

[d] Instituto de Salud de la Migración, Hospital UTPL; Confederación Iberoamericana de Medicina Familiar (WONCA-Iberoamericana-CIMF). Ecuador. johanna.montalvo@hotmail.com

[e] Sociedad de Medicina Familiar de Venezuela (SOVEMEFA); Ambulatorio Militar "La Rosaleda". Venezuela. cristydacosta@yahoo.com

[f] Sociedad Colombiana de Medicina Familiar (SOCMEF); Banco de la República de Colombia. Colombia. ayeyas@yahoo.es

[g] Facultad de Medicina, Universidad Autónoma de Guadalajara (UAG). Mexico. aebarrell@yahoo.com

[h] Instituto Mexicano del Seguro Social (IMSS), Clínica de Medicina Familiar No.10. Mexico. 10.daniboy880109@hotmail.com

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Resumen

Estudio exploratorio, transversal, descriptivo y cuali-cuantitativo, con el objetivo de determinar las condiciones de acceso y cobertura de los servicios de salud de Medicina Familiar y Atención Primaria para la población migrante en Iberoamérica. Se preparó un cuestionario con 22 preguntas relacionadas con el fenómeno de la migración y la prestación de servicios de salud en medicina familiar y atención primaria, el cual fue validado en apariencia y contenido por profesores de las Universidades de México, Colombia y Ecuador. Posteriormente fue respondida y documentada cada pregunta por los docentes e investigadores de 13 países de la región. Las conclusiones y recomendaciones propuestas por el Grupo de Trabajo sobre Migración y Salud de la VII Cumbre Iberoamericana de Medicina Familiar, fueron: a) reconocer el derecho a la salud de las personas migrantes y sus familias; b) incorporar en los programas de pregrado, posgrado y formación continua, las competencias necesarias para la atención integral de la población migrante y de sus familias y c) la creación de un observatorio de salud de los migrantes.

Palabras clave: Servicios de Salud; Salud; Migración; Medicina Familiar; Atención Primaria; Vulnerabilidad

Resumo

Estudo exploratório, transversal, descritivo e quali-quantitativo, com o objetivo de determinar as condições de acesso e cobertura dos serviços de saúde de Medicina de Família e Atenção Primária para a população migrante na América Latina. Foi elaborado um questionário com 22 perguntas relacionadas ao fenômeno da migração e da prestação de serviços de saúde em medicina de família e cuidados de saúde primários, que foi validado na forma e conteúdo por professores de universidades no México, Colômbia e Equador. Posteriormente, foi respondida e documentada cada pergunta por professores e pesquisadores de 13 países da região. As conclusões e recomendações propostas pelo Grupo de Trabalho sobre Migração e Saúde da VII Cúpula Ibero-Americana de Medicina de Família, foram: a) reconhecer o direito à saúde dos migrantes e suas famílias; b) incorporar em cursos de graduação, pós-graduação e educação continuada, as competências necessárias para o atendimento integral dos migrantes e suas famílias e c) a criação de um observatório da saúde dos migrantes.

Palavras-chave: Serviços de Saúde; Saúde; Migração; Medicina da Família; Atenção Primária; Vulnerabilidade

Introduction

The phenomenon of migration has had different directions throughout the history of man. During the Colony, the flow of migrants was massively carried out from European countries to America, Africa and even Australia. Later, during the First and Second World War, as well with the Civil Spanish War and many other events happening in the so called “Old Continent”, they continued to enforce that much of its population look forward to settle in America.[1]

Much of the world migratory flow in the American Continent, has been directed mainly to the English-speaking countries: United States of America (USA) and Canada, although there is an increasing presence of Asian countries (China, India, Vietnam, etc.).

In the case of Mexico, it is the largest issuing country of emigrants to the USA (approximately 13 million); and is also transit step to the north of the continent through this pathway to migrants from Central and South America and the rest of the world. It is also one of the main receptors of Ibero-American immigrants along with Spain and the previously mentioned USA.[1] The economical remittances generated by this emigration, placed it in 2014 as the third country in the world in reception of remittances, only after India and China.[2]

Although global migration has considerably increased in the last decade, from 150 to 214 million,[3] intraregional migration has also grown at a 17% rate per year, not necessarily having to do with the migration of Central America and the Caribbean to the USA. It is related to the mobilization of people in other sub regions of Latin America, which according to data from the American States Organization (OAS) and the Economic Cooperation for Development Organization (OECD), represents up to a quarter of the total migration of the population in this region.[4-6]

According to the above, Argentina is constituted as the main recipient of migrants in the Southern Cone, with approximately 1.5 million legally established migrants.[4] Brazil is a very stable country, with the most important emigration being internal to large cities, not so in external immigration, which reports up to 17% from Portugal.[5,6]

In the Andean Region of South America, it can be observed as the main migrants expelling country is Colombia, mainly as the result from the armed conflict with the guerrilla and paramilitary groups. The other country with great mobility today is Venezuela, which due to the known political, economic and social conflict has gone from being a regional immigrant recipient country to a high emigrant territory.[4-6]

Historically, Ecuador has been a country that expel emigrants, their main destinations have been the USA, Spain and Italy. In recent years it has been observed that due to the global economic crisis, the recognition of the country as a middle income and the creation of a new migration policy, the attraction for many immigrants from neighboring countries have increased.[7]

In Central America and the Caribbean, the main migratory flows are to the USA and Canada. Intraregional emigration is concentrated in two countries: Costa Rica and the Dominican Republic. In the first case, mainly consisting of Nicaraguans, Colombians and retired Americans and in the second case, predominantly by Haitians.[4-6] In 2007, Spain had approximately 1.8 million foreigners, predominantly from Ecuador, Colombia and Argentina.[1]

For the purposes of this research, human migration is defined as the movement of people from one place to another with the intention of permanently settling in the new place. Movement is often over long distances and from one country to another, but internal migration is also possible. The migration can be of individuals, families or large groups.[8,9]

Objective

Determine the current situation regarding the access and coverage of the migrant population to the healthcare services of Family Medicine and Primary Care in Ibero-America.

Method and Materials

Exploratory, cross-sectional, descriptive study and mixed approach: Quantitative-Qualitative was carried out between the months of September 2017 to January 2018 with the purpose of situational diagnosis. One or two experts in the topic from the 20 member countries of WONCA-Iberoamericana-CIMF were invited to participate. The participants were known professors, researchers or practicing clinicians and were given the task of investigating and documenting the responses to a questionnaire with 22 questions related to the migration phenomenon and the provision of Healthcare services in Family Medicine and Primary Care in their respective countries.

The instrument explored six general dimensions: migratory and economic flows; family profile and migrant characterization, also the vulnerability of the irregular migrant; availability of protection programs and access to healthcare services; health risks in the health-disease process and the actual training of human resources to care for migrants.

This questionnaire was prepared, reviewed and validated in its content and appearance by professors from different educational institutions in Mexico, Colombia and Ecuador. In a second stage the validation was done by the members of the working group in the study. The questionnaire was then sent via email to each of the participating researchers. The information provided was concentrated into a regional report and then re-sent to the group's participants for their review and approval. After this process it was presented for open analysis and discussion in the working group during the 7th Ibero-American Family Medicine Summit in Cali, Colombia in March 2018.

Results

Of the 20 countries in the Region, only 13 responded to the survey: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Spain, Mexico, Nicaragua, Panama, Paraguay, Uruguay and Venezuela. The following are the obtained and recorded results.

Emigration in Ibero-America (IBA)

Regional emigration is very varied and has different characteristics in each of the sub regions of Ibero-America. Although CIMF is constituted by four sub regions (Mesoamerica, Andean, Southern Cone and Iberian Peninsula), the presentation of the results may or may not coincide with this sub regional segmentation.

In the Southern Cone, it is observed that in addition to the influx of migrants to Europe and the USA, there is also a significant intraregional flow. Argentina reported in 2012, that the main destinations of its emigrants were, Spain (30.2%), USA (23.3%), Chile (8.5%), Paraguay (6.1%), Israel (5,0%), Bolivia (4.7%), Brazil (2.9%) and Uruguay (2.3%)[10] Brazil has also had a greater emigration to Europe (51.5%), with a predominance towards Portugal (13.4%), Spain (9.4%), Italy (7.1%) and the United Kingdom (6.6%). Second place (23.9%) to the USA and third to the Asian continent (9%, of which, 7.4% goes to Japan).[11]

In the case of Paraguay, the emigration is to the contiguous countries, mainly Argentina, which from 2000 to 2010 had an increase of 70.5% of Paraguayan immigrants. It is followed by Spain and Brazil with almost 80 thousand and 39 thousand respectively in 2015.[12]

For Chileans, the country they emigrate to is Argentina, followed by the United States and then other destinations, such as Sweden, Australia, Brazil, Venezuela, Spain, France and Germany.

Uruguay reported in order of importance the same destinations as Argentina and Brazil, such as Spain, USA and later Argentina and Brazil.[13]

The Andean Region, integrated in this study by Bolivia, Colombia, Ecuador and Venezuela. Bolivia reported that according to the 2012 National Population Census, the main reception sites of Bolivians are: Argentina (38.2%), Spain (23.8%), Brazil (13.2%), Chile (5.9%), USA (4.2%), Italy (1.8%) and Peru (0.8%). Before the economic crisis of 2008 and the visa requirement for Bolivians to countries of the European Union (April 1, 2007), Spain was the main destination.[14,15] Bolivia has about 10 million citizens and approximately 1.6 million emigrants. In the 2012 census, 11.1% of the households declared having an emigrant relative.[16,17]

Colombia is the country with the largest number of emigrants from South America (4.7 million), which is equivalent to 10% of its current population, followed by Peru and Brazil. According to World Bank data for 2011, the main destinations of Colombian emigration were USA (28.8%), Venezuela (28.4%), Spain (17.6%), Ecuador (8%), Canada (2), 1%) and subsequently Mexico, Panama and Australia.[18,19]

Ecuador is in the 102nd position of the 194 ranking of emigrants. The top 10 countries where they migrated in 2015 were: United States, Spain, Italy, Venezuela, Chile, Canada, Colombia, United Kingdom, Germany and Switzerland.[7]

In the case of Venezuela (2015), 606,344 Venezuelans lived abroad. However, there is a lot of irregular migration, which is difficult to measure. In February 2018, the report of National Migratory Trends in South America, it is observed that between 2015 and 2017 the global migration of Venezuelans increased by 132%, being the countries chosen: Colombia, USA, Spain, Chile, Argentina, Italy, Ecuador, Panama, Brazil, Mexico, Peru and Portugal. According to consolidated data of the International Migration Organization for (IOM), in 2015, the percentage of Venezuelans outside the country was 2.3% of its population and in 2017 it is estimated at approximately 4.7%, which indicates that almost 80% of the recent emigration from Venezuela has occurred mainly during the years 2016 and 2017. When comparing the figures of 2015 with those of 2017, an explosion in the movements of Venezuelans towards other countries is confirmed.[20] (Table 1)

Table 1. Emigratión in IBA: main destinations according to country, 2010-2017.

Country of origin	Main countries of destination
Argentina	Spain, USA, Chile
Bolivia	Argentina, Spain, Brazil
Brazil	USA, Portugal,Japan
Colombia	USA, Venezuela, Spain
Chile	Argentina, USA, Spain
Ecuador	USA, Spain, Italy
Spain	France, Germany, USA
Mexico	USA, Canada, Spain
Nicaragua	Costa Rica, USA, Guatemala
Panama	USA, Costa Rica, Spain
Paraguay	Argentina, Spain, Brazil
Uruguay	Spain, USA, Argentina
Venezuela	Colombia, USA, Spain

Source: Data obtained from research according to references.[10-25]

Mesoamerica region is integrated into this study by Mexico, Nicaragua and Panama. Amazing was that to confirm that Mexico is the country with the greatest migratory flow to the USA, in 2015 it reached around 13 millions of emigrants, 97.81% of this total emigration to USA and; Canada in second place 0.61%; Spain 0.41%; Germany in fourth place, 0.15% and Guatemala 0.15%.[22]

Nicaragua reports that 14.0% of its population lives abroad, mainly in Costa Rica and the USA, although it is followed by Guatemala, El Salvador and to a lesser degree Spain and Honduras, representing approximately three quarters of intraregional migration in Central America.[23]

In Panama, 52% of emigrants go to the USA; 6.4% Costa Rica; Spain 6.2%; Colombia 3.8% and Mainland China receives 2.8% of Panamanians.[24]

Spain is one of the main receiving countries of Latin American migrants. After the economic crisis that began in 2008, many Spaniards were left without work or their life expectancies were frustrated, so they decided to migrate to other countries. In 2009 there were 1,000,047 thousand Spanish residents abroad, according to the National Institute of Statistics of that country, the number of Spanish migrants increased during the following eight years, reaching in 2017 to 2.40 million people, of which, 794,209 (33%), are born in Spain, the remaining 67%, are nationalized foreigners, surpassing the figure of 1.6 million people. His favorite destination to emigrate was the European Union (425,919, in 2017). In 2009, 819,731 nationalized Spaniards returned to their country of origin, calculating that of them, 578,763 (71%), did so to Latin America. Eight years later, the number of nationalized who have returned to their country has doubled (from 755,923 to 1,000,042 people). The main receiving countries of Spanish migrants are France, Germany, United Kingdom, Argentina and Venezuela. The last two were referred to the nationalized Spaniards who returned to their country of origin.[25]

Immigration in the Iberoamerican countries

According to the last 2010 Census, 1,805,957 people of foreign nationality lived in Argentina, representing 4.5% of the total population. Of these, 3.67% come from the American Continent. It is the main recipient country of intraregional migration, with Paraguay (36.4%), Bolivia (23.5%), Chile (13%), Peru (10.6%), Uruguay (7.9%) having greater relevance, and Brazil (2.8%).[10] This migration has been favored by the regional integration agreements (the Common Market of the South [MERCOSUR] and the Andean Community of Nations) that facilitate intraregional mobility. On the other hand, there is also growth in the number of non-South American migrants who are more vulnerable than regional migrants due to the difficult access to migratory regularity.[20] In recent years there has been an increase in Dominican and Venezuelan immigrants, with the latter reaching a percentage increase of 903% (1,936 in 2017). Other flows of significant immigrants are those affected by the conflict in the Syrian Arab Republic, which from October 2014 to October 2017, has received 828 applications for admission. Likewise, 4,747 residences were granted to citizens of Senegal between 2010 and 2015 (97.7% Men and 2.3% Women).[26]

In Chile, according to United Nations (UN) data, there were 369,436 immigrants in 2010, a figure which increased to 469,436 in 2015, a 27% increase, which corresponds to 2.7% of the total population. Between 2005 and 2016, 323,325 Definitive Permanencies were granted in Chile, with the Peruvian community benefiting the most, with 123,401 (38%); subsequently the Bolivian (13.5%), and the Colombian (13%).[27-29]

Immigration in Uruguay seems to be less intense and diverse, the data reported correspond to people from Argentina and Brazil mainly. The main issuer of the European immigrants is Spain.[13]

According to the 2010 Census, Brazil has 0.3% of the population composed by foreigners, which totals just under 600,000 inhabitants, from Portugal (21%), Haiti (8%), Bolivia (8%), Japan (7%), Italy (6%), Spain (5%), Argentina (5%), China (5%) and USA (3%).[30]

Under a special Refugees condition, in 2015 they received 10,308 applications, the majority being from Venezuela (33%), Cuba (13%) and Angola (13%). In 2016, 9,552 refugees from 82 nationalities were registered,[31] as reported by the UN, the countries of origin were: Syria (27%), Colombia (13%), Democratic Republic of the Congo (13%), Angola (12%), and Palestine (5%). In the same year, 35,351 asylum applications were received from people from Haiti (20%), Senegal (15%), Venezuela (12%), Angola (7%), Nigeria (7%), Cuba (6%), Syria (3%) among others (Table 2).

Table 2. Immigration in Ibero America: main countries of origin, 2010-2017.

Accepting country	Main countries of origin
Argentina	Paraguay, Bolivia, Chile
Bolivia	Argentina, Brazil, Spain
Brazil	Portugal, Haiti, Bolivia
Colombia	Venezuela, Ecuador, USA
Chile	Peru, Bolivia, Colombia
Ecuador	Colombia, Peru, USA
Spain	Marruecos, Rumania, Ecuador
Mexico	USA, Gautemala, Spain
Nicaragua	Honduras, El Salvador, Mexico
Panama	Colombia, Venezuela, Nicaragua
Paraguay	Brazil, Argentina, Spain
Uruguay	Argentina. Brazil, Spain
Venezuela	Colombia, Spain, Portugal

Source: Data obtained from research according to references.[7,10,13,14,20,26-38]

As for the Andean Sub region, for the year 2015 1,404,448 immigrants lived in Venezuela, representing 4.5% of the country's total population,[20] having as main countries of origin Colombia, Cuba, Bolivia and Haiti. As mentioned before, for many years, Venezuela was a country that received immigrants, as reflected by the high percentage of this population; however, in recent years it has become a country that emits migrants.

Bolivia in 2012, reported 119,033 people born abroad, representing 1.2% of the total population, of which 52.3% are men and 47.7% women. Their countries of origin were Argentina (30.4%), Brazil (18.5%), Spain (8.6%), Peru (7.8%) and Mexico (7.1%). Of this international immigration, 44.0% reside in Santa Cruz; Cochabamba has 17.6% and La Paz houses 14.4%. Of these, eight out of 10 live in the urban area; 23.4% said they had arrived in the country between 2010 and 2012. When comparing the data of 2012 with those of 2001, there was an increase in the number of immigrants under the age of 14 with 4% and a decrease of 3.9 % in the group of 15-64 years.[14,32]

Regarding the situation of immigrants in Colombia, the data indicate a total of 109,971 people from other countries, the most important are Venezuela, Ecuador, USA and Spain, which corresponds to 0.27% of the total country population (DANE, 2005). The percentage participation by continents of origin is: South America (43.3%), North America (31.2%), Central America and the Caribbean (13.8%), Europe (11.0%), Asia, Oceania and Africa are the continents with less origin of foreigners.[33]

In Ecuador, about 200,000 people entered from 2001 to 2010, estimating that the immigration rate in 2010 was 1.2%, increasing 0.3% in relation to 2001. The countries of origin for that year were Colombia, Peru, USA, Spain, Cuba and Venezuela in order of importance and frequency.[34]

In Mexico it is reported as the main group of immigrants are people from the USA (69.7%), Guatemala (4.9%), Spain (4.3%), Colombia (1.3%), Argentina (1.3%), other immigrant groups are much smaller. Together they all represented 1% of the total population, according to the last 2010 Census, which detected 961,000 foreigners.[35]

Nicaragua in 2010 estimated that 40,000 foreigners lived in its territory, according to World Bank data, highlighting the intraregional immigration of Central Americans, especially from Honduras and El Salvador, which are favored by the free mobility agreements (CA-4).[36] The Central American Free Trade Agreement or CA-4 is an agreement signed in June 2006 by four of the countries of Central America (Guatemala, El Salvador, Honduras and Nicaragua), establishing free mobility among citizens of the signatory countries without restrictions beyond their national identity documents. However, minors are required to present a valid passport to avoid illegal trafficking of children.[37] Of the immigrant population residing in the country, Hondurans make up the largest group, grouped 36.3%, following Mexicans, Cubans, Spaniards, Russians, Germans and Colombians. Those of African origin represented 4.16% of the foreign population and Asians 1.2%. According to data from the National Police, it is estimated that only 5 to 10% of people who arrive or transit through the country are registered, which they estimate could translate into at least 60,550 to 121,100 irregular immigrants in the period from 1990 to 2005, which come mainly from Peru, Ecuador, Colombia, India, Dominican Republic, Costa Rica and Mainland China. The proportion of extra-regional migrants went from 18.0% of immigrants in 2006 to 60.0% in 2009, with the main countries of origin being Eritrea, Somalia and Ethiopia.[38]

In the immigration that is registered in Panama (2010), it was found that the main group corresponds to Colombians (28.2%), followed by Venezuelans (17.1%), Nicaraguans (9.1%), Chinese (5,9%) and Dominicans (5.4%).[24]

In Spain, the main countries of origin are Morocco (11.96%), Romania (11.25%) and Ecuador (7.21%). In recent years, the number of immigrants living in Spain has decreased by 427,112 people (6.8%).[7]

The importance of remittances in the countries of the Region

The valued monetary remittances generated by the emigrants are very important for the economy of the countries of Ibero America (not only of Latin America). In this sense, we see that of the top twenty countries receiving remittances from the world ranking in 2016, there are two in the region: Mexico in fourth place with 28,143 million dollars (4.8% of the world total), which equals 2,3% of the Gross Domestic Product (GDP)[22] and Spain in thirteenth position with 10,080 million dollars (1.7%). Remittances have been increasing progressively in recent years and are expected to continue that way. The main countries of origin of the economic flow are France, Germany and USA.[7,22,39]

Nicaragua is another country whose importance of remittances is fundamental. This is shown when we observe that in the first quarter of 2017, income from remittances corresponded to 9.6% of GDP, with

income from the US economy (56.0%), Costa Rica (20.2%), Spain (9.6%), Panama (5.9%), El Salvador (1.0%), Canada and Mexico (0.9% and 0.3% respectively).[40] Although the economic dependence on remittances for Nicaragua is evident, in countries like Panama it does not have the same importance, in 2016 a total of 505.7 million dollars was received; mainly from the USA, Costa Rica and Spain, which represented 0.92% of GDP.[7]

In the Southern Cone, the economic flow through remittances does not seem to be so important, so we see that in the case of Paraguay (2016), remittances worth 656.9 million dollars, 103.3 million dollars more than in 2015, came in. Money comes mainly from three countries: Argentina, Spain and Brazil.[7] Likewise, in Uruguay, 2.4% of households received remittances in the surveyed year with an average monthly amount of 150 dollars, 60% destined for Montevideo.[13] In the case of Brazil, monthly remittances were received with an average of US $ 200 million dollars (2,400 million a year).

In both Argentina and Chile, income from remittances has a low economic impact. In the case of the first, in 2016, 349 million dollars were received, equivalent to 0.4% of GDP.[41] Apparently the Argentine emigrants do not send money on a regular basis to their families. In the same sense, income from remittances in Chile is not considered important and comes from countries like Argentina, USA and Spain mainly.[7]

In Colombia, remittances sent according to reports from the Bank of the Republic, represent between 1.7 to 1.8% of GDP, with Valle del Cauca being the department that receives the most remittances (33%), reaching up to 3% of GDP for the Vallecaucanos.[7,33] Bolivia in 2016 received remittances worth 1,217.2 million dollars from Argentina, Spain and the United States (18.4 million dollars more than in 2015), which is equivalent to 3.60% of GDP.7 Although, refers to a significant decrease in recent years due to causes attributable to the international crisis.[42]

Ecuador has two sources of financing: oil and remittances.[43] The second ones constitute the second source of income of the country, representing in 2008 7.4% of the GDP, later a decline has been observed, which as of 2011 has oscillated around 3.5% of this Product.[34] In 2016, remittances came mainly from the USA, Spain and Italy. The rest came from the United Kingdom, Mexico, Chile, Peru, Canada, Germany, Switzerland, Belgium, France and Colombia.[44]

Venezuela is a difficult country to analyze, since its figures are not reliable. According to official data, remittances sent to Venezuela by emigrants, for the year 2016, represented 0.0% of GDP, even with negative growth (-6.3%).[41] However, these data are not credible, since today more than ever the emigration of Venezuelans to many other countries implies that the flow of remittances is greater. The difficulties posed by the Venezuelan government in the exchange control, forces the citizens to use informal mechanisms for the entry of foreign currency, as observed among the population. In this sense, a private polling company registered that 88% of emigrant families claim to receive money from abroad.

Main reasons for emigration in Ibero-America (IBA)

Base don the recorded information there are six main reasons why people emigrate in Ibero-America: a) economic and labor issues, b) family reunion, c) political issues d) war conflicts, e) studies and f) environmental factors.

In relation to economic and labor issues we see that they are also directly related to family reunions. Virtually all countries have these causes of migration, stimulated by poverty and lack of employment or better remuneration, as occurs in the 13 countries surveyed. At this point it is important to distinguish between regular or legal migration and irregular or also known as illegal migration. In IBA there is a high frequency of irregular migration, which is markedly intraregional, as occurs between the USA, Mexico, and the countries of Central America. For many of these migrants, visa procedures are very cumbersome, expensive and difficult to obtain. The same occurs between the countries of the Andean sub region and the Southern Cone, with a high percentage of intraregional immigrants between Colombia, Venezuela, Ecuador, Bolivia, Peru, Brazil, Chile, Argentina, Uruguay and Paraguay. However, this condition of frequent irregular migration entails greater risks to their health, given that they try to evade migration filters, crime and even expose their lives.[10,13,19,20,22,33-35,45-50]

In Ecuador as well as in Bolivia and Paraguay, the phenomenon of feminization of migration has been presented since it has been considered that the main causes of emigration are the economic crisis, decrease in the employment rate, and family reunion, besides that women enter the labor market more easily.[34]

On the other hand, we also have regular or legal migration, which under the same economic motivators travel with greater security and planning, often seeking to establish themselves in the receiving place. These people usually have better levels of education, which allows them to get a better job with better income. This also occurs in the 13 countries surveyed, with the situation in Spain being the tenth largest recipient of immigrants worldwide, but also an important issuer of young immigrants (25 to 35 years old), with university degrees and languages, who Due in part to the economic crisis that persists, they seek better employment opportunities, mainly in other European countries.[51,52]

Political issues and armed conflicts have been triggers of large-scale migration, as happened in Nicaragua, between 1970 and 1980 by the Sandinista Revolution and the Counterrevolution in times of the Cold War, or the armed conflict in Colombia produced by the Revolutionary Armed Forces (FARC-EP), The Dictatorship of Pinochet in Chile and more recently the political conflicts in Argentina, Bolivia, Paraguay and the “Migration Escape” of Venezuela, which in the latter case is due to economic and political collapse.[19,38,49,53,54]

Another cause of Migration reported was that of studies abroad, mainly in Chile and Colombia, since in the latter country postgraduate education is very expensive.[33,45,49]

The environmental factors were reported by Bolivia and Nicaragua. The first one referring to droughts, floods and landslides due to the softening of the earth. The second refers to meteorological phenomena such as Hurricane Mitch (1998), which increased emigration to Costa Rica by 40%.[36,47]

Main work areas of immigrants in receiving countries

In general, all countries report that the activities in which immigrant workers work are related to the three sectors of production, predominating agriculture, livestock, construction, domestic workers, services, trade, killing and processing of meats, the textile industry, etc.

Brazil, like Chile, Colombia, Bolivia, Argentina, Ecuador, Spain and Mexico, report that a high percentage of its migrant population has advanced or university studies, dedicated to scientific and/or academic activities, as well as business. In some cases, as in Spain, it is common to find a large contingent of workers who occupy positions in the labor structure well below the real level of their qualifications, occurring more frequently with informal workers.[10,19,22,42,55-62]

Do migrants travel alone or with family in the Region?

There are no reliable data on this, however, several of the countries provided information that allows us to make some inferences, for example: Nicaragua reports that the majority of migrants to Costa Rica travel alone, with the intention of later regrouping with the family. The information reveals that a significant percentage of Costa Rican households are of binational composition, finding that 36.8% of Costa Rican-born households live in households with a Nicaraguan head of household and, to a lesser extent, spouses and other relatives. Of these binational households, 36.9% of the total heads of families were born in Costa Rica, and 62.6% in Nicaragua.[63,64] Another important fact is that provided by Paraguay, referring to the fact that the people who mostly emigrate travel in principle alone and with the passing of the years take their relatives; they are young people of productive age, and especially women. The Permanent Household Survey (EPH), in 2012, shows that about 60% of registered emigrants are women: 52% in Argentina and 80% in Spain. Regarding the ages, the majority is in the range of 20 to 34 years (34%, between 20 and 24 years, 18% between 25 and 29 years).[65]

In Bolivia, patterns of emigration are more or less common among the population, such as the fact that when you want to improve income “only one family member goes out”, while when looking for a job “it is almost normal to see that the whole family leaves the country in search of new destinations”.[66,67] Between 2004 and 2007, a predominantly female flow (64%) was observed, which apparently was motivated by the greater ease to get a job. Of the women-mothers who migrated from Cochabamba, 91% did so under the independent pattern and only 9% under the associative pattern of family reunification. According to the relatives of these women, the reasons that motivated the migration were: unemployment (55%), others (31%), family reunification (9%) and 4% intrafamily abuse.[66] Bolivian emigrants in Spain had higher irregularity rates than others in the region, which obviously makes them more vulnerable in labor and legal terms and with greater difficulty in regrouping their family, being also more likely to have to return.[68]

In Colombia, as it is referred to, migrants seeking better employment opportunities tend to travel alone at the beginning and reunite the rest of the family in the receiving country.45 The same situation occurs with Venezuelans, most of them young, single, alone traveling emigrants. In fact, according to some unofficial research, Venezuela is the second country with the highest percentage of children living abroad.[69]

The case of Argentina, in the emigration to Spain, reports a somewhat different situation, according to official reports, 53.2% of men arrived in that country alone, without a partner or children, while 46.3% did so with a partner and/or children. Women traveled 44.1% without a partner and children and 18.9% with a partner and/or children.[70]

In Ecuador, migrants travel alone with the hope of reuniting their families in the immediate future, this reflection is corroborated by the statements of the Vice Minister of Human Mobility who in 2014 indicated: "This year we have a terrible and unfortunate number that exceeds 600 children who have traveled unaccompanied in search of their families ", triple the number of cases registered in 2013.[71]

Finally, in Spain it is referred that the emigrant is usually male, young of 30-34 years, mainly of Catalonia, Community of Madrid and Valencian Community and in some occasions we can speak of young couples with children.[72]

Assaults and/or abuses against immigrants

The migrant is very vulnerable from the moment he decides to leave home and start looking for a better future. It requires the courage and the decision to part with the family, customs, security, food. To face the challenges of the migratory transit to the dreamed destination, and finally, to try to insert itself in the target society, to assimilate and reach the goal of a better quality of life.

The migratory process is not simple, the immigrant is exposed to different risks to his health, both due to common illnesses, as well as accidents, aggressions and/or abuses. In this sense, we see that the attitudes of rejection towards immigrants are varied from country to country, for example, in Uruguay, Bolivia and Argentina, people present aggressive-passive attitudes, such as indifference, marginalization, social exclusion, and intolerance, hindering intercultural links and producing changes and reactive behavior among newcomers.[73-76] In the case of Chile, racist attitudes can be observed in daily life with clear examples such as the leasing of rooms at abusive prices, in addition to unworthy conditions of overcrowding and lack of hygiene; various physical aggressions, in particular to black people.[77]

Other countries have a more important component of sexual violence, as in Colombia, Nicaragua and even Paraguay, which in the case of the former, has stood out as a country of origin, transit and destination for trafficking in persons, with crimes such as sexual exploitation, forced labor and drug trafficking. In the case of the second, the United Nations Children's Fund (UNICEF) estimates that there are around 4,800 children and adolescents who are sexually exploited commercially in Managua. This is an indicator of the high number of trafficking in persons.[78,79]

Venezuela apparently does not have problems of abuse towards migrants, the only seemingly violation of their human rights occurred in 2015, through the unjustified deportation of Colombian citizens ordered by the State. In this context, mention was made of the apparent breach of the administrative procedure of deportation and the possible violation of the rights of some of the deported persons.[80]

It is considered that Ecuador has a remarkable increase in immigration, especially of undocumented immigrants since 4 years ago, this phenomenon has caused changes in society and newspaper reports have been observed in cases of xenophobia and labor exploitation.

According to the reports provided, Mexico and Spain are the most violent countries for immigrants, although, under different circumstances. In the case of Spain, reference is made to a greater variety of xenophobic and racist attacks. According to the RAXEN 2016 report, there are 500 verified or documented

incidents, compared to the 452 that were recorded in the 2015 report, when there were evidence of 284 assaults and 136 incitements to hatred. From January to December 2016 this organization collected disturbing data when registering in the Community of Valencia (93 incidents), Madrid (72), Catalonia (58), Andalusia (57), Castilla-León (31), Aragón (27), and the Balearic Islands, Murcia, Euskadi, Navarra (with more than 20), detecting incidents in all the Autonomous Communities.[81,82] Regarding sexual assaults, one third of the female victims are immigrants, 75% were Spanish aggressors and 25% were not born in Spain.[83] Reports from Médicos del Mundo (Voluntary healthcare organization) show that 85% of the patients who attended have experienced violence before, during or after their migration, and a third of asylum-seekers have been tortured.[84] In addition, immigrant and refugee women, as well as minors in transit due to suffering a high percentage of economic violence, are in a particularly delicate situation, psychological, physical and sexual (Table 3).

For its part, Mexico seems the most violent country in relation to organized crime, not because of xenophobia towards migrants. It happens mainly with those who are in transit and even more, in the proximity of the borders with the United States and Guatemala. Mexican immigrants of all nationalities who try to cross the border illegally receive mistreatment at the US border 65-85% of the time, the main aggressions are: physical violence with theft, especially money and identification and the physical, verbal and psychological violence, extortion, kidnapping and sexual violations, which although they are also present, the percentage of incidence is lower compared to the others.[85-87]

Formal assistance programs to migrants in the countries of IBA

Regarding the presence of legislation and formal health care programs for the migrant population, we see that only three countries have them, Argentina, Ecuador and Mexico. In the case of Argentina, there is the Support Program for Social Integration of Migrants (Migrant COUNTRY). The establishment of a "Migrant and Refugee Orientation Center" is proposed, which allows for the provision of valid information, such as the completion of immigration procedures, legal advice and accompaniment, prevention of gender violence, institutional violence, and the taking of complaints in case of acts of discrimination, and above all, empowerment workshops, language classes, introduction to employment and craft workshops, in addition to providing a place for those people who do not have headquarters to meet.[88]

In Ecuador, in March 2007, the National Secretariat for Migrants was created - SENAMI being responsible for defining and executing migration policies, aimed at the human development of all its stakeholders, serving as a link in all actions of attention, protection and development of the migrant, according to the policy of the Ecuadorian State;[89] programs such as "Healthy Ecuador I come back for you" and "Return of People with Catastrophic Diseases" granted by the Ministry of Public Health, as well as "Return of People with Disabilities" granted by the Vice Presidency of the Republic of Ecuador are contemplated. Currently, all assistance programs for migrants are carried out by the Ministry of Foreign Affairs and Human Mobility.[90]

In the case of Mexico, there are government institutions whose objective is to work for the benefit of this vulnerable population, such as the Institute of Mexicans Abroad (IME), the Migration National Institute (INM), among others, with various programs In this regard, the most important are:

Table 3. Vulnerability and Access to Healthcare Services.

Country	Assault and abuse of migrants	Child Migration	Shelters for migrants	Formal programs of attention to migrants	Access to Healthcare Services	Free medications for migrants
Argentina	Passive-Aggressive-attitudes	Diverse immigration	No	Yes	Gratuitous	Yes
Bolivia	Passive-Aggressive-attitudes	Immigration from Brazil, Colombia, Ecuador and Peru	Yes, religious and civil	No	In some specific programs	No, only for regular migrants
Brazil	No	No data available	No	No	Gratuitous	Yes
Colombia	Sexual violence and trafficking	No data available	Yes, religious and civil	No	In medical or surgical emergency	No
Chile	Racist and xenophobic attitudes	Diverse immigration	Yes, of the State, religious and civil	No	In medical or surgical emergency	Yes, in specific institutions
Ecuador	Xenophobia and labor exploitation	Immigration from Colombia and Peru	Yes, of the State, religious and civil	Yes	Gratuitous	Yes
Spain	Very intense xenophobic and racist attacks	Diverse immigration	Yes, of the State, religious and civil	No	In medical or surgical emergency. Varies in some Autonomous Communities	Yes, only in some Autonomous Community
Mexico	Physical, economic, and sexual aggressions by the organized crime	Emigration to the United States	Yes, of the State, religious and civil	Yes	Free for 90 days (Popular Insurance)	Yes, in specific institutions
Nicaragua	Sexual violence, accentuated in childhood	Emigration to the United States	Yes, of the State, religious and civil	No	Gratuitous	Yes
Panama	No	No data available	Yes, of the State, religious and civil	No	Free in migrant shelters	Yes, in specific institutions
Paraguay	Sexual violence and trafficking	No data available	No	No	In medical or surgical emergency	Yes
Uruguay	Passive-Aggressive-attitudes	No data available	No	No	In medical or surgical emergency	Yes, in specific institutions
Venezuela	No	No data available	No	No	In medical or surgical emergency	No

Source: Data obtained from research according to references.[3,10,22,28,36,60,73-106,119-131]

Mujer Migrante: Offers reliable and timely communication and information services for migrant women and their families -in Mexico and abroad, mainly in the USA, as well as foreigners established or in transit through Mexico, particularly in Central America-, in order to reduce the risks of their condition of double vulnerability: women and migrants.[91]

Temporary Immigration Regularization Program: The purpose is to regularize the situation of temporary immigrants in Mexico.[92]

Seguro Popular: The National Commission of Social Protection in Health facilitates the temporary incorporation of the Social Protection System in Health of the Popular Insurance for 90 days, during its transit through the national territory, covering the three levels of medical care, no matter your status as a regular or irregular migrant.[93]

Go healthy, come back healthy: It is a program that contributes to the health of migrants and their families with intersectoral actions of promotion and prevention of health, in the place of origin, transit and destination of these groups, mainly in the USA and other cities.[3]

Other countries such as Paraguay, Uruguay, Nicaragua and Venezuela have legislations that guarantee the right to health for the entire population, including migrants, however, they do not have specific programs. Bolivia legally has the possibility of supporting regular migrants in some priority programs such as childbirth care, child or elderly care, as will be seen later on.

In Spain, Royal Decree Law (RDL) 16/2012 excluded from health care thousands of people including migrants in transit, except in some situations such as emergency care or assistance to pregnant women, minors, asylum seekers, victims of It deals, however, with the violations of the law, even those populations that did have recognized rights have been denounced by organizations such as REDER and other Non-Governmental Organizations (NGOs).[94]

Access to medical healthcare for undocumented immigrants

In most of the countries such as Colombia, Chile, Uruguay, Paraguay and Venezuela, medical attention is provided to immigrants in case of medical or surgical emergency, even in the case of an irregular situation, with the expenses borne by the State being covered.[28,95-97] Spain, through Royal Decree (RD) 1192/2012 and Royal Decree Law 16/2012: Article 8 states that non-EU foreigners who are in Spain registered in the Register of Foreign Residents or are residents in a regular administrative situation, have the right to healthcare under the same conditions as Spanish citizens. Likewise, foreigners not registered or authorized as residents in Spain (immigrants in irregular administrative situation), will receive healthcare only in the following situations: a) Due to urgency due to serious illness or accident, whatever its cause, up to the situation of medical discharge, b) By pregnancy, childbirth and postpartum and c) Children under eighteen years of age will receive health care under the same conditions as Spanish citizens.[98,99] Despite the existence of the DR, not all communities apply it as is, in Catalonia, Euskadi and Asturias, they are guaranteed the right to receive healthcare if they are registered in their territory. In Castilla-La Mancha, they are billed for the care provided. Only in Andalusia is healthcare provided to immigrants in an irregular situation under the same conditions as the rest of the Spanish.[100,101]

In the case of Brazil, Ecuador and Nicaragua, the medical service is provided indistinctly to any person who requests it, regardless of citizenship or immigration status. This fact has motivated that in the case of Nicaragua, many people, including Honduran citizens, cross the border only to receive health care and return to their country.[36,90] In the cases of Mexico and Panama, they reported that besides providing protection to the healthcare of irregular migrants, they also have shelters that provide temporary assistance in basic issues such as food, housing, clothing and legal advice.[93,102]

The attention of the irregular migrant who can not pay for the medical service

In some countries such as Argentina, Brazil, Ecuador, Nicaragua and Paraguay, medical care for irregular migrants is free.[90,103] In Panama it can be provided in this way only in hostels, while Chile and

Uruguay do so only in cases of being affiliated with the National Health Fund (FONASA), in the first case or a mutualist in the second.[104-106] Colombia and Spain only in the case of medical or obstetric-gynecological emergencies that have already been mentioned before.[99,107] Mexico for 90 days from your registration in the free Seguro Popular[93] y Bolivia does this in informal social security, with the authorization of the director of the medical unit, since formally only regular migrants who do not have health insurance can be cared for in the following areas: pregnant women, children under 5 years old, adults over 60 years old, sexual and reproductive health services for women of childbearing age and people with disabilities.[108] In Venezuela, this possibility has recently been limited by conditioning medical attention to the presentation of the "Carnet de la Patria".

In case the migrant can not buy the medication

In terms of providing medicines free of charge to migrants, it is striking that ten of the thirteen countries can provide it under different characteristics. Argentina, Brazil, Ecuador, Nicaragua and Paraguay do so indiscriminately with their citizens in public health institutions and within a basic table of medicines.[90,109] While Bolivia provides it only to regular migrants and in the programs referred to in the previous paragraph. Spain, only in some autonomous community.[99] Chile, Mexico, Uruguay and Panama only in certain health institutions.[91,104-106] The countries that do not provide medicines to irregular migrants are Colombia and recently Venezuela, which can be explained by the current economic, political and social crisis.

Main health problems of the immigrant population requiring consultations

The main reasons for consulting healthcare services in the 13 countries surveyed are repeated with relative frequency. Therefore we will enclose them in two dimensions, according to the information received: the biological sphere and the mental health.

In the biological diseases area, the most frequent were respiratory and gastrointestinal and other infectious diseases such as tuberculosis, hepatitis, those transmitted by vectors, hosts and reservoirs such as malaria, dengue, filariasis, schistosomiasis. In addition to accidents and injuries. These conditions were a common denominator for Bolivia, Spain, Mexico and Argentina, although the latter also refers as frequent headaches, allergies, vascular problems (from vascular insufficiency, to cerebral vascular accidents).[76,102,109-113] Bolivia also reports high frequency of "altitude sickness".[110] For Chile, the main demands of medical attention are the diseases that require surgical intervention (37%), delivery (20%), illness with medical treatment (18%) and pregnancy (5.8%).[28]

The most frequently reported mental health problems are the following:

Nicaragua highlighted that people consulted and with migrant relatives suffer stress (67%), depression (58%), headache (39%) and intrafamily violence (5%).[114,115] Brazil mentions that the immigrants with the most mental and behavioral disorders are the Koreans of São Paulo: anxiety disorders (13%), post-traumatic stress disorder (9.6%), mood disorders (8.6%), somatoform disorders (7.4%), dissociative disorders (4.9%), psychotic disorders (4.3%), eating disorders (0.6%), disorders derived from psychoactive substances (alcohol, tobacco or drugs, 23.1%). These Korean patients present more psychiatric disorders than the

population in Korea, especially post-traumatic stress disorder, and a rate similar to that found in the Brazilian population.[116] Argentina, in addition to the organic problems already mentioned, also mentions that 33% of the migrant patients surveyed, who are treated in a hospital in the City of Buenos Aires, presented acculturative stress, also called Ulysses Syndrome, with somatization data. Finally, Uruguay reported that there are no differences between the pathology of immigrants and national morbidity. Colombia, Panama and Venezuela do not have information available in this regard.

Most used Medical services in the Health Systems by irregular immigrants

When asked about the use of medical services by immigrants, twelve of the 13 countries reported not having official information about it, however, based on the research carried out by the members of the working group among their inter-institutional colleagues, and by the personal experience of each of them, they reported that the first level of care and emergency services are the most demanded, probably followed by services of gynecology-obstetrics and pediatrics, as well as public health, for the control and treatment of the main causes of demand for medical attention referred to in the previous section. It is also known that there are assistance centers for migrants provided by different religious institutions, foundations, NGOs, among others. Spain responded that irregular immigrants do not have access to the health system since 2012. Regularized immigrants have the same rights as Spanish citizens. That said, the services most used by immigrants are related to the needs of maternal and child health.[99,117,118]

Hostels for irregular migrants in transit

The shelters for irregular migrants are constituted as shelters and “sanitary and legal checkpoints” (although it is not their main function), which allow people to survive, reflect, even insert themselves into the labor and socially of the host country. Most of them provide accommodation, food, clothing, security, legal advice, general orientation, spiritual support and in many cases medical and psychological care. In cases where the shelter is of the State, assistance is also frequently provided to return to their places of origin. In the study presented, only six of the 13 countries have shelters for migrants financed by the respective governments, such as Chile, Ecuador, Spain, Mexico, Nicaragua and Panama. These five countries also have other facilities that have the same objective, but are of a religious or civil nature, with non-governmental financing.[119-124] Bolivia and Colombia, have shelters of this last type, mainly of a religious nature where the State does not participate.[125-128] In Ecuador, there are shelters for people waiting to be deported, one of them is located in a hotel in the capital that has all the basic services.[129] Finally, five of the countries surveyed, most of the Southern Cone, Argentina, Brazil, Paraguay, Uruguay, and Venezuela, do not have shelters that support migratory mobility.

About child migration in IBA

Of the 13 countries, only eight provided information on child migration in their respective countries. In the Southern Cone, Argentina, according to the last population census of 2010, there were 140,312 minors of 14 years of foreign nationality at that time. In addition, in the composition of asylum and refuge

applications, 89% were of legal age and 11% were infants, predominantly men (65%), unaccompanied or separated from their families.10 For Chile, the immigrant population under 18 years corresponds to 1.4% of the total, with the group with the greatest presence being between 20 and 35 years old.[28]

In the Andean Subregion, Bolivia mentions that the most recent reports on child immigration correspond to the Population and Housing Census 2001. In this, reference is made to the fact that in the Bolivian Amazon, Brazilian immigrants under the age of 15 represent 40%, Colombians,4%, Ecuadorians 19.2% and Peruvians 14.3%.[60] According to the Observatory of the Rights of Children and Adolescents (ODNA), in 2010, 1% of the population of Ecuador under the age of 18 is from another country; this percentage corresponds to 27% of the total number of foreigners. The majority comes from Colombia and, in smaller number from Peru.[130] For its part, Venezuela does not have official information on this subject, however, according to some unofficial sources and press reports, as well as daily observation, it can be inferred that the majority of immigrants, both in the past and in the Currently, they are adults who arrive alone in the country, with few children entering or entering this form.

For Mesoamerica, Mexico and Nicaragua, they report that in the case of the former, 1.5% and 1.6% of children 0-9 years of age (men and women respectively) and 5.6% and 5.7% % of the group of 10-19 years (men and women), were repatriated from the US to Mexico, descending from 20,438 in 2010 to 11,743 in 2015.[22] For Nicaragua, between October 2013 and June 2017, the US Border Patrol captured 16,546 unaccompanied minors from Honduras, 14,086 from Guatemala and 13,301 from El Salvador, but only 178 from Nicaragua. The number of children deported from the US to Nicaragua is lower than in other neighboring countries, despite the socioeconomic difficulties facing the country.[131]

Infantile immigration in Spain broke the record in 2017, since in the first nine months there were 5,380 unaccompanied foreign minors in the reception centers of the autonomous communities and cities, 34.6% more than in 2016, when there were 3,997. Central Government statistics reveal that a total of 16,379 immigrant minors arrived in Spain since 2014.

Do immigrants in the host country live alone or with their families?

Regarding the question of whether immigrants live alone or as a family in the host country, we see that it was only answered by five of the twelve countries (Argentina, Bolivia, Spain, Mexico and Uruguay). Argentina reports that at present, the family structure of immigrant families is as follows: couple and children 43.78%, couple alone 24.42%, children alone 12.90%, alone 11.06%, parents and siblings 0, 92%, parents 1.38% and other 5.53%. On the other hand, immigrants from bordering countries have arrived mostly when they were young, consequently, a high proportion of them and they had not yet formed their families of procreation before leaving. Mostly they resided with their parents and only a minority had a spouse and children. Although there are many immigrant women who are already mothers, the proportion of those who have their children in the country of origin (long-distance mothers) is quite low. This practice is very uncommon among women of Bolivian origin and more widespread among those of Paraguayan origin.[103]

Regarding family composition, according to data provided by Bolivia, in the 2001 National Population and Housing Census (no more recent data were found), 43.3% of foreigners born in Amazonian countries (Brazil, Peru, Colombia, Venezuela, Ecuador) were single, 51% married/cohabitant and 5.8% separated/widowed/divorced.[60]

In Spain, the immigrant population lives as follows: 33% only (35% of men, 31% of women); 28% with another person; 27% in units of 3-4 people; and the remaining 12% in units of more than 4 people. The average size of households is 2.5 members, below the average of Spanish households (2.8 according to the 2001 Census).[132]

In the case of Mexico, it is mentioned that according to the 2010 Population Census (the last), 54.4% of the immigrants were married and 45.6% were single.[35]

The information provided by Uruguay is not of a national nature, corresponds to the report of a Health Center of Montevideo, according to which, 75% of the records of migrant patients attended from January to July 2016, arrived alone, being a large majority of women (close to 100%).

Migrant population who live alone, without returning to join another couple

This question was answered only by six of the thirteen countries, Bolivia, Ecuador, Spain, Mexico, Nicaragua and Uruguay. The first mentioned that the presence of singles is comparable to that of married (35%), with a notable presence of couples in cohabitation (24%).[42] In Ecuador, according to the Employment and Unemployment Survey of 2006, it records that, regarding the marital status of people who left the country, 48.1% have a commitment (married 42.3% and free union 5.8%), highlighting in this group men with percentages of 49.6%. While in that population that did not have a spouse (separated 2.9%, divorced 2.0%, widowed 1.3%, single 45.7%) women stand out with 53.8%.[133]

Spain reports that of married people, 38% of men and 26% of women are physically separated from their spouses, in most cases because they have not achieved reunification in Spain. On the other hand, 62% of immigrant parents and 47% of mothers have children in the country of origin (of them, more than two thirds are minors). The reunification of the spouses is somewhat greater among Eastern Europeans and Latin Americans (73% in both cases) than among Africans (66%). However, because African immigration is older in Spain and have more children on average (2.5, 1.6 for Eastern Europeans and 1.9 Latin Americans), the average size of both their households (2.8 members) as of their homes (4.8 members) is higher than that of the other groups (2.3 and 4.2 Europeans and 2.4 and 4.1 Latinos). Finally, the highest birth rate among Latin Americans, in relation to Eastern Europeans, explains that the average size of their homes is higher, despite the fact that the degree of family reunification is similar in both groups.[132]

In Mexico, it is reported that the family structure of female immigrants who did not remarry or unite as a couple was 9.4% and men 10.8% in 2010.[22]

In Nicaragua, the phenomenon of emigration has resulted in families having gone from being nuclear to single-parent families and in many cases to being extended families; Most of the time, it is the single mothers who emigrate, leaving their children to other relatives. It is estimated that almost half of the 900 thousand Nicaraguans residing abroad left sons and daughters in their country of origin.[134]

Finally, in the case of Uruguay, the report corresponds to information from the Ciudad Vieja Health Center, mentioning that 72% of the immigrants who attended live alone or in groups without their families who were left in their country of origin.

Type of medical services offered by the family doctor to migrants

In general, the performance of family doctors in thirteen countries is very similar, focused on patient care from the perspective of family medicine and primary care, with activities based on the risk approach, comprehensive care and continues, in many cases with rehabilitation activities and epidemiological surveillance. However, none of the countries mentioned have their own health care programs for properly structured migrants.

The role of the Family Medicine or General doctor in the health of migrants

Regarding the role of the Family or General practitioner in the health systems of IBA, only Spain has defined the role of the professional in the health care of migrants. Twelve of the 13 countries give the same treatment in the care of these patients than any other citizen of their country. However, the social determinants of health in migrants are not considered nor are the factors of mobility and risks of their migratory status. In this sense, Spain points out that it is necessary to individualize and personalize the attention to the immigrant patient. A clinical history that includes the aspects related to the migratory process and a careful physical examination to reach the diagnosis in these patients. The attention to the immigrants presents some differences with respect to the native patients, especially in the first stages of their arrival and always taking into account the country of origin and the time of stay in the receiving country.[111,135]

The Family Medicine doctor should also advise and carry out activities of prevention and health promotion when the immigrant is going to return to the country of origin (counseling, vaccinations, antimalarial prophylaxis, etc.). In addition, in the holistic approach of patients, it is important to pay attention to the psychological, sociocultural and religious aspects that can influence the health of the patient and their family, remembering that the migratory process is a vital and stressful event, being attentive to the presentation of serious psychiatric symptoms.[111,135]

In summary, the Family Medicine doctor when dealing with immigrants, should be culturally sensitive with medical care, competent, respectful, flexible and sensitive clinical efficiency.[111,135]

The issue of migrant health is within the curriculum of the Medicine Career or the graduate program of Family Medicine

Of the 13 countries surveyed, only Spain has a formal Migrant Health program in the specialty curriculum of Family Medicine,[136] whose competences are directed to the effective communication management with this population and to the attention of the risks of infectious and imported diseases, as well as to situations of family and social risk, such as people in social exclusion, disabled patients, family violence, etc.

In some programs of specialization in Family Medicine of Ecuador and Mexico, there are modules or topics intended for the assistance of migrants and their families, emphasizing the adoption of linguistic competences, communication and interculturality, from the holistic approach of the specialty.

For its part, Argentina, which like the other twelve countries does not have a formal program in Medicine or in the specialty of Family Medicine, has developed since 2007 the working group: Health and Migrations, dependent on the Directorate of Teaching, Research and Professional Development of the Ministry of Health of the Government of the Autonomous City of Buenos Aires, which carry out training called "Training of Trainers: Migrations, Health and Interculturality Course. Conceptions and practices". As of 2010, it was formalized as a postgraduate continuing education activity, reaching at this time its seventh edition.[137]

Regarding the departure of healthy migrants and their return to the sick country of origin

No country has information about it, although it is not possible to document this fact, it is easy to understand that in many of the countries that receive immigrants, they do it as human capital of exceptional quality, young, strong, motivated, determined, etc. However, after being for years in the informal sector and exposed to exploitation, working days longer than those approved by law, with social determinants against their health and without formal access to health services and social protection systems, It is evident that many people who emigrated return to their sick and aging countries, to be served by the health systems that guarantee their country of citizenship, becoming a social burden.

Regarding the departure of emigrants without addictions and who have acquired them in the host country

Regarding the complicated issue of imported addictions through migration, no country has timely information that can provide a clear idea of the situation. Spain is the country that indirectly can provide some data generated through the epidemiology of AIDS. In this sense, it has been observed that although the transmission mechanisms involved in the transmission of the disease correspond to those of their countries of origin, unprotected sexual contacts being the main route of infection in the immigrant community. It is noteworthy that 41% of cases in people from North Africa had been infected through the use of drugs by parenteral route, a mechanism that is rare in the countries of origin, but is frequent in Spain. This data suggests that many of the risk behaviors for infection are acquired in that country and support the hypothesis that at least 25% of immigrants with AIDS have become infected due to this situation of socioeconomic, cultural and emotional vulnerability.[135]

In another area such as that of prostitution exercised by immigrant women in Spain, which is the product of the need to earn an income; the absence of family, personal and social protection; sexual exploitation and trafficking, among others. It is easy to understand that the health risks are not only sexually transmitted infections, it has also been reported that there is an important relationship with other diseases and psychological and psychiatric disorders such as anxiety, depression, somatization, behavioral disorders, psychotic disorders and post-traumatic stress; In addition to self-medication and addictions (alcohol, cocaine and marijuana), which are not usually recognized, so it is difficult to quantify.[135]

Likewise, immigrant women are more vulnerable to intimate partner violence, given their defenseless situation, and may have more devastating effects due to chronicity, silence, deterioration and absence of palliative social resources. This situation can lead to the deterioration of mental health with depression, anxiety, sleep disorders, which also carries risk of addictions such as abuse of alcohol and barbiturates, or other medications.[135]

Conclusions

The research carried out reveals that there are great deficiencies in the mechanisms of data collection at the level of health institutions and others linked to the phenomenon of migration, in most of the participating countries.

When analyzing the information collected in the questionnaire and the origin of it, it is obvious that the bibliographic sources consulted by the participating researchers are multiple and very different, not comparable to each other (censuses, internal surveys, particular investigations, records of organizations, interviews, personal experience, others), in some cases could be considered somewhat subjective. However, these limitations and scope, the information presented was very well documented and allows us to make the comments that are presented below.

The issue of migration and healthcare services in Ibero-America should be a priority issue on the political agenda of governments, health institutions, universities and each and every family medicine professional and health Primary Care service provider.

It is important to highlight the lack of preparation of human resources in Family Medicine and Primary Care in the area of migrant health, which constitutes an urgent challenge to be solved, given the great responsibility that governments have in terms of control and epidemiological surveillance, in addition to health being a fundamental right of every human being. Not to mention the economic importance of migration in most countries, as well as the cultural and human wealth they bring to societies.

It is also concluded that the Access and coverage of the migrant population (especially the irregular population) is very deficient in most of the countries, even in those that could have a more solid sanitary structure, generating greater risks to health, not only for migrants, but also, for the general population.

Due to the lack of previously commented information, some of the questions could not be answered, which limits the interpretation of the data, however, the research carried out by the members of the working group in the health institutions of their countries (qualitative), can support the results that are presented, although it will be important to deepen with more specific investigations, in each of the countries of the Region.

Finally, the results presented in this document were analyzed and discussed in working groups during the VII Ibero-American Family Medicine Summit, reaching the consensus of the representatives of the 17 countries participating in the working groups to the following recommendations:

I. Recognize the right to health of migrants and their families, ensuring equal access to protection, protection, and rights enjoyed by the citizens of each country.

II. Incorporate in the curriculum of the undergraduate, postgraduate and continuing education programs, the necessary competencies for the integral attention of the migrant population and their families.

III. Creation of a migration health observatory, with a registry of reliable and validated information, that allows analysis and follow-up to make effective decisions focused on people and their families.

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