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Barriers in access to health services: Afro-Colombian women migrants

Barreras en el acceso a los servicios de salud: Mujeres afrocolombianas

Barreiras no acesso aos serviços de saúde: Mulheres migrantes afrocolombianas

ABSTRACT

Introduction: Internal migration involves facing a series of barriers that prevent or delay the use of health services, which are configured in an intersectional manner, the gender, ethnicity, and socioeconomic conditions. **Objective:** Understand the barriers to access health services experienced by migrant women from Chocó, who reside in the city of Medellín. **Materials and methods:** A qualitative study developed from a phenomenological perspective. 4 focus groups and 15 interviews were conducted with migrant women from Acandí, Condoto, and Istmina (Chocó) residing in Medellín. **Results:** Afro-Colombian internal migrants face different barriers in health services, such as difficulties in geographic accessibility, barriers associated with skin color and culture, and economic limitations, which causes unequal access to comprehensive and quality health services. **Conclusion:** It is important to establish health policies with a differentiated perspective, which consider the geographical, economic, and cultural specificities of these migrant Afro-Colombian women, with the aim of reducing inequities in the provision of health services, and thus improving their quality. of life in the host society.

Keywords: Barriers to access of health services; Internal migration; Women; Intersectionality; Health of ethnic minorities. (Source: DeCS, Bireme).

Sustainable development goals: Good health and well-being. (Source: SDG, WHO).

RESUMEN

Introducción: La migración interna supone enfrentar una serie de barreras que obstaculizan o retardan el uso de los servicios de salud, las cuales se configuran de manera interseccional teniendo en cuenta, el género, la etnia y las condiciones socioeconómicas. **Objetivo:** Comprender las barreras de acceso a los servicios de salud que vivencian mujeres migrantes de departamento Chocó, y que residen en la ciudad de Medellín. **Materiales y métodos:** Estudio cualitativo desarrollado desde la perspectiva fenomenológica. Se realizaron 4 grupos focales y 15 entrevistas a mujeres migrantes de Acandí, Condoto e Istmina (Chocó). **Resultados:** Las migrantes internas afrocolombianas enfrentan diferentes barreras en los servicios de salud, como dificultades en la accesibilidad geográfica, barreras asociadas al color de piel y su cultura, y limitaciones económicas, situación que genera un acceso desigual a servicios de salud integrales y de calidad. **Conclusión:** Es importante establecer políticas de salud con perspectiva diferenciada, que consideren las especificidades geográficas, económicas, y culturales de estas mujeres afrocolombianas migrantes, con el objetivo de disminuir las inequidades en la prestación de los servicios de salud, y mejorar así, su calidad de vida en la sociedad de acogida.

Palabras clave: Barreras de acceso a los servicios de salud; Migración interna; Mujeres; Interseccionalidad; Salud de las minorías étnicas. (Fuente: DeCS, Bireme).

Objetivos de desarrollo sostenible: Salud y Bienestar. (Fuente: ODS, OMS).

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For ethical reasons and owing to the sensitivity of the accounts collected, the data and materials produced during this study are not available in public repositories. The information collected contains testimonies and personal experiences that could compromise the confidentiality of the participants. Nevertheless, upon specific and duly justified requests, the data may be shared upon direct request to the authors, provided that compliance with the ethical principles and data protection principles established in the study is ensured.

RESUMO

Introdução: A migração interna envolve o enfrentamento de uma série de barreiras que dificultam ou atrasam o uso dos serviços de saúde, as quais se configuram de forma interseccional, levando em consideração gênero, etnia e condições socioeconômicas. **Objetivo:** Compreender as barreiras de acesso aos serviços de saúde que vivenciam mulheres migrantes do Chocó, que residem na cidade de Medellín. **Materiais e métodos:** Estudo qualitativo desenvolvido a partir de uma perspectiva fenomenológica. Foram realizados 4 grupos focais e 15 entrevistas com mulheres migrantes de Acandí, Condoto e Istmina (Chocó), residentes em Medellín. **Resultados:** Os migrantes migração interna afrocolombianos enfrentam diferentes barreiras nos serviços de saúde, como dificuldades na acessibilidade geográfica, barreiras associadas à cor da pele e à sua cultura, e limitações econômicas, o que provoca um acesso desejável a serviços de saúde integral e de qualidade. **Conclusões:** É importante estabelecer políticas de saúde com perspectiva diferenciada, que tome em consideração as especificidades geográficas, econômicas e culturais destas mulheres afrocolombianas migrantes, com o objetivo de diminuir as desigualdades na prestação dos serviços de saúde, e melhorar assim, sua qualidade de vida na sociedade de acolhimento.

Palavras-chave: : Barreiras ao acesso aos cuidados de saúde; Migração interna; Mulheres; Interseccionalidade; Saúde das minorias Étnicas. (Fonte: DeCS, Bireme).

Objetivos de desenvolvimiento sustentável: Saúde e bem-estar. (Fonte: ODS, OMS).

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INTRODUCTION

Access to and effectiveness of health services depends on the infrastructure, equipment, and trained personnel available to meet the needs of the population. These needs vary according to the social, cultural, and economic characteristics of the communities. Furthermore, access to health is also affected by contextual factors and social determinants that may generate inequalities and undermine the rights of certain groups. The use of health services may be altered by health policies, by the barriers existing within the health system, and by population factors such as gender or ethnicity. According to Machado *et al.*[1], despite the principle of universality, inequalities in access to health services remain significant, and the ethnic factor is closely related to the violation of rights in marginalized communities. Nevertheless, general health regulations tend, in practice, to overlook the cultural, linguistic, and geographic particularities of Indigenous and Afro-Colombian peoples.

This study adopts an intersectional perspective for the analysis of access to health services, understood as an approach that makes it possible to comprehend how different social categories, such as gender, ethnicity, migratory status, and socioeconomic position, interact and overlap in the production of health inequalities. From this perspective, access to and effectiveness of health services depend on the infrastructure, equipment, and trained personnel available to meet the needs of the population, which vary according to the social, cultural, and economic characteristics of the communities. In this way, in order to understand social phenomena and their effects on women's health in a holistic and comprehensive manner, it is necessary for the field of health to adopt an intersectional approach to the understanding of health inequalities and their complexities in specific contexts such as Latin America[2]. Therefore, 'intersectionality is understood as a set of mutual and interrelated processes that make it possible to analyze multiple inequities, such as health status'[3].

Nevertheless, in the department of Chocó, profound inequalities persist in the availability and distribution of health services, associated with limitations in infrastructure, low resolutive capacity at the first level of care, and geographic accessibility barriers, particularly in municipalities such as Acandí, Condoto, and Istmina. Recent reports reveal deficiencies in the functionality and provision of healthcare services, as well as restrictions on the continuity of care, particularly in rural and dispersed territories, a situation that affects timely and effective access to basic services[4].

The department of Chocó is one of the departments most affected by forced displacement and by the dynamics of the armed conflict in Colombia, a situation that has deepened the conditions of poverty, exclusion, and social vulnerability among broad sectors of the population. In this territory, the persistence of violence and the presence of illegal armed groups have a serious impact on the daily life of communities, especially in rural and dispersed areas, where access to fundamental rights such as health is seriously limited. According to reports from the Ombudsman's Office (Defensoría del Pueblo) between January and February 2026, this territory experienced confinement due to the armed conflict, entailing restrictions on free movement, difficulties in accessing food, and limitations on health and education services[5].

Furthermore, between January 1 and October 30, 2025, 4,109 displaced people were reported in the department of Chocó. Similarly, this territory ranked among the departments with the highest number of confined people, registering a total of 21,164 affected people, making it one of the most heavily impacted departments at the national level, together with Huila, Cauca, and Norte de Santander[6].

Forced displacement in Chocó is primarily driven by the presence of illegal economies, particularly drug trafficking and illegal mining. These activities were present in 100% of the cases analyzed in this study. Both economies operate in territories of high strategic value and with weak institutional presence, which facilitates control by illegal armed groups. The

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phenomenon occurs primarily in areas with weak institutional capacity and high levels of conflict, which demonstrates a direct relationship between violence and territorial control for economic purposes[7].

These dynamics of violence generate not only forced displacement but also territorial confinement, seriously affecting the daily life of communities. The dispute over control of illicit economies limits access to healthcare, food, education, and other fundamental rights, deepening the conditions of exclusion and vulnerability among the population.

In short, Chocó presents a scenario of vulnerability in which structural factors (poverty, state abandonment, ethnic discrimination) converge with the dynamics of the armed conflict (disputes between guerrillas and paramilitary successor groups, illicit economies). Taken together, these circumstances have resulted in one of the worst crises of forced human mobility in Colombia[7]. These structural and territorial conditions not only deepen the humanitarian crisis and forced displacement but also directly affect current access to fundamental rights such as health, particularly for the populations living in rural and dispersed areas.

The Afro-Colombian migrant population moving from Chocó to Medellín faces barriers to accessing the health system, including the lack of insurance coverage, denial of services, misinformation, and geographic difficulties. In addition, within health services they face racial barriers, such as discrimination based on skin color, and the denial or delay of authorization for medical procedures. These conditions severely limit the exercise of the right to health and reflect significant inequities[8]. According to Aday and Andersen[9], entry barriers to the health system include aspects such as geographic distance, means of transportation, and service hours. Internal barriers refer to the difficulties in accessing services, such as excessive procedures and waiting times. Exit barriers are related to the structure of the system that hinders continuity of care.

These limitations unequally affect vulnerable groups, as is the case of Afro-descendant women in Chocó, who face challenges associated with their gender, ethnicity, and socioeconomic conditions. This situation is aggravated by the presence of the armed conflict, understood as a situation of prolonged violence between governmental authorities and organized armed groups, or among such groups, characterized by a minimum level of intensity in hostilities and a sufficient degree of organization of the confronting parties[10]. Added to this is the lack of adequate services, especially in the field of sexual and reproductive health, a situation that deepens inequities and limits the full exercise of their rights. Within the framework of the Colombian armed conflict, all armed actors have exercised forms of violence that undermine sexual and reproductive health, particularly that of women. These forms of violence were not initiated by the armed actors; rather, they are grounded in the ongoing naturalization of gender-based violence suffered by girls, young women, and women in general throughout the country in their daily lives[11].

This panorama contributes to an increase in pregnancy- related complications and higher maternal mortality, also due to the absence of specialized services and the lack of preventive health strategies[12]. Many maternal deaths are preventable and are attributed to problems such as 'the quality of prenatal services, accessibility barriers, the continuity of services, and the lack of resources'[13].

Therefore, this scenario fosters the expulsion of population from the department of Chocó and, in particular, of these women who migrate either due to forced displacement—responding to the violence generated by the armed conflict—or due to the lack of basic services[14]. In this context, Chocoan women are forced to move to large cities in search of security and better living conditions, especially since 'the family seeks to forget the anguish, the despair, and the unease they experienced, and one way of doing so is to migrate to places, whether distant or wherever they believe they may find new possibilities'[15], which also allows them to access health services that guarantee better living conditions.

In this scenario, Medellín, the capital of the department of Antioquia, has established itself as an important destination for women

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migrating from Chocó, which is identified as a population-expelling department, insofar as the city of Medellín receives a large number of people originating from Chocó[16]. This migratory dynamic, moreover, has a high level of female participation, since women are the primary migrants, motivated by the need to find better living conditions for themselves and their families, with Medellín being a city of potential opportunities.

Even though these women migrate in the hope of improving their lives and those of their families, they face barriers to accessing basic health services in the receiving society. They are affected by violence, racism, and discrimination, which hinder their integration. Thus, the purpose of this article is to understand the barriers to accessing health services experienced by migrant women from Chocó who reside in the city of Medellín.

MATERIALS AND METHODS

Phases of the Process

A qualitative study was conducted from a phenomenological perspective, aimed at understanding the lived experiences of Afro-Colombian migrant women from the department of Chocó. The purpose was to show the deep meaning that these women attribute to their experience of accessing health services, considering the meanings that emerge from their everyday lives.

The fieldwork was carried out during 2024 in the municipalities of Acandí, Condoto, and Istmina (Chocó) and in the city of Medellín (Antioquia), following the phases described below.

Phase 1. This phase focused on epoché, allowing for an exploration of access to healthcare in Afro-Colombian communities without preconceived judgments. The snowball sampling technique was used as a strategy for accessing the field, to facilitate the identification of women who met the inclusion criteria and to diversify their profiles based on their migration trajectories and experiences within the healthcare system. Initial contact with potential participants was made through Afro-descendant community networks and grassroots organizations, which serve as spaces for guidance, support, and social coordination for these women. Based on this initial approach, the first participants were identified, and they subsequently referred other women from their social networks who met the study criteria. Access to the field was developed progressively, supported by relationships of trust built with community leaders and the participants themselves, which facilitated recruitment and exposure to diverse experiences within the study population.

The following criteria were considered: being an Afro-Colombian woman, having been born in Acandí, Condoto, or Istmina, residing in Medellín at the time of the interview, being of legal age, and providing informed consent.

Phase 2. This phase involved data collection between April and June 2024, through semi-structured interviews and focus groups in outlying districts (comunas) of Medellín with a high presence of Afro-descendant populations. Four focus groups were conducted in Medellín, along with fifteen interviews with Afro-Colombian migrant women. This made it possible to reach theoretical saturation by addressing health experiences both in Chocó and in Medellín and exploring their experiences, emotions, and personal assessments. Additionally, a socio-familial and demographic record was completed to contextualize migratory trajectories and living conditions.

Each interview lasted approximately one hour. Prior to the interview, the purpose of the study, the confidentiality of the information, and the participants' rights were explained, and their participation was formalized through informed consent.

Some women took part in both the individual semi-structured interviews and the focus groups. This was considered methodologically suitable because it made it possible to contrast personal accounts with collective perspectives and to deepen the analysis of emerging dimensions. This dual participation was carefully managed to avoid redundancy and was used to enrich the internal triangulation of the analysis.

Accordingly, the focus groups were intended solely for Afro-Colombian migrant women in order to explore collective perceptions, shared experiences, and sociocultural meanings without the presence of actors holding institutional power.

Phase 3. An exhaustive and repeated reading of the transcripts was carried out in order to gain a comprehensive understanding of the experiences narrated by the participants. Subsequently, relevant units of meaning were identified and transformed through variations aimed at distinguishing accidental elements from those that constitute the essence of the phenomenon.

An eidetic understanding was achieved in order to identify essential meanings, and the information was organized according to recurring themes such as barriers to access, perceptions of health care, and experiences associated with migration. Finally, these themes were integrated into broader eidetic structures representing the central patterns of emerging meaning, thereby ensuring internal coherence and interpretive rigor.

Phase 4. The findings were interpreted, and the structural barriers and related emotions were identified in order to develop a comprehensive understanding of access to health from the perspectives of the migrant women.

Ethical considerations

The research was approved on May 17, 2023, by the Ethics Committee of the Faculty of Legal and Social Sciences of the University of Caldas and was classified as minimal risk, in accordance with Resolution 8430 of 1993. All Afro-Colombian migrant women and institutional actors were informed of the purpose of the study, the conditions of participation, and the guarantees of confidentiality, after which their informed consent was obtained. To protect the participants' identities, alphanumeric codes were used in the transcripts and in the presentation of the findings. Moreover, during the selection process, it was verified that the Afro-Colombian migrant women belonged to the municipalities of Chocó included in the study and that they resided in Medellín at the time of data collection.

RESULTS

In this study, Afro-Colombian migrant women with an average age of 41 years participated, coming from three municipalities of Chocó: Acandí, Condoto, and Istmina. The majority were single and heads of single-parent households. The reasons for migrating included forced displacement and the search for better opportunities. They lived in socioeconomic strata 1 or 2 and worked mainly as homemakers, while some of them engaged in activities such as street vending. This sociodemographic profile makes it possible to understand the structural conditions within which their experiences of accessing health services are shaped. Geographical, economic, and sociocultural barriers were identified that hindered their access to health services in Medellín.

As a result of the fieldwork, geographic, economic, and sociocultural barriers were identified that Afro-Colombian migrant women face in accessing health services in the city of Medellín, as described below.

Geographical barriers: The challenge of navigating the unknown

Upon arriving in a new city such as Medellín, these women tend to settle on the outskirts of the city and in vulnerable areas such as hills or slopes, which, in addition to reducing their possibilities of geographic mobility, also undermine their health, owing to the long journeys they must make on foot from one place to another and the need to use more than one means of transport. Thus, given their economic conditions, some women settle in places of high vulnerability and poverty in which the social inequalities that already exist in their places of origin continue to be reproduced. This residential location operates as a mechanism for the reproduction of territorial inequalities.

> *'Most of the people who have migrated live in peripheral areas (…) So it is also difficult for a person with reduced mobility. I cannot host in*

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my home someone with reduced mobility because I have three floors with stairs, and you have to climb a hill'. (Migrant woman, Acandí 3).

Additionally, Afro-Colombian women who migrate from Acandí, Condoto, and Istmina to Medellín face challenges in adapting to a new environment. They have difficulties orienting themselves and accessing health services, which affects their physical, mental, and emotional well-being. This also affects their rights, especially the right to health. These difficulties constitute a form of exclusion associated with the urban territory.

Unfamiliarity with the place becomes an obstacle that hinders women's access to health services by increasing the travel time between their homes and the healthcare facilities. This creates processes of exclusion that place them at a disadvantage relative to other women and groups. In Medellín, with its different dynamics, these women experience fear because they do not know the streets or how to reach certain places, which becomes a barrier to accessing health services.

From this perspective, it is important to consider that these fears are related not only to the mobility of the body in an unfamiliar space, but also to the position of that body in social life and the meaning attributed to it by 'others'[17], with fear being related mainly to gender. The role of women in social life is linked to their marginalization in the construction of the city. The fear they feel affects their reality and their experience within the urban space. This experience is influenced by their condition as migrant, Afro-descendant women with economic difficulties. Thus, fear is configured as a social and symbolic experience, beyond an individual difficulty.

'(…) we are not all going to take the same route. Because there are people who do not know that there is a half-hour route and may take the one that lasts an hour'. (Focus group participant 1).

These experiences show that urban mobility is lived as a process of forced learning, marked by unfamiliarity with the territory and by inequalities in access to time and space.

'That stretching of time is very hard for us, rural or migrant women (…), because when you arrive in this city and you are new (…), this is enormous. And the fear of getting lost—the stories we know also fill us with that fear; we do not have that agility to look from one side to the other'. (Migrant woman, Acandí 3).

In this way, travel time to medical care centers in Medellín is affected not only by the fear of getting lost and unfamiliarity with mobility in the city, but also by the long distances from remote areas to healthcare facilities and traffic conditions.

'(…) to go to the doctor by public transportation it takes me about an hour, because they see us in Prado. (…) About an hour, because we have to take the metro and get to the Prado station (…), since the bus drops us off very far away. The metro (…) drops us off closer' (Migrant woman, Acandí 1).

This shows that women face barriers to accessing health services owing to the need to use multiple means of transport, which reflects the distances between their homes and such centers. Time and space are key elements in this analysis, insofar as these women experience 'waits' and must travel along routes that affect their daily lives. In this way, following Hiernaux and Lindón[18], a geographic perspective is constructed not only from places, spaces, and subjects, but also from the spatial experience itself.

'(…) it takes us an hour and fifteen minutes to get to Buenos Aires. And ho do you get there? Metro and tram. In other words, you have to combine transport—without traffic, 40 minutes. And with a traffic jam? Three hours, four hours. The last downpour meant two hours coming to the city center, and when they also send us to Itagüí, it's complicated' (Woman focus group participant 3).

In this way, migrant women in Medellín face significant geographic barriers to accessing health services, which are intertwined with their daily routines and mobility processes. Although transportation is an impediment, there are other

obstacles that affect their access, including economic limitations that further complicate access to medical care. This phenomenon will be examined in greater detail in subsequent sections.

Economic barriers: Between subsistence and medical care

The Afro-Colombian migrant women interviewed tend to perform jobs that provide limited income, which must be allocated primarily to meeting their families' basic needs, such as food and the care of their children and other dependent relatives. In this context, medical expenses may represent an additional cost since, as they are not always anticipated, access to health care is often hindered. This situation forces women to choose between using their money, for example, to buy food or to meet their health needs. This prioritization of economic resources may be interpreted as a survival strategy in the face of precarious living conditions.

Transport costs for women who need to reach medical care centers can be high, when they lack sufficient financial resources, their only alternative is to walk.

> *'Back then (…) I went to an appointment (…); I had to be there very early, I had to get an ultrasound (…), the appointment was at six. So (…) I had to take a motorcycle taxi and (…) it charged me 18,000 (…). Then, on my way back, I spent another 7,000'.* (Migrant woman, Istmina 3).

> *'With transport, whenever I don't have money, I have to go on foot, and it is exactly one hour walking'.* (Migrant woman, Condoto 4).

Out-of-pocket expenses are linked not only to transportation but also to the payment for medicines, since, even though the Health Service Provider Entities (EPS) may be public and have an obligation to provide medicines at no cost—or, at least, not at such high costs—on many occasions, when these medicines are unavailable or are delivered incompletely, these women must cover the costs themselves, a situation that becomes more acute in the case of high-cost medicines.

> *'I have been counting (…) 69 days without high-cost medication. I filed the writ of protection (tutela) last week (…). If I buy my prescription, it costs me 1,189,000 pesos. In March, I bought it; in April, I could not buy it; in May, I could not buy it'.* (Focus group participant 4).

It is important to highlight that many of these women are the main income providers for their households, a situation that forces them to prioritize their work responsibilities. Consequently, missing work to attend medical appointments represents a loss of income. For this reason, they often prefer not to use health services, as they perceive doing so as an investment of time that compromises their economic stability. Therefore, these women prioritize their economic circumstances over the use of health services, since they must guarantee their own subsistence and that of their families, taking into account the conditions of economic precariousness resulting from the structural inequalities that pervade the Colombian context and affect the experience of accessing health services.

In this way, economic barriers are not limited solely to direct access to health services but also extend to situations such as the costs of money transfers, referrals, and lodging in other cities. These expenses, which are not covered by health insurers, represent an additional burden for these women, who often lack sufficient resources to cover the multiple needs arising from their own medical care or that of their relatives.

Therefore, the economic barriers faced by these Afro-Colombian migrant women significantly affect their access to health services. The costs associated with transport and medicines, and the loss of income from being absent from work, are constant challenges. In addition, the lack of coverage for transfers and referrals to other cities further increases the economic burden. These difficulties, in addition to limiting access to medical care, also affect the economy of these women and their families.

In this way, the economic factor presents itself as a barrier to accessibility, giving rise to processes of social exclusion that affect the well-being of

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Chocoan women in Medellín. According to Cerda and Marmolejo[19], there are three ways of studying accessibility: physical, economic, and social conceptions. The economic perspective focuses its analysis on the advantages that the optimal use of one's time and income provides an individual[20]. Therefore, time also constitutes a central category in the analysis of the economic dimension, since these women must organize their time around work, family, children, caregiving, domestic work, and travel within the city, among other tasks. In this sense, to understand the processes of social exclusion, Martínez[20], following the approaches of Cass *et al.*[21], proposes analyzing accessibility as the capacity to reconcile time and space in order to carry out daily tasks, maintain relationships, and create the places that individuals require for their participation in society.

To the latter economic barriers, others are added which are related to sociocultural aspects, which also influence these women's experience in accessing health services, as will be addressed below.

Sociocultural barriers: Afro-descent, gender, and knowledge in tension

According to Jirón and Mansilla[22], unequal access may also give rise to other factors, such as differentiated gender relations or cultural barriers that hinder interactions between different social groups. This implies recognizing that social differences such as gender, age, ethnic origin, and religion may become factors that generate differentiated experiences, resulting in restricted accessibility. In this sense, according to the aforementioned authors, accessibility must go beyond addressing physical, infrastructural, and service-related barriers, since individual and group sociocultural conditions (of gender, ethnicity, life-cycle stage, among others) constitute another type of barrier.

In this way, ethnicity and gender played an important role in relation to the barriers to access to health services among migrant women from Acandí, Condoto, and Istmina residing in Medellín. These women reported experiencing discrimination by medical personnel when they required care and feeling excluded from the health system, as differential treatment compared with other population groups was evident.

> *'You feel (…) the indifference or the treatment because of your ethnicity, and many times I have felt discriminated against when receiving health care. Even the person who arrives last is seen before you, and they make you wait. Many times, I have had to complain. They even tell you that Black people smell bad (…)'* (Migrant woman, Condoto 2).

This differential treatment is even more evident when health days or brigades are held, during which, on repeated occasions, health professionals tend to wear face masks when providing health care to people belonging to ethnic minorities—unlike when providing care to mestizo people resulting in differential treatment occurs, placing Afro-descendant migrant women at a disadvantage, as they face risks not only to their physical health but also to their mental and emotional health.

Additionally, ethnicity combined with gender became a factor of exclusion within health services, which led these women to experience discriminatory treatment, such as racism and obstetric violence, situations that were amplified by their being women and Afro-Colombian. In this way, ethnicity, in its intersection with gender, produces unequal experiences.

> *'The issue of obstetric violence among Afro women… 'How many more children are you going to have?' 'While you were doing it, didn't it hurt?' That is to say, that type of action causes people, in a certain way, to give up, or pressures communities to stop accessing something that is a right but is mediated by these stressful situations that… she will say, 'I have a midwife who cares for me better'; the healthcare conditions to give birth may not be in place, but if she believes the birth will be better and calmer, then she will do it'.* (Focus group participant 2).

In this context, ancestral medicine linked to Afro-descent appears to be an important alternative when these women experience barriers to accessing health services or when they do not feel comfortable resorting to them. However, ancestral medicine (widely recognized and

legitimized by the Afro-Colombian population and by the women interviewed) and Western medicine begin to come into tension when the women access health services in Medellín. This difference in approaches creates conflict during medical consultations, as ancestral practices and beliefs do not always find a place within the formal health system, even though, for Afro-Colombian women they constitute a legitimate and effective form of knowledge within their communities.

> *'I have an aunt who is a knowledge-keeper (sabedora), and I sometimes go to her. And I have heard that it is somehow more helpful (…)—the knowledge-keeper, the bonesetter (sobador), works on you—than what the doctor does… I have always thought that we should return once again to ancestral medicine. If I could choose, I would prefer to make use of ancestral medicine. A thousand times over. A thousand times over'*. (Migrant woman, Condoto 2).

> *'(…) many doctors judge you when you are already starting to make remedies with herbs, with things; they think, what is that for, and so on, and they do not understand the context from which that knowledge comes, right? And nor (…) is there that respect, and it is because the health system has pushed it out'*. (Migrant woman, Acandí 3).

Based on the above information, these Afro-Colombian women feel that their culture and ancestry are delegitimized, invalidated, and called into question, and ridiculed by medical personnel, which undermines cultural practices that form part of their processes of identity and belonging. This evidences a hierarchy of knowledge within the health system.

> *'When I was about to have surgery, the anesthesiologist told me, 'You people really like your little herbs. Don't go taking little herbs.' The truth is that I do like them; I was raised on herbs, but it was said in a disparaging way'*. (Migrant woman, Acandí 5.)

In this way, tensions arise between contemporary medicine and the traditional and cultural knowledge of Afro-descendant women, whereby the ancestral practices of these communities are rendered inferior and culturally homogenized, making the cultural elements of the right to health invisible —a situation that increases social inequalities among Afro-descendant migrant women.

In brief, the sociocultural barriers linked to ethnicity, gender, and ancestry shape unequal experiences of access that directly affect the comprehensive health of Afro-Colombian migrant women.

DISCUSSION

The findings of this study show that the barriers to accessing health services faced by Afro-Colombian migrant women in Medellín cannot be understood as isolated obstacles, but rather as the result of structural processes that articulate territorial, economic, ethnic, and gender inequalities. In this regard, the results confirm that internal migration, shaped by the armed conflict and labor precarization, creates conditions of vulnerability that limit the effective exercise of the right to health.

From a broad perspective, the inequalities identified do not operate in isolation, but are configured through the simultaneous articulation of power relations associated with gender, ethnicity, social class, and migratory status. In the Colombian context, this approach has been widely developed to understand how structural racism, sexism, and socioeconomic hierarchies produce differentiated experiences of exclusion and vulnerability, particularly among Afro-descendant women[23]. Thus, intersectionality makes it possible to analyze how these categories are historically co-constituted and expressed in social and institutional practices that affect the effective access to fundamental rights such as health.

Consistent with the intersectional approach, the findings show that the geographic, economic, and sociocultural barriers faced by Afro-Colombian migrant women in Medellín arise from the intersection of inequalities related to gender, ethnicity, and migratory status. This generates specific forms of exclusion and

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vulnerability in access to health services, making intersectionality a key tool for understanding the experiences and strategies that women develop in response to such barriers[24].

With regard to geographic barriers, factors such as distance, traffic, unfamiliarity with mobility dynamics and reference points, and the fear of getting lost were identified as crucial for understanding the difficulties these women face in accessing medical care in Medellín. Thus, geographic or physical-geographic barriers are linked to the distance that users of the health system must travel to reach the care center (depending on whether they live in urban or rural areas), the connectivity provided by means of transport, travel time, and the location of health centers[25]. In this sense, when it comes to reaching the various health care facilities, geographic access to health refers to the physical distance between a potential consumer and the service provider, according to a specific measurement standard that includes traffic patterns, means of transport, and travel duration[26].

Unfamiliarity with geographical location also plays an important role, as it significantly contributes to delays in accessing health services and thus constitutes a barrier within the geographic factor, given that the women are unfamiliar with the location of health centers and may be aware of only one[27].

Similar results are observed in the study by Sawadogo, *et al.*(which emphasizes that the distance between the places of residence of migrant women in the new territories where they reside and the health centers is very great, a scenario that becomes more complex due to the lack of transportation and connectivity. Likewise, in the cases presented by Tschirhart *et al.*[27], it is recognized that migrant women had to travel for up to four hours, using different means of transport such as bicycles, tractors, motorcycles, automobiles, and walking long distances.

In general, international evidence shows that migrant women may experience delayed access to perinatal services when they are unaware of the available services and face mobility and transportation difficulties in the host territories; for instance, this situation has been described among Ghanaian migrant women in Canada[29,30]. In Latin America, these barriers have also been widely documented, highlighting the fact that access to health services among the migrant population is conditioned by structural inequalities, the segmentation of health systems, and economic limitations that differentially affect women, particularly when gender, ethnicity, and labor precariousness intersect[31]. Thus, unfamiliarity with the functioning of the system and institutional care pathways, together with the material restrictions on mobility, contributes to postponing the search for services and to deepening health inequities.

Difficulties related to transportation and the distance between the place of residence and health facilities reduce the probability of timely access to care services. This situation affects the population living in rural areas more intensely, where geographic barriers are more frequent than in urban contexts. In the case of pregnant women, adequate planning of childbirth and care pathways can contribute to reducing these limitations and facilitating access to health services[32].

Similarly, migrant women, especially those in situations of forced displacement, face greater risks to their sexual and reproductive health—particularly adolescents and girls. who during migration may be exposed to human trafficking, labor exploitation, forced marriage, unplanned pregnancies, and gender-based violence. Although migration may represent settings of violence, conditions of precariousness and lack of protection tend to deepen inequalities and increase their vulnerability[33].

In this way, migration directly affects health by increasing exclusion from access to health services and exposure to infectious diseases, especially among migrants, who face greater barriers and vulnerability[34], not only because of the conditions inherent to displacement, but also because of unfavorable social and contextual factors that are expressed in prejudice, stigmatization, and discriminatory practices[35].

Another barrier to accessing health services is the economic one. Medical expenses are not always covered by the health system. (EPSs in Colombia).

In addition, the cost of transportation, lodging, medical appointments, payments, and medications, which migrant women often have to cover themselves, can become unaffordable. As single-parent mothers and income providers, they prioritize their obligations over their health, since accessing health services entails expenses and the loss of working time, which affects their income[36].

In the cases described by Loganathan *et al.*[37], migrant women, unlike local women, must pay for the entirety of their healthcare and, for this reason, often have no other option than to give birth at home in order to avoid incurring monetary costs they cannot afford[38]. In addition, Damle *et al.*[39] claim that Latin American migrant women in the United States face difficulties in accessing costly health services, many of whom are working mothers and, for the most part, single or divorced. This situation often forces them to leave their jobs to care for their children, which contributes to their food insecurity and exposes them to additional vulnerabilities.

Finally, geographic, economic, and sociocultural barriers were identified that affect access to health services. Sociocultural barriers, such as ethnicity, gender, and ancestral practices, give rise to different experiences that contribute to social inequalities. These barriers restrict access to health services and affect the well-being of Afro-descendant migrant women. These barriers 'arise from the articulation between different actors (the population, service providers, and intermediary institutions such as insurers and regulators) that hold distinct interests, representations, and beliefs, and that form part of different social groups'[25]. In this way, Afro-Colombian women from Acandí, Condoto, and Istmina not only considered that their beliefs were being delegitimized, but also experienced discrimination, questioning, and ridicule within the context of their culture and ancestry. Thus, the lack of sensitivity on the part of medical personnel toward the traditions or beliefs of these women contributes to discriminatory treatment[40].

Migrant women in Canada from Africa distrust Western medicine, its professionals, and its medications, viewing these practices as an affront to their religious and cultural values[41]. When medical personnel attempt to impose cultural values and practices associated with Western medicine on them, marked cultural dissonance arises[42].

On the basis of the foregoing findings and reflections, it is important to analyze the barriers to access to health services in an integrated, intersectional manner. Afro-Colombian migrant women seek healthcare while facing geographic, economic, and sociocultural barriers, due to the context of armed conflict and their roles as single-parent mothers and economic providers.

In this way, the broader perspective makes it possible to understand more clearly why migrant women experience barriers to accessing health services. Thus, Biondini[43] shows how gender, ethnicity, nationality, and socioeconomic status act together, and illustrates this by presenting the case of Peruvian migrant women in Argentina who, despite experiencing numerous barriers to accessing health services, tend to 'lower their heads' and not protest against unfair and discriminatory treatment by health professionals. In a similar context, another study conducted with migrant women from Bolivia and northwestern Argentina found that they face accessibility barriers to accessing the health system during their migratory journeys linked to agricultural work in Argentina[44].

In this way, the analysis of access to health services from an intersectional perspective makes it possible to understand how different factors, such as gender, age, ethnicity, socioeconomic position, and religion, influence people's experiences. These differences create power relations and social inequalities, generating exclusionary treatment and discrimination that affect the well-being of certain groups, especially Afro-descendant migrant women in difficult economic conditions.

Therefore, intersectionality emerges as a theoretical-methodological approach for understanding the social relations of power and the context in which social inequalities arise, making it possible to conduct a 'complex' study of the reality experienced by individuals, both women and men, by examining different social positions and historically situated categories[45].

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In this context, racism also appears as a barrier within health services that produces inequalities, insofar as Afro-descendant women are frequently excluded and treated differentially, affecting the guarantee of their right to health. In the study by Chitongo *et al.*[46], for example, Black migrant women are blamed for not attending prenatal check-ups. However, it is overlooked that these women perform more caregiving work and do not have sufficient support to leave their duties and attend these services.

Access to health services for Afro-descendant migrant women involves recognizing physical, geographic, economic, and sociocultural barriers. An intersectional approach is needed that considers their position in society and how factors such as ethnicity, gender, age, and socioeconomic status affect their health. It is essential to create comprehensive public policies and generate spaces for intercultural dialogue in order to guarantee their rights and reduce institutional violence and health inequalities.

In this sense, the barriers can be understood not only from their spatial dimension but also from the varied restrictions that individuals encounter daily in their movements throughout the city[22]; therefore, the analysis must go beyond the physical and infrastructural elements of health services, incorporating social, cultural, and economic factors. The position of Afro-descendant migrant women must be recognized, considering the interconnection of time, space, and the body, which encompasses both physical and social dimensions.

CONCLUSIONS

The study showed multiple geographic, economic, and sociocultural barriers that recognizes the inequalities in access to health services among Afro-descendant migrant women in Medellín. Factors such as distance, unfamiliarity with the transport system, economic precariousness, and sociocultural discrimination limit their access and reproduce exclusion in urban environments.

The results highlight the need to establish public policies with an intersectional approach that recognize the particularities of gender, ethnicity, place of origin, and socioeconomic status, while also integrating their own cultural knowledge and practices. This approach makes it possible to make visible the structural inequalities that influence the healthcare of this population.

The study focused on a specific group; its methodology is replicable in other contexts and may guide comparative research in different cities in order to broaden the understanding of health inequalities. It is proposed to evaluate existing institutional strategies and promote intercultural care models that better respond to the needs of Afro-Colombian migrant women, thereby contributing to reducing social gaps, particularly in healthcare.

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