Social Provisioning and Transit Migration in the Colombia-Panama Border

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Disclaimer:

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Content

Dedication

For those who are seeking a better life regardless of the precarities of their journeys, and for those who make these journeys more bearable.

I would like to express my deep gratitude to Nanneke and Roy for encouraging me to always question; and to my family in Colombia, my family-friends in The Hague, and Sebas for their care during this process.

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COLVENZ	Association of Venezuelans in Colombia [*Colonia de Venezolanos en Colombia*]
DHS	Department for the Homeland Security of the United States
EPS	Health Care Promoting Entity [*Entidad Promotora de Salud*]
GIFMM	The Interagency Group for Mixed Migration Flows [*Grupo Internagencial sobre Flujos Migratorios Mixtos*]
HIV	Human Immunodeficiency Viruses
IOM	International Organization for Migration
PPNA	Non-covered Poor Population [*Población pobre no asegurada*]
PPT	Temporary Protection Permit [*Permiso por Protección Temporal*]
SENAFRONT	National Frontier Service of Panama [*Servicio Nacional de Fronteras*]
SGSSS	General System of Social Security on Health [*Sistema General de Seguridad Social en Salud*]
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene

Abstract

This study focuses on the ways perceptions and realities of transit migration shape the politics and practices of health-related social provisioning for transit migrants in the Colombian side of the Darien Gap, particularly in the municipalities of Turbo and Necoclí. It contributes to understanding the logics of inclusion and exclusion that justify which services are provided to this population and how. Moreover, it studies the intersection between the vulnerabilities of transit migrants and the precarious conditions that they find in this border zone. This research is based on 15 interviews with formal actors involved in the provisioning of health and 12 residents of Turbo and Necoclí, as well as on observations in strategic locations where migrants access public health services. This study finds that transit migrants arrive to health provisioning system in which non-governmental actors support and complement the public provisioning of health for transit migrants and that the conception of transit migrants as outsiders of the system of provisioning is problematized in a context in which legal citizenship does not guarantee social rights.

Relevance to Development Studies

In the framework of Development Studies, social policies [and the provisioning systems that derive from them] are intended to transform social welfare, social institutions and social relations (Mkandawire, 2001, p. 11) in order to promote secure livelihoods. The question that arises then is *for whom*? This research bases on the intersection between these three elements to study the way formal and informal actors organize in Turbo and Necoclí, territories considered as "precarious transit zones" (Hess, 2012, p. 436), to ensure healthcare provisioning for transit migrants who aim to arrive to Central and North America. In this order of ideas, this research examines how the boundaries of inclusion into the healthcare provisioning system have been reworked and justified in differentiated ways.

Keywords

Transit migrants; formal and informal providers; social provisioning; host communities; othering

Chapter 1. Introduction

People try to reach the United States and, as I see it, their motivation must be life itself, because they have to go through a lot of suffering to arrive there [T1](Perea, Turbo, 2nd August 2022)[1].

Migration can be considered as a practice to seek and secure the protection of life, but it might also give rise to new threats and vulnerabilities in migrants' lives (Salazar and Voorend, 2019, p. 6). This human phenomenon generates certain types of risks that social provisioning systems try to minimize through differentiated strategies, but it also challenges the usually immobile character of said services in a particular territory (Serra Mingot and Mazzucato, 2016).

In the Colombian context, these challenges increase in complexity when social provisioning responds to transit migration in border zones, particularly since the peripheries of the state are characterized by precarious economic and political conditions that turn out defining the functioning of the welfare regimes. This research project focuses on the case of transit migrants that arrive in Turbo and Necoclí as part of their journeys through the Darien Gap, a region bordering Panama and characterized by a weak presence of the Colombian state and a strong presence of armed groups.

Formal and informal actors[1] have organized in the zone in order to try to respond to some of the basic needs of migrants once they arrive, while at the same time, borderland communities are living under precarious conditions with unsatisfied basic needs. Though qualitative interviewees with health providers and residents of Turbo and Necoclí, and non-participatory observations, this research project intends to identify the politics[2] and practices of health care provisioning, and particularly the underlying reasons, mandates, and motivations that lead formal and informal actors to provide health for transit migrants, a population that could be perceived as outsiders of a welfare regime.

The importance of recognizing these political motivations relies on the fact that they define on one hand, the type of relationships that are built around the social provisioning, the way identities are reconfigured to recognize 'the other' as part of a certain political community and at the same time, the factors that could lead to xenophobia and exclusion. On the other hand, these underlying reasons shape in differentiated ways the types of services that are provided to this population. Thus, this research focuses on the way health provisioning for transit migrants is organized around particular conceptions of migrants as the 'others', and since 'othering' finds roots in a specific context of precarious economic and social conditions, these conditions are highlighted during the research in order to frame the health provisioning for this population.

Turbo and Necoclí were chosen as zones of study because both of them are key sites of migrants' journeys, precisely before they enter the Darien Gap jungle. According to The United Nations High Commissioner for Refugees [UNHCR], the Darien Gap is one of the most important transit points in irregular migrants' journeys from South America, Africa and Asia to Mexico, The United States, and Canada, as well as one of the most challenging parts of the route (United Nations High Commissioner for Refugees, 2022a, p. 1). During an exploratory conversation with a worker at a service desk for Migrants and Refugees [*Punto de Atención y Orientación a Refugiados y Migrantes*-PAO], a focus on health was recommended since

[1] All quotes like this were translated from Spanish by the author. See the original text in the Appendix 1.

in their first-hand experience, it is one of the services that migrants need most. At a starting point, the research was going to include also the Water, Sanitation and Hygiene [WASH] provision to this population, but after secondary data review, it became clear this topic would require a separate research. Thus, this research concentrates on the provisioning of health in Turbo and Necoclí, taking into account the effects of the Covid-19 Pandemic on welfare services in the region and the context in which migrants and host communities interact.

It is also important to highlight that the decision to present the perspectives and experiences of the health providers in Turbo and Necoclí and local authorities rely on the lack of information related to the social provisioning systems that transit migrants find when they arrive to these territories. The decision is also based on the possibility to keep communication channels open with these actors to share the results of the analysis as a way to retribute and thank them for their time and dedication to the research.

Moreover, the deliberate decision to only focus on the voices of Turbo and Necoclí residents, and not the direct experiences and perspectives of migrants, is also based on some practices of the ethics of care that this research seeks to engage with. As it is possible to see in the following chapters, most transit migrants are traveling under precarious conditions that demand care and responsibility from researchers working with them. In addition, since transit migrants face communication challenges during their journeys, it could be complicated as a researcher to give them back the final product of this work, falling easily on the appropriation of knowledge.

In this order of ideas, it is necessary to highlight that the scope of this research is defined by the formal actors and residents who participated in the *in situ work*. Subsequently, to reach a broader understanding of the health provisioning system for transit migrants it is necessary to hear the voices of formal actors who were not involved in this research and that of transit migrants. Moreover, it is important to consider that transit migration through the Darien Gap is in constant change, and therefore its characteristics and the way medical attention is organized, as presented in this research, correspond to the situation experienced during August 2022. In addition, it is necessary to highlight that the perceptions about the healthcare system and transit migration that residents of Turbo and Necoclí shared during this research are not intended to lead to generalizations.

This document is divided into six different chapters as it follows: the present chapter introduces the questions that motivated this work and provides a general background about the situation of migrants that are crossing the Darien Gap and important characteristics of this Colombian region. The second chapter presents the conceptual framework that is used to understand how politics and practices have been constructed around the provisioning of health in Turbo and Necoclí, particularly for transit migrants. The third chapter explores the ontological, epistemological, and methodological foundations that led to the development of this research, as well as my positionality as researcher in this context, the limitations that derive from it, and the ethical delimitations of this work.

Chapter 4 offers a description of the healthcare system in Colombia, the principles, and mechanisms through which migrants, and particularly transit migrants, can have access to it. Moreover, it explores the specific architecture of the healthcare provisioning system for transit migrants in Turbo and Necoclí, and it presents the different roles that mainly formal actors assume towards them, and the challenges they face in their daily activities. The fifth chapter illustrates how the realities of transit migrants and the view of health providers and residents on them as outsiders on the welfare regimes influence the way they are incorporated or excluded from this particular system of provisioning. Finally, Chapter 6 presents the general remarks and conclusions that result from this research.

Research Questions

How do perceptions and realities of transit migration shape the politics and practices of health-related social provisioning in the Colombian border region of the Darien Gap?

Sub-questions:

1) How have border communities of Turbo and Necoclí experienced precariousness or opportunities in terms of provisioning of and access to health?
2) How is the provisioning of health organized in Turbo and Necoclí? What actors are providing health services? Which services are they providing to whom and on what basis?
3) Which formal and informal actors provide health to transit migrants? Why do they do this, and how do these reasons influence the way they are organized?
4) How do migrants in transit influence practices and perceptions of social provisioning of health in Turbo and Necoclí?

The Colombia-Panama Border

As a starting point, it is important to mention that Turbo and Necoclí are municipalities located in the Urabá Gulf in the Department of Antioquia. Migrants take different routes to cross the Darien Gap, all of them starting in Turbo or Necoclí. According to the National Department of Planning [*Departamento Nacional de Planeación*], in 2022 Turbo has a population of 134.278 inhabitants and Necolí a population of 45.503 inhabitants (Departamento Nacional de Planeación, 2022).

Municipalities in Colombia are divided into seven categories according to the size of their population, their annual budget, and their geographic position (Departamento Administrativo la Función Pública, 2019, p. 58). While the biggest cities in Colombia are under Special Category or Category 1, Turbo is considered Category 4, and Necoclí is in Category 6. Belonging to a particular category defines, among other things, the budget that is transferred from the national level to the municipalities to cover social expenses related to education, health, and WASH; the higher the category, the higher are the available resources (Duque-Cante, 2017, p. 81).

It is important to highlight that since 2019, all municipalities that are in border zones and have more than 70.000 people, must be classified at least in Category 4 (Departamento Administrativo la Función Pública, 2019, p. 59). However, Necoclí does not enter this classification due to the size of their local resident population and the fact that this criterion does not consider people on the move that temporarily stay in a municipality.

In order to have a broader perspective on the situation of Turbo and Necoclí, it is important to highlight that while the propensity of the population with Unsatisfied Basic Needs was 14,3% in Colombia in 2018, this number increases to 39,2% in Turbo and to 57,6% in Necoclí. Moreover, the propensity of the population living in misery for the same year was 3,8% at a national level, while for Turbo it was 14,7% and for Necoclí it was 28,6% (Departamento Administrativo Nacional de Estadística, 2021).

Furthermore, the border zone between Colombia and Panama is not exempt from peripherical dynamics that characterize other parts of the Colombian territory, such as a weak governmental presence and strong dominance of armed groups, especially the *Autodefensas Gaitanistas de Colombia* or Gulf Clan [*El Clán del Golfo*], who rule drug and arms trafficking on

this Colombian border (Garzón *et al.*, 2018) and who control the migration industry in the territory to a large extent (Guarnizo, 2021b). During 2022 there have been two armed strikes in which the Gulf Clan imposes closing businesses and roads, and forces people to stay in their homes, limiting their capacity to satisfy their basic needs and access to social services. There is no clear information on the direct implications of these armed strikes for transit migrants or the strategies they find to deal with these situations.

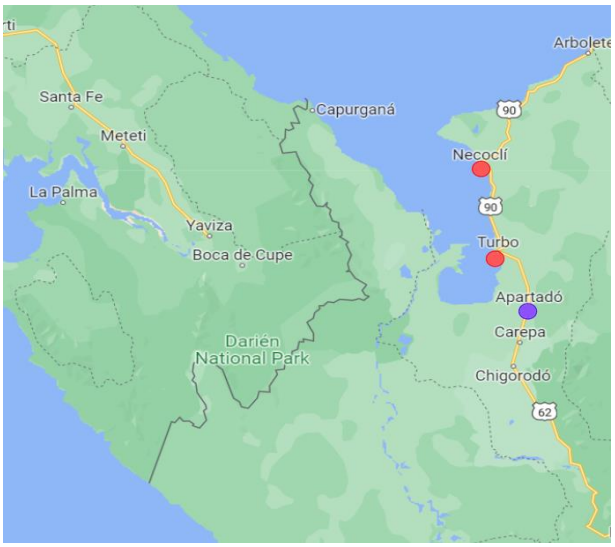
Transit migration through the Colombia-Panama border

Transit migrants traveling from the South and East of Colombia (see Image 1) arrive to Turbo and Necoclí mainly by bus looking for a maritime transport to cross the Urabá Gulf (see Image 2). In the particular case of Necoclí, some of them can stay at hotels, while others are staying in tents and hammocks at the beach, close to the two docks of the municipality. The fact that they are staying at the beach allow them to go to the sea to clean their cloths and take a bath (See Appendix 2). Furthermore, some have the possibility to buy their boat tickets to two formal companies once they arrive, while others have to stay in Necoclí for a few days to get the money to buy the tickets. Beyond the two formal companies offering the transportation through the Urabá Gulf, other migrants are crossing the gulf at night in smaller boats and without any safe condition (Zúñiga, Necoclí, 11th August 2022). According to an informal conversation with a local authority, migrants are supposed to present a pass document in order to regularize their situation in the Colombian territory, however, he mentioned that the there are so many migrants, they are not even asking for it.

Image 1. Migratory routes

Source: Defensoría del Pueblo, 2019 cited in Gámez, 2021

Image 2. Map of the Colombia-Panama border



Source: Google, 2022

Once migrants arrive to the other side of the Gulf, there are mainly three routes they take through the Darien Gap: 1) Turbo-La Miel-Puerto Obaldía; 2) Turbo, Cacarica River, Panama City; and 3) Turbo, Capurganá, Yaviza (Angulo et al., 2019, pp. 13-15). Guarnizo, (2021b) claims that the route that has been more used in the last years goes from Necoclí to

Capurganá on the Colombian side, and then on the Panama side, they take different routes to arrive in Bajo Chiquito, Lajas Blancas, Metetí, or Canaán Membrillo.

Crossing the Darien Gap consists mainly of a journey that takes between 5 and 10 days walking by foot through the jungle. Alongside the route, transit migrants do not find any type of service until they arrive to the migratory reception desks in the Panama side, so they have to stay in tents during the night, drink water from the rivers and cook with small gas stoves. Migrants usually travel in groups, composed by families or groups of men who have been traveling together before or who just met before entering to the jungle (See Appendix 2). In the last months, children traveling alone are becoming more common. Transit migrants tend to be part of smuggling operations, but in some cases, smugglers disappear, and migrants have to find their way to get out of the jungle by themselves. Moreover, it is also common that migrants are victims of robbery and women are victims of sexual violence (Gámez, 2021; Oropeza, 2022; Quiceno, Online interview, 27th July 2022).

Angulo et al. (2019, p.3) wrote a report for the Colombian Ministry of Foreign Affairs, in which they claim that migration journeys through the Darin Gap have increased since 2007 due to a multiplicity of reasons. First, Colombia implemented a visa waiver agreement for Chinese and South African citizens, which fostered their arrival to the national territory and then to move to the United States. In 2008, Ecuador implemented its politics of Open Arms to migrants, under which migrants arrived in Ecuador and then moved to Colombia to continue their journey to the North. Migrants have also been arriving to the Latin American continent through Brazil, thanks to commercial and administrative agreements between this Latin American country and different African states and Haiti during the 2010s (Angulo et al., 2019, p.3).

In this regard, the UNHCR ensures that "before 2010, the Darien crossing was used mostly by people from Asia and Africa and, as of 2010, by Cubans; in 2016, the first increase in Haitians using this route was recorded" (2022, p. 1). In the particular case of Haitians, a first diaspora arrived to different Latin American countries, including Chile, Argentina and Brazil from 2010 to 2014 due to the earthquake of 2010 and the hurricanes Isaac and Sandy that occurred in 2012, as well as the political instability that has characterized the country since then and that has been aggravated by diplomatic tensions between Haiti and the Dominican Republic (International Organization for Migration, 2017, pp. 34, 36-37). After 2014, migrants have been moving to new destinations in South America as well as moving out of the region to North America (International Organization for Migration, 2017, p. 40).

Since May 2021 the number of Venezuelan migrants going through the Darien Gap started to increase and from January 2022 onwards, they became the majority of the population crossing through this zone (SENAFRONT Migración Panamá, 2022). Since around 2014 residents of Venezuela have been leaving the country due to the generalized conditions of "violence, insecurity and threats as well as lack of food, medicine and essential services" (United Nations High Commissioner for Refugees, 2022b).

Thus, in the past ten years the protagonists, the circumstances, the available resources, and the routes they follow have changed (Guarnizo, 2021a). 2021 was a very unusual year since the number of migrants going through this zone increased significantly in relation to the previous years (See Table 1). However, from March 2020 to January 2021 Panama closed its borders in response to the Covid-19 pandemic, which led migrants to stay in Turbo and Necoclí (International Organization for Migration, 2021). Under these circumstances, these territories ceased being a transit zone and migrants had to face the marginalization of host communities in these territories, changing the conditions of the contexts in which they arrive.

Between January and September 2022, approximately 151.528 transit migrants arrived at the Panama border through the Darien Gap. The 9th of October the National Frontier Service of Panama SENAFRONT published its monthly report, in which it is possible to see

that just in September around 48.204 transit migrants crossed the Darien Gap. Under these circumstances, local authorities, mainly from Necoclí are calling the attention of the national government, since the maritime transport system is insufficient to take transit migrants from Necoclí to Capurganá and they were having to wait in the municipality until they get an allocation in a boat. Wilfredo Menco, from Necoclí's municipal attorney office ensures that just in the second week of October there were 3.500 transit migrants in very precarious conditions at the beaches of Necoclí waiting for a boat (Rivera-Rueda, 2022).

Table 1. Estimated number of migrants going through the Darien Gap 2010-2021

Year	Estimated number of migrants
2010	599
2011	283
2012	1.777
2013	3.051
2014	6.175
2015	29.289
2016	30.055
2017	6.780
2018	9.222
2019	23.968
2020	8.594
2021	133.726

Source: own elaboration based on UNCHR, 2022, p. 1

From the 151.528 migrants that have arrived during 2022 to Panama through the Darien Gap, about 75% are men and 25% are women and 21.570 are under 18 years old. According to SENAFRONT, migrants are coming mainly from other Latin American Countries: 71% of them are coming from Venezuela, 5,6% are from Haiti, 4% are from Ecuador, 2,8% from Cuba, and 2% from Colombia. There are also migrants coming from Senegal, India, Bangladesh, Ghana, Nepal among other African and Asian countries[3] (SENAFRONT Migración Panamá, 2022).

It is important to highlight that the transit though this particular route has been changing according to a "New Migration Enforcement Process" for Venezuelan citizens, that the Department of Homeland Security [DSH] launched on the 12th of October of 2022. According to this new measure, "Venezuelans who enter the United States between ports of entry, without authorization, will be returned to Mexico…and will be ineligible for this process [legal process to enter the country] in the future"(Department of Homeland Security, 2022). Moreover, the measure defines that Venezuelans are ineligible to enter the United States among other conditions if they "have irregularly entered Mexico or Panama after the date of announcement [12th of October 2022]" (Department of Homeland Security, 2022).

Furthermore, the DHS ensures that "The United States is also planning to offer additional security assistance to support regional partners to address the migration challenges in the Darién Gap" (Department of Homeland Security, 2022). The fact that the United States has externalized its borders through Panama is reshaping the realities of transit migration dynamics in Turbo and Necoclí.

Chapter 2. Conceptual Framework

To begin, this chapter frames the reflections around social provisioning in the way political communities are imagined and enforced around the idea of the citizen and 'the other'. Moreover, it situates the roots of the othering in a context of precarity, in which the notion of the full citizenship needs to be problematized under 'informal welfare states'. This chapter also looks at borders as zones where migrants face particular precarities and risks that are produced and reproduced by particular social and political forces.

Social provisioning for citizens and 'others'

In scenarios of limited resources, social provisioning by governmental and nongovernmental actors is inextricably defined by the exercise of determining who is entitled to have access to a service or good deemed necessary to reach a certain level of well-being. "Determinations of eligibility, entitlement, and inclusion are necessary activities at all levels of service delivery. This moral work… has to do with who ought to get what, and who ought to pay the price" (Gingrich and Köngeter, 2017, p. 271).

Through the lens of the state, this modern artefact is cemented on the idea of a social contract with a group of people defined as citizens, who are not only bounded through a legal status of incorporation but also through 'communities of value', in which certain patterns of behaviour and ideals are shared and reflected in particular cultures, religions, and languages (Anderson et al., 2011 cited in Anderson, 2021, p. 22). As Bauböck (2006 cited in Hughes and Anderson, 2015, p. 1) claims, citizenship "marks a distinction between members and outsiders based on their different relations to a particular state" (p. 1).

The idea of citizenship has been defined as a binary relation with those who are not considered as such, a criterion that has been historically defined by gender, economic capacity to have access to property, race, or the migratory status of a person, being the latter a criterion that is still in place (Anderson, 2021, p. 21). Migrants who have not been part of a naturalization process constitute the group of non-citizens, who are not simply excluded, but differentially included in the logics of the nation-state (Hughes and Anderson, 2015, p. 1). In this regard, de Lucas (2002, p. 3) points out that migrants regarded as non-citizens can only access minimum services to secure their wellbeing in the countries in which they arrive. The author proposes the example of access to health to illustrate that it is not common to talk about a social right to health for migrants, but instead about the minimum sanitary services that are needed in order for them to continue alive (de Luca, 2002, p. 4).

In order to get a deeper understanding of the relationship between citizenship and social provisioning, Esping-Andersen links the guarantee of social rights to the status of citizenship, or what he calls the 'social citizenship', as the core of welfare state regimes (1990, p. 21). In this regard, Esping-Andersen's perspective raises concerns regarding the social provisioning for people on the move. Particularly, since the narratives of 'the other', the non-citizen, that are built around the modern Nation State (Wimmer and Schiller, 2003, p. 567) juxtapose and clash, on one hand, with the notion of the State as guarantor of Universal Human Rights and the underlying idea of individuals as citizens of the World (General Assembly of the United Nations, 1948, pp. 1, 6), and, on the other hand, with humanitarian provisioning based on the principle of Humanity (United Nations Office for the Coordination of Humanitarian Affairs [OCHA], 2012).

In this respect, Noy and Voorend (2015) claim that

> Existing research highlights the importance of international human rights frameworks which serve as a catalyst for governments' recognition of immigrants' social rights (Favell 2006; Garcia 2010, 2014; Jacobson 1996; Sassen 1996; Sharma 2006). While human rights are inalienable rights and entitlements based on personhood, rather than citizenship or nationality (Soysal 1994), it often falls to nation-states to protect or provide these rights. However, as part of the political exercises that define and articulate the principal mechanisms of inclusion and exclusion within societies (Fischer 2009; Mkandawire 2005), states typically conceptualize these social contracts vis-à-vis citizens, rather than with migrants or other visitors. Thus, citizenship rights, those extended by states only to citizens, and social rights, those that are granted by governments to anyone within their territory, including migrants, do not necessarily coincide with a broader recognition of human rights (p. 606).

This juxtaposition of forces is even more complex in contexts in which being a citizen does not necessarily mean to have full access to social rights. Hughes and Anderson (2015, p. 2) call it "fantasy of 'full citizenship'" and claim that legal citizenship alone hides the "gendered, class and racialized borders within formal citizenship". In this order of ideas, the authors argue that women, poor populations, black and indigenous groups, naturalized migrants, among others, have been recognized as citizens, but citizenship does not mean real inclusion into society.

The binary relation citizen/non-citizen and the "fantasy of the 'full citizenship'" are determinant factors to understand the logics of inclusion and exclusion of certain populations to social provisioning systems in both the Global North and the Global South. However, the faces of these realities are differentiated, since they are marked by other ongoing logics of inclusion and exclusion that take place in each particular context.

Social provisioning for citizens and 'others' in contexts of precarity

The "fantasy of the 'full citizenship'" proposed by Hughes and Anderson (2015) for migration studies reflects what some authors focused on social exclusion and adverse incorporation have been writing about the boundaries and challenges that certain populations experience to achieve social, institutional, economic, and political inclusion. The borders within formal citizenship could be associated with social exclusion understood as "the process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live" (de Haan 1998, cited in Gingrich and Köngeter 2017, p. 273). Moreover, Silver (2007) adds that social exclusion "precludes full participation in the normatively prescribed activities of a given society and denies access to information, resources, sociability, recognition, and identity, eroding self-respect and reducing capabilities to achieve personal goals" (p. 1).

The consequence of setting certain populations aside of political, economic, and cultural participation makes them prone to not being able to forge a stable living, which creates conditions of precarity (Ramírez et al., 2021, p. 6). In this regard, Ramírez *et al.* (2021) claim that the experiences of vulnerability, insecurity and unpredictability that individuals face are intrinsically connect them to the political, social and economic forces that produce and reproduce precarity (p. 5). Basok et al. (2015) highlight that in the particular case of migrants, these connections between the micro and the macro levels allow to see how their precarity is shaped by state policies, regulations and practices, as well as by cultural perceptions related to stereotypes, xenophobia and prejudice (p. 13, 18).

In this context, welfare states emerged to absorb the shocks of social and economic exclusion for the most vulnerable (Gingrich and Köngeter 2017, p. 266), becoming crucial institutions to grant the entitlement of social rights (Sassen, 2003, p. 46). However, according to Ian Gough (2013), in the particular context of Latin America it is only possible to talk about "informal security regimes" or "insecurity regimes". For the effects of this study, only the former will be explained.

Informal security regimes are characterized by 1) a blurred division of labor in diffused capitalist systems, marked by kin connections, community relationships and illegal activities; 2) exclusion of certain populations from participation in social activities and political roles; 3) predominance of informality and lack of clear division between productive and reproductive labor; 4) identity and mobilization though social provisioning not only based on class relations but also on ethnicity, kinship, religion, cast, among others; 5) taking place in states where clientelism is common, and therefore, social provisioning is a result of short-term relationships between patrons and clients; 6) the traditional state-market-family matrix not being enough to explain welfare regimes, so communities also are involved; 7) welfare not only being understood in terms of de-commodification, meaning, the provisioning of services as a matter of rights (Esping-Andersen, 1990, pp. 21-22), but instead, focusing on fostering social inclusion and human security; 8) existing community-based relationships that have adapted to contexts of conflict; 9) blurred relationships between the market, the state, and communities that drive to a complex system in which it is not possible to ensure that social policies diminish the risks generated by the private sector (Gough, 2013, pp. 210-213).

Furthermore, Sonia Fleury (2017) claims that although during the first decades of the 21st century, Latin American welfare regimes are becoming more inclusive and diversified, there is still a strong existence of "benefits without rights and rights without benefits" (Fleury, 2017, p. 8). Moreover, the author states that social provisioning is highly familiarized[4] (Fleury, 2017, p. 5), pointing out the prevailing dependence of welfare networks generated between states, markets, and communities to family relations.

Risks and precarities in border zones

Gough's (2013) and Fleury's (2017) conceptualizations of welfare regimes take place on a national level, leaving aside the differentiations between the centers and the peripheries within a particular nation-state. This missing point hides the social inequalities that define social provisioning at a micro-level, driving to deeper logics of marginalization, for example, in border zones in comparison to large urban centers. In this order of ideas, to fully understand social provisioning in contexts of precarity, it is necessary to look at the variety of temporal and spatial scales of the social forces that define intentional development interventions and the structural transformations that may come with them (Novak, 2016, p. 486).

The juxtaposition of the regulatory frameworks that define citizenship and nationality in the context of borders, and the social interactions that occur in the framework of borderlands shape the opportunities, positions, and risks that individuals must assume in their everyday lives (Novak, 2016, pp. 486, 488; Huijsmans, 2019, p. 3). In this order of ideas, when risks are situated in borderlands, and the precarity of migrants' journeys are put at the center of the discussion, it is necessary to unpack the "spatial vulnerabilities" (Findlay, 2005 cited in Basok et al. 2015, p. 19) that characterize the places where migrant´s daily life occurs, in order to understand how geographic conditions make some people more vulnerable than others. According to Basok *et al.* (2015) "borders, routes and means of transportation…are all places where migrants' precarity is produced, contested, negotiated and mitigated" (p. 20).

The capacity of migrants to negotiate their uncertain and unstable conditions in border zones is defined by the border regimes that are in place. According to Hess (2012, p. 436), in the European Union border regimes re-direct people's routes and interrupt their trajectories, which lead to question the concept of 'transit migrant'[5]. Instead of referring to them as transit migrants, the author calls attention on the precarious conditions that characterize the spaces in which their journeys take place, zooming into the relationship between these precarities and the border regimes. Accordingly, she arrives to the idea of "precarious transit zones" to reflect the stratified rights that border regimes impose in these particular zones (Hess, 2012, p. 436). In the particular context of Latin America, a broader use of this concept could help to analyse the overlap of the precarious conditions that border externalization measures (like the a "New Migration Enforcement Process" for Venezuelan citizens) could generate with the precarious economic and social conditions of the communities where migrants go through.

Thus, this chapter introduced the conceptual framework that underpins the analysis of the politics and practices of social provisioning for transit migrants. Moreover, it introduces some theoretical reflections that are needed to contextualize the construction of 'the other' in Latin American welfare regimes and particularly, and particularly, to situate it in border zones.

Chapter 3. Methodology

This chapter presents the ontological, epistemological and methodological decisions that were taken in order to develop this research. These decisions are entangled with my positionality with the topic, with the ethical considerations and with the limitations that define the scope of understanding of this analysis.

As a methodological starting point for this research project, migrants, receiving communities, and formal and informal actors are approached from an actor-oriented perspective, which means they are recognized as agentic coproducers of their experiences but also embedded in particular social structures that delimitate their capacities and choices. Moreover, this research is based on a constructivist approach, since it focuses on the meanings of the experiences of both residents and formal providers of health. Knowledge is then produced through a reflective process that allows to question and revisit previously available information. Knowledge is thus "produced, relational, conversational, contextual, linguistic, narrative and pragmatic" (Kvale and Brinkmann, 2009, p. 53).

Two different methodological approaches were used to respond to the research question, namely, in-depth interviews and non-participatory observation. On the one hand, single interviews with formal actors and residents in Turbo and Necoclí took place from the 27th of July to the 17th of August 2022 (See Appendix 3). Formal actors were chosen based on their involvement in the provisioning of health for transit migrants in both municipalities, based on their mandates and missions. They are immersed in the architecture of social provisioning based on the mechanisms of provisioning, coverage rules, available resources and services provided by them.

For formal actors, interviews were topical, i.e., based on the programs and projects they design and implement. For both formal actors and residents, interviews were individual and semi-structured, and, while three of the fifteen interviews with formal actors took place through online platforms, those of residents were executed exclusively face-to-face. In order to reach formal interviewees, a snowball sampling was applied, in which the gatekeepers were the Orientation for Migrants Service Point in Turbo and Necoclí and an acquaintance of mine who works in Comfama, a health provider in the region of Urabá. Besides the snowball sampling, other interviewees were reached through direct emails and calls to the organizations. In the case of interviews with the residents, they were encountered either through the hospital (as a patient or family member) or through their business catering to migrants (by selling camping equipment or running a hotel). Thanks to the participation of the interested ones, it was possible to get in touch with the personal experiences and perceptions about the health system and transit migration. Both formal actors and residents were asked if they wanted their names to appear at the research or if they wanted to be anonymized or make use of a pseudonym. The real and anonymized names that are used in the research correspond to the will of the interviewees.

On the other hand, non-participatory and covert observations took place alongside the interviews. These observations were semi-structured, which means that the main criteria used to define them were the practices and actions of social providers and residents. However, observations were not limited to these criteria. Moreover, personal feelings and perceptions were also included. Observations focused on the interactions between migrants and residents with health providers at hospitals, attention offices, docks, among other places identified as critical points. To reach a saturation point, multiple observations were performed in the same places at different moments. Fieldnotes were taken in personal notebooks and were systematized in daily fieldwork reports.

To achieve thoroughness and rigour, both interviews and non-participatory observations were done based on interview guides (see Appendix 4). Transcripts from the interviews and fieldnotes have been coded and processed in ATLAS.ti, using theory-driven and data-driven codes.

Groups of codes were created to organize the information based on the references to the architecture of the health system of provisioning for transit migrants, the justifications to provide health care services to transit migrants, the experiences of inclusion and exclusion that these migrants face when accessing to health services, the perceptions of authorities and residents about the conditions of transit migrants, the experiences of the residents with the Colombian health system and the challenges that formal actors encounter for the provision of these services. This allowed to develop an iterative process between theories and data. To reach credibility, I applied triangulation based on contrasting information gathered in the interviews, the non-participatory observation, and secondary data.

Ethical considerations and positionality

The fact that I am Colombian, that I had travelled to Necoclí and the region of Urabá as a tourist before, and that I have worked with local authorities in Colombia define the starting experiences, expectations, and feelings that I have as a researcher, influencing the direction of the data gathering processes and analysis. However, since it is the first time that I do research in the field of migration studies, and that I get involved with health providers in Turbo and Necoclí, I could be perceived as a beginner in the topic. This malleable positions as outsiders/insiders define the credibility and approachability towards the participants of the research (Adu-Ampong and Adams, 2020).

My positionality affected my research in terms of my motivations and practical considerations. In the last years I have been personally motivated to understand the underlying reasons for inequality to exist and get reproduced. Since migration has become a structural element of my own live and I have experienced it under privileged conditions, I am moved towards questions related to how inequalities shape the journeys of the migrants; and who ensures wellbeing for those who are also on the move but in precarious conditions. These personal questions are reflected in this research paper.

On the other hand, thanks to the previous job of a relative as the coordinator of a health program in the Uraba region, I got the opportunity to interview the Directors of the Francisco Valderrama and San Sebastián de Urabá Hospital, who were then key actors to continue the snowball sampling, especially with the local authorities. This relative also helped me to get effective responses from some NGOs, that otherwise were not responding to my calls for an interview.

During my Research Project I engaged with some of the practices proposed by the Ethics of Care. Among these practices, they are to clearly explain the participants the framework and the scope of the research, to assume commitments around the use of the information in a signed informed consent by both the participant and me, to give them my personal information so they can contact me in case they want to add or erase some information from the interviews and to send to the ones that manifested their interest a translated version of the research once it is finished.

Limitations

- Interviews with key actors

The scope of the analysis of this research is defined by the perspectives and experiences of the interviewees that were reached during the *in situ* work. In that order of ideas, the missing voices of key actors become a limitation to get a broader overview of the health provisioning system for transit migrants. It is important to highlight that the missing voices come from three different angles:

- International Organizations: even though different efforts were made to Colombian Migration Office [*Migración Colombia*], PAO, HIAS, UNICEF, UNHCR and the IOM, it was not possible to get formal interviews with them. However, *Migración Colombia*, PAO and UNICEF participated in informal conversations, which meant that they did not sign an informed consent but provided relevant information about the activities that their organizations are developing in the zone. UNLAB and Clínica Central Someba, which are local organizations that were identified during the *in situ* work, were also part of these informal conversations. The interviewee from Mercy Corps requested not to use the information of the interview in name of the organization.
- Informal providers: three informal actors were approached but it was not possible to get interviews with them for different reasons that are explained in the Appendix 5. The general perception about this experience is that transit migrants tend to look for formal actors, and that if informal actors provide health services to them, more time in the zone will be needed to identify them.
- Transit migrants: as was explained in Chapter 1, this research does not include the voices of the transit migrants that are in fact receiving health care attention. The decision to not include their own experiences with the provisioning system was made based on the ethical consideration of not asking for their time and information and then not being able to contribute directly to improving their situation with this research.

- Security considerations

During the first week of my arrival to Urabá (August 1st to August 7th), *El Clan del Golfo* had installed an armed attack [*Plan Pistola*] against police members in the northern region of Colombia, mainly in Cordoba and Urabá. This attack consisted of the request to kill one police officer every day and offering a certain amount of money for the murder. Since this attack was focalized to the police, daily life of residents and transit migrants in Apartadó[6] and Turbo was not directly affected, and therefore, people were still able to attend their medical appointments and go to emergencies. However, in informal conversations with people in public transport, with taxi drivers and at cafeterias and restaurants, people manifested that they felt a tense environment and that *you can be in the wrong place, in the wrong moment* referring to the fact that anyone could become a victim in a middle of shooting or a bomb.

Turbo was one of the most affected regions by this situation and, since one of the police stations is located near the Major's office and the hospital, the local government's offices remained closed. This situation had a significant impact on the research, given that commuting from Apartadó to Turbo was only possible on two occasions, although more frequent visits were planned. Furthermore, when present in Turbo, only quick visits to key locations were possible, after which returning to Apartadó was required. The main security advise was to remain as far as possible from any police officer or station. The 7th of August *El Clan del*

Golfo published a statement saying that they were going to stop all their armed actions. After relocating to Necoclí on August 9th, the tension significantly decreased (See Appendix 6).

To reduce the risks and the impacts associated with the *in-situ* work, several measures were taken. First, during the first week of travel, I was accompanied by a close family member, and I stayed with a friend of the person who works in the health sector in Urabá, who also introduced me to other health providers for transit migrants in Turbo and Necolí. For the next two weeks, I was accompanied by another close acquaintance, mainly in the municipality of Necoclí.

Furthermore, thanks to fellow student Darly Díaz, the Freedom of Press Foundation [*Fundación para la Libertad de Prensa* -FLIP] installed an alarm plan during the time I was in Urabá, which required me to check-in and check-out every day to confirm my wellbeing. During the *in-situ* work, it was not necessary to activate any direct alarm with police stations in the municipalities in which I was present. On top of these considerations, participants were asked about any security concerns that they may have about the topic of the research. For more details on the consent, the treatment of the information, and the communication with the participants, see the Protocols for Interviews and Observations in Appendix 4.

Chapter 4. Transit migration and access to healthcare provisioning

This chapter structure goes from the general presentation of the Colombian Health System to the particular healthcare provisioning for transit migrants in Turbo and Necoclí, going through the access and experiences of residents of these municipalities with this system of provisioning and the general access of migrants to medical attention in Colombia. After following this route, this chapter focuses on the practices of healthcare provisioning for transit migrants, the way formal actors are organized, the challenges they face in their everyday activities and the roles they assume.

A brief presentation of the Colombian Health System

The provision of health in Colombia is organized under Law 100 of 1993, which establishes the General System of Social Security for Health [*Sistema General de Seguridad Social en Salud*-SGSSS]. According to this Law, the SGSSS is based on six different pillars, two of them being of relevance for this study: Universality[7] and Solidarity[8] (Ley 100 de 1993, pp. 1-2).

Under the system, Colombian and migrant population are affiliated to one of the two regimes that constitute the SGSSS according to their work conditions. People that have a labor contract, are pensioned or are independent workers with the capacity to pay a monthly fee for health and pension must be affiliated to the Contributive Regime. On the other hand, the most vulnerable and poor people who do not have the capacity to pay this fee must be affiliated to the Subsidized Regime (Ley 100 de 1993, p. 46). The Law also contemplates special regimes for soldiers, teachers, politicians, among other professions, as well as their families.

When any person in Colombia affiliates to the SGSSS, they are immediately affiliated to one of the 30 Health Care Promoting Entities [*Entidad Promotora de Salud*-EPS] that exist in the country. These administrative entities must ensure that the population has access to prompt and effective health care services, which means they are in charge of articulating the medical services for the population (Ministerio de Salud y Protección Social, 2018). In this order of ideas, for a person to receive any type of medical attention, the EPS to which they are affiliated must first approve the service and define in which hospital or medical center it will be provided.

Moreover, there is another category called the Non-Covered Poor Population [*Población Pobre no Asegurada*-PPNA], which covers Special Populations[9] who are still not affiliated to the SGSSS, which includes indigenous groups, Venezuelan migrants with a residence permit and their underage children, victims of the Armed Conflict, demobilized combatants of the Armed Conflict, inmates, among other. In order to receive medical attention as a PPNA individual, a person needs to be registered in a Special Census for the Special Population they identify with (Ministerio de Salud y Protección Social, 2022b), and the local authorities assume the role of the EPS. In this regard, local governments constantly create strategies to affiliate these populations to the SGSSS (Coral, Apartadó, 5th August 2022; Ministerio de Salud y Protección Social, 2022b). In the case of Necoclí, for example, advertisement was found at the Major's Office inviting PPNA to register in the SGSSS at the Secretary of Health.

Beyond the designed coverage of the SGSSS, health services are organized under three categories which are Low Complexity, Medium Complexity and High Complexity. The first level includes the services of odontology, general medicine, nursing, Growth and Development [*crecimiento y desarrollo*], laboratory tests, preventive programs, pharmacy, and urgencies. The Medium Complexity level includes services related to gynecology, nutrition, pediatrics, psychology, chirurgic services, orthopedics, and internists. Finally, the High Complexity level covers all the specializations and sub-specializations such as urology, neurology, among others (Ministerio de Salud y Protección Social, 1994). According to Amanda Coral, medical doctor and expert in the healthcare system in the Urabá Region (Apartadó, 5th August 2022), all municipalities in Colombia must have at least one Low Complexity Attention Point.

Colombians' Access to Health in Turbo and Necoclí

Turbo and Necoclí have public hospitals located in the outskirts of the urban areas, about 20 minutes away by foot or 5 minutes by motorcycle or bus from the town center. Both are located on the main road of access to the municipality. The San Sebastián de Urabá Hospital in Necoclí is a Low Complexity Center, while the Francisco Valderrama Hospital in Turbo is a Medium Complexity Center. The only hospital that provides High Complexity Services is the private Panamericana Hospital in Apartadó, which is, as mentioned before, the capital of the Urabá region (Coral, Apartadó, 5th August 2022).

Table 2 shows the percentage of the population who is affiliated to the SGSSS in Turbo and Necoclí according to the Ministry of Health and Social Protection. However, as mentioned by the Director of the Francisco Valderrama Hospital in Turbo, Geiler Perea (Turbo, 2nd August 2022), these values are not accurate due to the use of an outdated census, which considers a lower population than the current one. According to website of the Ministry of Health and Social Protection (2022a), the number of people affiliated in Turbo is 144.250, while the census indicates a total population of only 134.278. A similar situation takes place in Necoclí: while the number of affiliated persons is 54.514, the total population according to the census is 45.503. The fact that this data claims that both municipalities have a coverage of 100% of the population, makes the PPNA invisible.

Table 2. Population affiliated to the SGSSS in Turbo, Necoclí and Colombia

	Turbo	Necoclí	Colombia
Percentage of the population affiliated to the SGSSS	100%	100%	99%
Population affiliated to the Contributive Regime as percentage of the total affiliated population (2021)	30%	10%	48,4%
Percentage of the population affiliated to the Subsidized Regime as percentage of the total affiliated population (2021)	68%	84,2%	47,15%
Percentage of the population affiliated to a Special Regime as percentage of the total affiliated population (2021)	2,2%	1,7%	4,4%

Source: own elaboration based on Ministerio de Salud y Protección Social, 2022a

In order to evaluate the provision of health in any municipality, Amanda Coral (Apartadó, 5th August 2022) mentioned that local governments compare the following indicators with their value at the national level: maternal mortality rate, perinatal mortality rate, number of deaths per year of children under 5 years caused by Acute Diarrheal Diseases, and number of deaths per year of children under 5 years caused by acute respiratory distress syndrome. Table 3 shows these indicators for Turbo and Necoclí in comparison with Colombia. The coverage of aqueduct and sewage systems is also presented. Although it is possible to obtain this information per hospital, to access it, one needs to be registered at the Special Registry of Health Service Providers [*Registro Especial de Prestadores de Servicios de Salud*], which was not possible at the moment of this research.

Table 3. Health, aqueduct and sewage in Turbo, Necoclí and Colombia

	Turbo	**Necoclí**	**Colombia**
Maternal Mortality Rate (per 100.000 live births) 2019	69,5	112,7	46,7
Perinatal Mortality Rate (per 1.000 live births) 2019	14,7	17	14,8
Deaths of children under 5 years caused by Acute Diarrheal Diseases (per 100.000 children) 2019	0	19,6	6,9
Deaths of children under 5 years caused by Acute Respiratory Distress Syndrome (per 100.000 children) 2019	40,2	19,6	13,4
Infant Mortality Rate before 1 year (per 1.000 live births) 2019	12,9	15,8	11,3
Coverage of aqueduct 2018	62%	41%	86,4%
Coverage of sewage 2018	32,4	25,2%	76,6%

Source: own elaboration based on Secretaría de Salud del Departamento de Antioquia, 2019; Así Vamos en Salud, 2022; Departamento Nacional de Planeación, 2022

As it is possible to see in Table 3, for 2019 the provision of health in Necoclí still faced significant challenges in comparison to the situation on the national level. These challenges are reflected in the Maternal Mortality Rate and the Deaths of Children under 5 years caused by Acute Diarrheal Diseases. Moreover, the coverage of aqueduct and sewage in 2018 is also insufficient and significantly low in comparison with the national level. Apart from the number of Deaths of children under 5 years caused by Acute Respiratory Distress Syndrome, Turbo has better health indicators than Necoclí. However, in some key indicators such as the Maternal Mortality Rate and the Infant Mortality Rate before 1 year, the municipality did not reach the national level. Even though Turbo also has a higher coverage of aqueduct and sewage than Necoclí, it remains significantly below the national level.

Experiences with the Health System in Turbo and Necoclí

Daniela Carmona, the social worker of the Francisco Valderrama Hospital (Turbo, 2nd August 2022), claimed that since the Francisco Valderrama Hospital in Turbo is the only Medium Complexity Center available for the surrounding municipalities, it constantly receives residents from other places. During the first visit to this hospital, which took place in the

morning hours, it was full of patients, who were either seated or standing in the halls, in and outside of the building, waiting to be called in to receive medical attention or help from administrative staff. People did not complain. Some of them were sleeping or talking to each other while waiting. It was common to see pregnant women and elderly people waiting in the queues (Observation notes, Turbo, 2th August 2022). The second visit to the hospital took place at noon, and it was not as crowded as the previous day. This time, there were no people waiting in the halls except from those standing in the queue for the pharmacy and the queue to set an appointment with a General Practitioner. However, one of the workers of the hospital told a woman, who required an appointment for her mother with an internist, that the next available one was in four months, and that it would be better to take her to the emergency service to receive a faster service (Observation notes, Turbo, 4th August 2022).

In contrast to Turbo, the atmosphere in the San Sebastián de Urabá Hospital of Necoclí, in the morning of August 9th, was calm. There were people outside of the hospital waiting to be called in for their medical appointments. Once people arrive, they are required to take a turn and wait until they are called. It was possible to see that attention was fast since there were people coming in and out constantly, but it was never crowded (Observation notes, Necoclí, 9th August 2022). Moreover, there were a lot of women with children. On August 16th there were more people at the hospital, although not to its full capacity, and it was possible to see that the majority of them were women, some with children and others by themselves.

During the interviews, residents of Turbo and Necoclí expressed having both positive and negative experiences with the healthcare system. While some of them ensure that they receive a prompt attention and that the medical staff is well prepared (Fuertes, Turbo, 4th August 2022; Interviewee 4, Turbo, 2nd August 2022;), others consider that they only provide basic services, and that even if the doctors are qualified, the EPS makes the system very slow (Arteaga, Necoclí, 10th August 2022; Pérez, Turbo, 2nd August 2022). Three of the interviewees mentioned that they prefer not to go to the doctor (Mosquera, Necoclí, 10th August 2022; Patiño, Necoclí, 15th August 2022), and two of them even refer to God as their own doctor: *the only doctor who supports me is God* [

T1

"dé esa vuelta tan grande para llegar a Estados Unidos, esa motivación tiene que ser, digo yo, la vida, cierto, porque hay mucho sufrimiento para pasar, la persona para llegar allá…" (Perea, Turbo, 2nd August 2022).

T2] (León, Necoclí, 12th August 2022). It is necessary to highlight that it is not possible to claim that interviewees' perceptions about the healthcare system represent more general perceptions of residents of Turbo and Necoclí. Moreover, perceptions of the health system are defined by the experiences of the residents with the different EPS, especially since each EPS manage their own resources, doctors, times of response to their patients, among other administrative features.

Migrant's Access to health in Colombia

The provision of health to migrants is defined by their legal status in the Colombian territory. When a migrant has a residence permit, and particularly, when Venezuelan migrants hold a Temporary Protection Permit [*Permiso por Protección Temporal*-PPT], they can be affiliated to the SGSSS through the Contributive or the Subsidized Regimes, and therefore have access

to health services as any other resident of the country. If they have the residence permit but they have not been affiliated, then they are considered PPNA and can have access to all health services under this condition. Nevertheless, health centres will affiliate them to the SGSSS as a recruitment mechanism used to accomplish the universality principle of the system. This is possible since the affiliation is digital and takes less than two days (Ministerio de Salud y Protección Social, 2022b).

In the Hospital of Turbo, Marisol Rincón and her mother, two Venezuelan women living in Colombia, mentioned that the latter can access all of the health services through appointments, including specialists and urgency care without any cost. Marisol expressed no complaints about the health services after receiving her residence permit. In fact, the throat echography she had that day was completely free of charge. However, her process to be granted a residence permit took three months and before she received it, she and her mother had to pay for any medical procedure as private patients (Turbo, 2nd August 2022).

The experience of Marisol and her mother before having the PPT shows the other face of the access to healthcare for migrants without any type of residence permit, as well as for transit migrants. Since, the majority of transit migrants do not receive a residence permit, but instead a license to travel through the Colombian territory, the only service that the Colombian State offers them through public hospitals is the attention of emergencies (Arroyave, Ramírez and Abramovits, 2021, p. 39). As Daniela Carmona (Turbo, 2nd August 2022) explained, *if it is a vital emergency, they could have access without any type of document, but for the entire ambulatory service* [those requested through medical appointments because of low urgency] *a permit is required* [T3]. If a transit migrant needs a health service in the public network and they are not part of a prioritized population, they will need to pay for the service as a private patient (Carmona, Turbo, 2nd August 2022; Díaz, Necoclí, 16th August 2022).

In terms of funding, if a transit migrant goes to the emergency room and they require a low complexity attention, this is provided by the hospital and then funded by the municipal authorities through administrative contracts between both entities. If the transit migrant requires medium or high complexity services, they are provided by the hospitals and then financially covered by the Secretary of Health of Antioquia (as mentioned before, the department in which the Urabá Region is located) (Carmona, Turbo, 2nd August 2022; Díaz, Necoclí, 16th August 2022; Torres, Necoclí, 9th August 2022).

Social Provisioning of Health for transit migrants in Turbo and Necoclí

Architecture

As a starting point, it is necessary to highlight that since Turbo and Necoclí are located at the entrance of the Darien Gap, the social provisioning of health in these municipalities must react to health conditions derived from previous journeys as well as to preexisting conditions that transit migrants may have. In other words, they do not respond to the physical and mental consequences of the journey through the Darien Gap since for that it necessary to be in the Pananama side of the border.

At the time of research, transit migrants mainly required medical attention in Turbo and Necoclí to treat mental health issues, Human Immunodeficiency Viruses [HIV], Covid-19, rabies, food and water poisoning and to receive pregnancy care (Interviewee 1, Online interview, 8th August 2022; Meza, Online interview, 10th August 2022; Perea, Turbo, 2nd August 2022). Responses to these medical necessities are differentiated according to the territory. In

Turbo the only institution providing health services to transit migrants is the Francisco Valderrama Hospital, while in Necoclí they can turn to the San Sebastián de Urabá Hospital and to different NGOs, which provide diverse types of services.

Regarding public attention, as it was briefly mentioned before, if a transit migrant goes to the emergency room and they require a low complexity attention, the hospital provides it and then requests the financial resources to the Secretary of Health of the municipal authorities in Turbo and Necoclí. If the emergency requires a medium complexity attention, the Secretary of Health of Antioquia, which is the Department's authority, will be responsible of covering the costs. This implies that if the patient is in Turbo, the Francisco Valderrama Hospital can provide the service and then request the payment to the Secretary of Health of Antioquia. On the other hand, if the patient is in Necoclí, the Secretary of Health of Antioquia would decide which hospital with medium complexity services the patient must attend. Since none of these hospitals offer high-complexity services, in that scenario the Secretary of Health of Antioquia will decide if the patient is transferred to Apartadó, in the Urabá region, or to cities outside of this area, such as Medellín or Montería (Carmona, Turbo, 2nd August 2022; Díaz, Necoclí, 16th August 2022; Torres, Necoclí, 9th August 2022).

As it was mentioned by Neyder Pupo, the general manager of the San Sebastián de Urabá Hospital (Necoclí, 9th August 2022), as well as by Fernando Torres, manager of coverage, insurances and affiliation to the health system of the Secretary of Health of Necoclí (Necoclí, 9th August 2022), since the financial resources are limited, authorities give special attention to prioritized transit migrants, such as pregnant women, children and the elderly. In this regard, they can have access to some low complexity services beyond emergencies if needed, for example, vaccinations or periodic controls (Díaz, Necoclí, 16th August 2022).

Furthermore, the NGOs providing healthcare services to transit migrants in Necoclí are the HIAS office, a mobile attention point of the Colombian Red Cross, and a mobile attention point of the Colombian Institute of Tropical Medicine, which provides its services in the name of the IOM. Each of these attention points are located in one of the two docks of Necoclí and have been working in the region since August 2021. This, to respond initially to the situation in Necoclí during the time the Colombian-Panama border remained closed, given that between 20.000 and 25.000 transit migrants were stranded in Necoclí and were unable to continue their journeys (Hernández, Necoclí, 10th August, 2022; Meza, Online interview, 10th August 2022). The United Nations International Children's Emergency Fund [UNICEF] is also present in the zone to provide WASH services, and although Mercy Corps does not have a permanent presence in these territories, it does participate in health brigades. Image 3**¡Error! No se encuentra el origen de la referencia.** presents the geographical distribution of the attention points for transit migrants in Necoclí, and Table 4 presents detailed information about the services they provide, eligibility to access them, the required documents, and funding.

As it is possible to see in Image 3, and as it was mentioned previously, migrants in Necoclí are staying close to the beach or in the beach, mainly in the zone highlighted in blue. Moreover, since the Colombian Red Cross and the Colombian Institute of Tropical Medicine mobile units are located at the beach, closer to the docks, in case they need medical attention, it is easier for them to arrive to these mobile units than to go to the San Sebastián de Urabá Hospital. In fact, during the interview with the Colombian Red Cross on August 10th 2022, a migrant who was staying in a tent on the beach arrived with an injury on his arm to get sutured and received immediate attention by a nurse. On the contrary, if transit migrants in Turbo need healthcare attention, they are required to go to the outskirts of the urban area.

Private health care centers do not tend to provide services to transit migrants, with the exception of UNILAB, which processes laboratory tests for the Colombian Institute of Tropical Medicine, and Necofarma Jireth, which gives migrants the medicines that are

prescribed to them, thanks to an alliance with a UN agency (although the interviewee did not remember which one precisely, it is most likely IOM or UNHCR) (Padilla, Necoclí, 16th August 2022).

In relation to informal providers of healthcare services, Amanda Coral (Apartadó, 5th August 2022) mentioned that it is not common for them to engage in these activities. However, she remembers that in 2021, when the Panama border was closed, some residents of Necoclí offered basic services, such as heartrate and blood pressure measurement, to migrants on the beach in the proximity of the port.

Since 2016 the UNHCR and the IOM have been co-leading and promoting a mechanism of coordination and dialog called The Interagency Group for Mixed Migration Flows [*Grupo Interagencial sobre Flujos Migratorios Mixtos*-GIFMM], which brings the actors involved in the response to the situation of migrants and refugees together (Plataforma Regional de Coordinación Interagencial para Refugiados y Migrantes de Venezuela, 2022). In Colombia, and particularly, in the Urabá Region the GIFMM has been leading the articulation of non-governmental and governmental actors who provide health care services to transit migrants. This articulation materializes in a monthly meeting, workshops and formative spaces, and a WhatsApp group to keep constant communication (Interviewee 1, Online interview, 8th August 2022; Meza, Online interview, 10th August 2022).

Moreover, the GIFFM has also designed and implemented an App called GIFMM with you [*GIFMM Contigo*] which transit migrants can download in their phones to have access to information related to the services that different organizations provide to them, their location, and opening hours. It is important to highlight that at the moment of writing this document, the public hospitals of Turbo and Necoclí did not appear as health providers in the App, which raises the question on the way the IOM and the UNHCR are reading the installed capacity of the public healthcare centers.

On the other hand, two weeks before the interview, the Necoclí Major's Office created a Migration Management Initiative [*Mesa de Gestión Migratoria*] to also generate alliances with the non-governmental sector and with national authorities. Since the initiative was nascent it was not yet clear how it is cooperate and do not clash with the GIFMM (Zúñiga, Necoclí, 11th August 2022).

Image 3. Actors providing health to transit migrants in Necoclí

Source: own elaboration

Table 4. Services provided to transit migrants by actor

Municipality	Actor	Service provided to transit migrants	Service provided to residents	Eligibility	Required documents for transit migrants	Funding		Source
						Funding for migrants	Institutional funding	
Turbo	Francisco Valderrama Hospital	**Emergencies** **Low Complexity:** general practitioner, prenatal care, prevention and promotion of health, pharmacy, children's growth and development. **Medium Complexity:** odontology, orthopedy, internal medicine, gynecology, pediatrics, general surgery, anesthesia, psychology, nutrition, phono-audiology.		Everyone	Passport or any ID	Emergencies: Free Low/Middle/High complexity services: own funding	- Low complexity emergencies: Secretary of Health of Turbo - Medium/High complexity emergencies: Secretary of Health of Antioquia	Perea (Turbo, 2nd August 2022), Carmona (Turbo, 2nd August 2022)
Necoclí	San Sebastián de Urabá Hospital	**Emergencies** **Vaccination** **Low Complexity:** general practitioner, prenatal care, prevention and promotion of health, pharmacy. **Medium Complexity:** odontology, pediatrics, nutrition, psychology, gynecology, internal medicine.		Everyone	Passport or any ID	Emergencies: Free Low/Middle complexity services: own funding	- Low complexity emergencies: Secretary of Health of Necoclí	Pupo (Necoclí, 9th August 2022), Díaz (Necoclí, 16th August 2022)
	Colombian Red Cross	Low complexity emergencies, General Practitioner, Children's growth and development, psychology, psychology and pedagogy for children, pharmacy.	No services	Foreign and Colombian transit migrants	Passport or any ID	Free	European Union	Hernández (Necoclí, 10th August 2022)
	Colombian Institute of Tropical Medicine-IOM	Epidemiological control of tropical diseases, general practitioner, odontology, psychology, nutrition.	No services	Transit migrants	Passport or any ID. Could be a virtual document	Free	The IOM sponsors the program	Meza (Online interview, 10th August 2022)
	Necofarma Jireth	Delivery of Medicines for transit migrants	Pharmacy and cash transfers	Residents/Transit migrants with a prescription from the IOM	Medication prescription from the UN Agency	Free	UN Agency (IOM-UNHCR)	Padilla (Necoclí, 16th August 2022)
	UNLAB	Laboratory Tests	Laboratory Tests	Residents and transit migrants with a medical order from the IOM	Not available information	Free	IOM	Phone call Sandra Milena Zuleta
	IOM (web page)	For the San Sebastián Hospital: Supply of medicines and biomedical equipment. Training to doctors about differentiated treatment to migrants. Digital tool in Haitian Creole, French, English and Portuguese to foster easier communication. Change of the hospital signs: English, French, and Portuguese.	Not available information	Not available information	Not available information	Not available information	Not available information	(International Organization for Migration, 2022a)
	UNICEF	-Water: drinkable water, portable jerrycans, filters. -Hygiene services: soaps, toothpastes, toothbrushes, sanitary pads, deodorants, creams for injuries.	Not available information	Not available information	Not available information	Not available information	Not available information	Field observation and Grupo Interagencial sobre Flujos Migratorios Mixtos (2022)
	HIAS	-Mental Health services -Response to gender-based violence	Not available information	Not available information	Not available information	Not available information	Not available information	Grupo Interagencial sobre Flujos Migratorios Mixtos (2022)
Turbo/ Necoclí	Mercy Corps	Sexual and reproductive health services	Not available information	Not available information	Not available information	Not available information	Not available information	Coral (Apartadó, 5th August 2022)

Source: own elaboration based on the interviews with formal actors

Challenges in the provisioning of health

Formal actors find mainly four main challenges when providing health services to transit migrants, which are: 1) Language; 2) Lack of information; 3) Lack of financial resources; and 4) Lack of infrastructural capacity. How each of these actors experience these challenges is different, as are the strategies developed to overcome them.

The seller of NecoFarma Jireh Pharmacy, Dayana Padilla (Necoclí, 16th August 2022) mentioned that when migrants arrive to the pharmacy and start talking in a language that she doesn't understand, *they come and drive me crazy* [

T4] (Padilla, Necoclí, 16th August 2022). The same challenge was mentioned by almost all the formal actors who provide health services. In consequence, all the signs at the San Sebastián de Urabá Hospital are in Spanish, English, French and Portuguese, which was a communication strategy sponsored by the IOM (International Organization for Migration, 2022a). Moreover, drinking water tanks installed by UNICEF along the port have instructions in different languages, such as Portuguese and Haitian Creole (See Appendix 2). Luz Helena Hernández, from the Colombian Red Cross (Necoclí, 10th August 2022) mentioned that they have incorporated the use of online tools to translate during medical appointments, and that they have also learned some of the most relevant words in other languages to provide a proper attention.

The second challenge is the lack of information about the number of migrants that arrive to Turbo and Necoclí and that leave through the Darien Gap. In this regard, Marisol Quiceno (Online interview, 27th of July 2022), who works as the Humanitarian Director at Doctors without Borders on the Panamanian side claimed that the only official data related to the number of people going through the jungle is collected by SENAFRONT.

On the Colombian side of the border, the Colombian Migration Office [*Migración Colombia*] operates a program called SIRE, according to which every company that provides a service to a migrant must report it. Accordingly, Marisol Quiceno (Online interview, 27th July 2022) and César Zúñiga, the director of the Risk Management Office at Necoclí (Necoclí, 11th August 2022) argued that Colombian authorities can estimate the number of migrants through the two boat transport companies that take them from Necoclí to Capurganá. Nevertheless, since irregular boats travelling at night through the Urabá Gulf are not considered, there exists a sub-registration of migrants. According to Alejandro Díaz (Necoclí, 16th August 2022), the Director of the Vaccination Office of the San Sebastián de Urabá Hospital, the lack of information has direct implications for the provision of health services, since the providers do not have the demographic data required to respond to the particular necessities of the population in transit. As he mentions, *it is not the same thing to take care of 10,000 adults who trying to make a living, as to take care of a population of 10,000 people composed of 7,000 children and 3,000 adults, who are barely managing to survive with those 7,000 children* [T5] (Díaz, Necoclí, 16th August 2022).

Furthermore, the lack of information is also related to the number of transit migrants who receive attention in public hospitals. When asked about how many migrants the Francisco Valderrama Hospital and the San Sebastián de Urabá Hospital receive per month, or what proportion of the emergency services are for transit migrants, both hospital directors did not give a clear answer (Perea, Turbo, 2nd August 2022; Pupo, Necoclí, 9th August 2022).

The third and fourth identified challenges relate to the resources needed to respond to the demands of both residents and transit migrants. Since both public hospitals in Turbo and Necoclí are legally constituted as Social Enterprises of the State, even if they are publicly funded, they function as private institutions and must therefore be sustainable. This, through

contracts they sign with the local governments and the EPS in the Contributive and the Subsidized Regimes (Perea, Turbo, 2nd August 2022).

In this regard, the Director of the San Sebastián de Urabá Hospital, Neyder Pupo (Necoclí, 9th August 2022) claimed that the hospital provides emergency services to transit migrants although they represent a financial loss for the institution, given that the local government does not pay the hospital for these services. Geiler Perea (Turbo, 2nd August 2022) and Míler Meza (Online interview, 10th August 2022), the Consulting and Public Health Area Coordinator of the Colombian Institute of Tropical Medicine also claimed that one of the biggest questions that has not been resolved at the moment is who will pay for these services, especially since the hospital must comply with its own payments, such as their payrolls.

Linked to the lack of financial resources, there is also the infrastructural capacity of both public hospitals. The Director of the Francisco Valderrama hospital in Turbo mentioned that they used to offer Low Complexity services and moved on to offer Medium Complexity services without any change in infrastructure, which means they are now receiving people from other municipalities as well as transit migrants (Perea, Turbo, 2nd August 2022). From the San Sebastián de Urabá Hospital, Neyder Pupo (Necoclí, 9th August 2022) added that an insufficient number of doctors work at the emergency department in Necoclí, and they do not have enough budget to hire more staff. Consequently, current employees are requested to work extra hours. In response to this challenge, Luz Elena Hernández (Necoclí, 10th August 2022) the General Practitioner of the Colombian Red Cross ensured that

> *if we don't provide health services to these patients* [migrants in transit] *and there are a lot of ill people, it is possible that the hospital will not be able to take care of them. Why? Because of the alliances* [between the hospitals and the authorities]*, they do not have the capacity. That is why we are here* [T6].

These four challenges worsened in 2021 when, as mentioned previously, Panama closed its borders as a measure to prevent the spread of Covid-19, and between 20.000 and 25.000 migrants had to wait in Necoclí for them to be reopened. According to César Zúñiga (Necoclí, 11th August 2022) and Míler Meza (Online interview, 10th August 2022), this meant that the urban population of Necoclí doubled in just a few months. In fact, Neyder Pupo (Necoclí, 9th August 2022) argued that during this period, the Hospital received 60 transit migrants per day in the emergency department, which was problematic since, according to him, only 10 required in fact urgent attention after triaging.

These particular challenges show that the realities of transit migration shape the local provisioning of health differently in time, and moreover, that this influence is also determined by external factors that affect the journeys of transit migrants, such as the decision of Panama to close its borders in 2021, and nowadays, the decision of the US to refuse Venezuelan migrants who have entered irregularly to Panama. Furthermore, these circumstances define the relationship between the governmental and non-governmental actors around the provisioning of health in two different directions.

First, in 2021 when the number of transit migrants demanding health services increased, NGOs arrived in the territory to support the public hospital and partially assume their services. After that conjunctural moment, they remained to provide medical attention in these areas to transit migrants. Thus, since 2021 NGOs became protagonists of the health provisioning mainly in Necoclí. In this regard, César Zúñiga (Necoclí, 11th August 2022), who works at the Municipality of Necoclí, ensured that

> *César: Fortunately, we have had the Red Cross, and believe me that in all the scenarios where we meet, I always reiterate our thanks on behalf of the administration, on behalf of the mayor. We always ratify that without them we would have never made it ...*
>
> *Carolina: ok...*

César: Believe me, it is very difficult, this town is very small. Look, the basic services of Necoclí are not even enough for us, and with that I tell you everything [T7].

In this order of ideas, the General Practitioner of the Colombian Red Cross (Hernández, Necoclí, 10th August 2022) ensured that her organization is aware of the situation in Necoclí and that in case the number of migrants in the municipality starts to raise again, they are already prepared to request additional support to their operations. This particular case shows how these actors have the capacity to back up the particular responsibilities of the state towards transit migrants.

Second, NGOs provide broader humanitarian services than governmental actors do. While public hospitals respond to specific emergency services, NGOs complement them with an extensive understanding of the necessities of transit migrants. For example, since women are highly exposed to sexual violence during their journeys through the Darien Gap, organizations such as Mercy Corps and the Colombian Red Cross in Necoclí provide contraceptive methods for them. Moreover, since drinking water is not always available, for example, to take a pill, they offer contraceptive injections instead.

This dynamic is explained directly by Interviewee 1 (Online interview, 8th August 2022) who claimed that *it is precisely NGOs who are offering these services* [referring to WASH services, mental health and sexual and reproductive health]. *These organizations are offering what the state can't guarantee* [T8]. Since these types of services are not provided by public hospitals, it is possible to ensure that NGOs are not only supporting the tasks of the state but also complementing them.

This chapter introduced the practices surrounding the social provisioning of health for transit migrants in Turbo and Necoclí. Their description and main challenges allow to identify the roles of the actors that are present in the territory. Their perceptions and that of residents of Turbo and Necoclí about the provision of health to transit migrants, and their influence on the reason why each of them assume these roles will be expanded in the next chapter.

Chapter 5. The inclusion of 'others' in the system of healthcare provisioning

In Turbo and Necoclí, formal actors and residents share a common reading about the diverse conditions of transit migrants once they arrive to these municipalities. However, these common perceptions have differentiated effects on the reasons that justify the provision of healthcare to this population, and thus, on the politics of the social provisioning. This chapter explores how the binary relation citizens/non-citizens is reworked in order to ensure the access to healthcare to transit migrants in a context of precarious access to these services. In order to do so, the chapter looks first at the perceptions that formal actors have about transit migration and the way they shape the politics and practices of social provisioning, to continue then looking at the perceptions of residents and the motivations they find to legitimize and problematize the provisioning of healthcare to this population.

Transit migrants in Turbo and Necoclí define the social and economic dynamics of these municipalities in everyday life. In fact, local authorities, non-governmental actors, and residents recognize that transit migration has been occurring and is not going to stop in the coming years. In this regard, José Alejandro Lozano (Necoclí, 9th August 2022), the seller at the cafeteria of the San Sebastián de Urabá Hospital, mentioned that he is now *used to see people arriving from everywhere every day* [T9], while Juan Aleixo Patiño (Necoclí, 15th August 2022), who works at a store and a hotel, expressed that the latter is constantly full of transit migrants.

Moreover, formal actors and residents recognize the tough conditions that migrants have to endure when they decide to cross the Darien Gap. Graciela León, an informal seller in Necoclí, mentioned that *one sees that people are going to suffer a lot, risking their own lives, it is really hard* [T10] (Necoclí, 12th August 2022). In this regard, Interviewee 1 remarked that transit migrants are arriving to Turbo and Necoclí with various unsatisfied basic needs, that are then aggravated by the conditions of the route (Online interview, 8th August 2022). In this order of ideas, all the interviewees, both health providers and residents, justify the access of transit migrants to healthcare services.

Some people are in great need [T11]: formal actors' perceptions on transit migration and politics of social provisioning

Amongst the actors of the formal sector that were interviewed there is the common perception that the logic of the transit migration in the Darien Gap is in constant change, not only in terms of the number of people who arrive to the territory, but also because of their demographic and economic conditions. Furthermore, the local authorities and non-governmental actors that were interviewed recognize that transit migrants have differentiated capacities to respond to the challenges and dangers that they must face in Turbo and Necoclí, resulting in different levels of precarity during the journey.

César Zúñiga, the Director of the Risk Management Office of Necoclí (Necoclí, 11th August 2022) claimed that

> *They arrive and they stay for 1 or 2 days, maximum 3, but it is very fluid, very fluid, but what raises more concerns is the Venezuelan migration because, for example, transcontinental migrants from Africa, Asia, and even Europe, even from the same continent, like Cuba... they arrive, and they have no problem because they bring resources with them. On the other hand, Venezuelans do not, so they arrive, they start to work*

for resources, and this is a very small town, where it is difficult for them to achieve this... if they stay in Medellin, there is a better way to get those resources, or in other cities... but in a small town it is difficult for them, so they start to recycle and to generate that income, and then they either pay for food and a bed or they get a [boat] *ticket, so it is difficult for them* [T12] (Zúñiga, Necoclí, 11th August 2022).

The situation is also illustrated by Alejandro Díaz, the Director of the Vaccination Office of the San Sebastián de Urabá Hospital (Necoclí, 16th August 2022) and by Neyder Pupo, the General Manager of the same hospital (Necoclí, 9th August 2022) in the following terms:

it is the issue of a change in the socioeconomic conditions of current migrants. Almost all the time we have had migrants maybe not in the best economic conditions, but with a decent subsistence in the territory. At the time when Cubans came through here they had dollars, later when Haitians came through here they also had dollars, they rented places and lived here; we were collapsed because we did not have the physical conditions to house so many people, but now although there are fewer migrants, they are a population that is lying on the street with children, begging, selling candies, consuming psychoactive substances [T13] (Díaz, Necoclí, 16th August 2022).

I don't know if you can take a walk, I don't know if you have already walked along the pier. It is my perception that now the situation is more difficult than ever. Venezuelan migrant population is who is mostly arriving to the municipality, they do not bring economic resources, even other migrants brought a budget to move on their journey, but these come, many stay, and remain in a situation of mendicity. They stay here in Necoclí, and Necoclí is a small town, there are no job opportunities, not even for the local inhabitants. Imagine this population, who arrives under those circumstances, this generates many problems [T14] (Pupo, Necoclí, 9th August 2022).

In that sense, formal actors identify the intersection between the "spatial vulnerabilities" (Findlay, 2005 cited in Basok et al. 2015, p. 19) that make Turbo and Necoclí "precarious transit zones" (Hess, 2012, p. 436) and the precarious conditions that characterize Venezuelans' journeys in particular. In relation to the first aspect, formal actors recognize that life experiences of residents of Turbo and Necoclí are mainly defined by social exclusion, not only from effective healthcare attention as seen in Chapter 4, but also from formal employment, infrastructure, among other relevant aspects needed to satisfy their basic needs.

In relation to transit migrants' conditions, health providers see them as a heterogeneous identity, meaning that they carry with them differentiated risks. Cesar Zúñiga, Alejandro Díaz and Neyder Pupo highlighted the risks associated to their nationality and economic capacity but other formal actors make emphasis on the gendered and aged face of risk. In this regard, Interviewee 1 (Online interview, 8th August 2022) and Marisol Quiceno, the Humanitarian Affairs Director of Doctors Without Borders (Online interview, 27th July 2022), pointed the attention to the differentiated dangers of hundreds of women that have suffered sexual violence prior and during the route through the Darien Gap, as well as pregnant women without any type of medical control, and unaccompanied children that depend on smugglers or other migrants that embrace them to continue their route.

The governmental and non-governmental arrangements to reduce transit migrants' exposure to risks sheds light onto the particular understanding these formal actors have of them and their needs. Thus, perceptions and realities of transit migration influence the underlying reasons that each of them has to provide services to transit migrants, shaping in different ways and levels the politics of the health provisioning.

The reading of 'the other' from the lens of the Colombian state

The politics of healthcare provisioning by local authorities and statal actors for transit migrants is defined by the principle of Universality in Law 100 of 1993 and other

reglementary laws that derive from it (Carmona, Turbo, 2nd August 2022; Perea, Turbo, 2nd August 2022; Torres, Necoclí, 9th August 2022), such as the Law 715 of 2001 and Law 1751 of 2015. However, as it was possible to see in Chapter 4, the Colombian state defines the limits of the principle of Universality, or in other words, the line between the citizen and the non-citizen, through the provision of emergency services and some low complexity services such as vaccination and laboratory tests to prioritized populations.

In this order of ideas, for transit migrants, other healthcare services are commodified[10] and the Colombian state works as a market actor, which means that its healthcare practices follow the logic of the private sector. It is necessary to clarify that even if this line between the citizen and the non-citizen is clear in the case of transit migrants, it is blurred in the particular cases of migrants that are not citizens but have a residence permit, as previously explained in Chapter 4.

Thus, the eligibility conditions that transit migrants find when they need to access a health care service reflect the reading of the non-citizen from the lens of the Colombian State. However, in a precarious transit zone, these eligibility criteria need to be contrasted with the real coverage of the service, since this shows other administrative and financial boundaries that also turn out reinforcing the definition of 'the other'. In other words, the "formal and ideological limits" of the state (Sharma, 2015, p. 101) meet with its material capacity to guarantee social rights (Sassen, 2003, p. 49). As an example, Alejandro Díaz, the Director of the Vaccination Office at the San Sebastián de Urabá Hospital (Necoclí, 16th August 2022) and Daniela Carmona, the social worker of the Francisco Valderrama Hospital (Turbo, 2nd August 2022) mentioned that

> *as such, we do not have an open vaccination offer for adult migrants because, as you know, the vaccination against COVID has been very controlled through doses sent by the government to be applied to a particular population; that is why we are just taking care of children without any restriction. At one time we had an open service thanks to an agreement we had with the Mayor's Office, but unfortunately there were so many people that the budget was greatly exceeded and at that moment the agreement was finished. I think, at this moment we are caring for children and I think pregnant women, I think these are the only two populations that are being covered freely* [T15] (Díaz, Necoclí, 16th August 2022).

> *Well, it is the issue of wanting to guarantee attention to the migrant population and then realizing that we do not have the economic capacity, so to speak, to cover the needs of the migrants and sometimes having to say 'wait a minute, now you must pay as a private patient because we do not have the resources', and we are not guaranteeing some of the rights they had in terms of access to healthcare and we know that this is a population with scarce resources* [T16] (Carmona, Turbo, 2nd August 2022).

Thus, local authorities' perceptions about transit migrants have little space to influence the way public medical attention is organized for migrants and the motivations it lays upon. Therefore, under these circumstances the interpretation that public institutions have about the transit migrant as 'the other' is static and reinforces the binary relation citizen/non-citizen in a context in which the latter is not uniform. On the other hand, realities of transit migration shape the public provisioning of healthcare for this population superficially and only under certain circumstances.

It is possible to identify two forces that can generate changes not necessarily in the politics but in the practices of social provisioning by the Colombian state. On one hand, as it was also mentioned before, in order to respond to an increasing number of transit migrants staying for certain periods of time in Turbo and Necoclí, as it happened in 2021, hospitals needed to reconfigure the schedules and activities of their personnel in order to respond to the necessities of the incoming population (Pupo, Necoclí, 9th August 2022). As previously, external factors such as Panama or US national measures turn out defining the logic of transit migration and with it, the responses from the local authorities.

On the other hand, international organizations such as the IOM have the capacity to influence the practices of the state through the technical and infrastructural support that the organization provides, particularly to the San Sebastián de Urabá Hospital in Necoclí. In that order of ideas, the formal, ideological, and material limits set by the Colombian state on the universal provision of health meet the commitment with Human Rights and the principle of Humanity that underly the mandates and missions of the IOM and other non-governmental actors.

The reading of 'the other' from the lens of the Non-governmental actors

As mentioned in Chapter 4, non-governmental actors support and complement the provision of public healthcare in Turbo and Necoclí. However, the underlying reasons to provide these services respond to different motivations. For example, the Colombian Red Cross states that their work is justified by the principle of Humanity (Hernández, Necoclí, 10th August 2022). Meanwhile, the Colombian Institute of Tropical Medicine mentioned that since the mission of the institute is to maintain an epidemiological control of tropical diseases and given the fact that they have a solid infrastructural capacity in the Urabá region, the IOM has contacted them to operate the mobile attention unit at one of the docks (Meza, Online interview, 10th August 2022). Through this institute the IOM is committed to a "humane and orderly migration that benefits migrants and societies" (International Organization for Migration, 2022b).

These motivations allow non-governmental actors to provide their services based on a broader view of the situation, but also on their own resources and capabilities. These organizations have particular views of the needs of the transit migrants, which are then translated into the prioritization of certain services over others. In that sense, Interviewee 1 (Online interview, 8th August 2022) recognized that even though it is not possible to talk about health without considering mental health, for which different organizations provide services, none of them cover, for example, oral health. Thus, preventing migrants from having access to certain types of services.

Moreover, non-governmental actors also make use of the binary relation citizen/non-citizen to define their criteria of eligibility. As an example, the Colombian Institute of Tropical Medicine (Meza, Online interview, 10th August 2022) and the Colombian Red Cross (Hernández, Necoclí, 10th August 2022) do not provide healthcare to residents of Turbo and Necoclí. However, it is important to highlight that, in contrast to the Colombian Institute of Tropical Medicine, the Colombian Red Cross provides services to foreign and Colombian transit migrants from other regions of the country, who's next step is the Darien Gap (Hernández, Necoclí, 10th August 2022). Once again, the dual condition citizen/migrant hides the fact that 'the other', the migrant, can also be a Colombian citizen, showing the multiplicity of identities that result defining the capacity of migrants to have access to healthcare attention.

On the other side, organizations such a Mercy Corps provide sexual and reproductive health services to both transit migrants and residents that are not affiliated to the SGSSS, as well as to Colombian internally displaced people. For them, the attention to these population responds to the principle of humanitarianism, and also in that way, residents may be more prepared to receive transit migrants (Interviewee 1, Online interview, 8th August 2022).

One, as human being, has the right to receive healthcare [T17]: residents' perceptions on transit migration and politics of social provisioning

Residents' perceptions about transit migrants constitute the base of the legitimacy of healthcare provisioning for this population. The reading of 'the other' as an outsider of a social and political construction reflects the "the formal and ideological limits" of any political community (Sharma, 2015, p. 101) and therefore, the criteria used to define their exclusion in a particular system of provisioning. However, in the particular case of Turbo and Necoclí, it is possible to see that these limits have been redefined since the legitimacy to ensure healthcare services to transit migrants in build over the narrative of the common identity as human beings. In other words, being human is *per se* a political community that ensures the legitimacy to include transit migrants in the provisioning of health.

According to Ana Milena Pérez, *one, as human being, has the right to receive healthcare…oneself without health is nothing* [T17] (Turbo, 2nd August 2022). In this regard, Ernestina Mosquera mentioned that *as a human being we all need healthcare, it is a right for everyone* [T18] (Necoclí, 10th August 2022), Leonardo Quejada added that *healthcare is a right, all people have the right to access to healthcare* [T19] (Turbo, 4th August 2022) and Interviewee 4 claimed that *I am not more than migrants…we are all the same, we are all human beings that is why it is important that we all receive medical attention* [T20] (Turbo, 2nd August 2022). Interviewee 2 (Necoclí, August 16th 2022) and Juan Aleixo Patiño, an informal seller and worker at a hotel in Necoclí (Necoclí, 15th August 2022), added that migrants could be carrying infectious diseases, which therefore require attention in order to prevent them from spreading.

In this regard, it is necessary to problematize the binary citizen/non-citizen relation, especially since, as Gasper and Truong (2010) claim, international migration "creates new liminal zones—zones of experience around a transition or boundary—where identity categories are unstable, ambiguous and plural" (p. 350). In the particular case of Turbo and Necoclí, these expressions of a shared identity that residents manifested about transit migrants could be explained by the fact that "certain types of human suffering evoke expressions of collective humanity… the host society is prepared to recognize and grant legitimacy to a 'suffering body'" (Fassin, 2001, 2005 cited in Basok et al., 2015, p. 16).

In this regard, Juan Aleixo Patiño (Necoclí, 15th August 2022) pointed out that he has seen cases of swollen feet and cuts due to long walks of migrants, and he gave the example of a Venezuelan woman who had to have her leg amputated due to a very small cut that was not treated in time. After this experience, he was convinced that transit migrants must have access to healthcare services. Thus, since the criterion that is used to define who is part of the same political construction is also the criterion that is used to justify their inclusion in a particular system of provisioning, residents of Turbo and Necoclí transcend the sense of belonging to the Colombian State to prioritize the shared idea of humanity with transit migrants.

Even though residents highlighted in a first place the common identity as human beings as the reason to justify heath provisioning for migrants, some of them also feel that the eligibility criteria of citizen/non-citizen used by the NGOs excludes them to access to medical attention. This perception needs to be framed in a context in which residents' daily lives and experiences with the healthcare system are defined by the "fantasy of 'full citizenship'" (Hughes and Anderson, 2015, p. 2), in which the Colombian citizenship does not mean a real access to healthcare rights and, in contrast, becomes an extra barrier to access other alternative health care services beyond the state.

In this regard, Noy and Voorend's (2015) claim that the legitimacy of the provisioning of health for migrants and the solidarity relations between locals and migrants are affected when they arrive in informal economies and weak states unable to respond to the unsatisfied basic needs of the local communities (608, 611). To illustrate Noy and Voorend's point, Graciela León, an informal seller (Necoclí, 12th August 2022) claimed that her granddaughter was once denied the attention she needed by the Red Cross. She explains that *transit migrants have good support, everyone receives proper attention, while Colombians are denied the attention* [T21]. Furthermore, Leonardo Quejada (Turbo, 4th August 2022) claimed that *migrants receive better attention than us, just because they are migrants* [T22].

In this order of ideas, even though residents strongly call for the provisioning of healthcare for transit migrants, the fact that they also find structural barriers to ensure their social rights could derive in a xenophobia. These feelings could turn out undermining the legitimacy in which healthcare provisioning for transit migrants is built and accentuating even more migrants' precarious conditions (Basok et al., 2015, p. 13).

Thus, this chapter presented the differentiated ways in which the realities and perceptions about transit migration shape the underlying reasons that justify and legitimize the provisioning of healthcare services for transit migrants, as well as their influence in the way these services are arranged. In a context in which it is not possible to talk about a 'full citizenship', the use of the binary citizen/non-citizen relationship to guarantee a social right as healthcare is problematic, not only because it hides the multiplicity of identities and risks that social provisioning needs to respond to, but also because it reproduces parameters of exclusion that leave aside both residents and migrants that are already living under precarious conditions due to structural exclusions.

Chapter 6. Conclusions

Migration challenges the usually immobile character of social provisioning in a particular territory (Serra Mingot and Mazzucato, 2016). This becomes even more complex when having to adjust to the logic of transit migration. This research focused on the case of healthcare provisioning for transit migrants in the Colombian municipalities of Turbo and Necoclí, two "precarious transit zones" (Hess, 2012, p. 436) they usually go through before entering the Darien Gap, on their journey to Central and North America. In a context in which residents have unsatisfied basic needs, and transit migrants could be considered as outsiders in the welfare regime, this research intended to reflect how perceptions and realities of transit migration shape the politics and practices of health-related social provisioning in this particular zone. In that order of ideas, the underlying reasons that justify and legitimize the provisioning of healthcare to transit populations were examined, as well as the way these motivations shape how service providers organize in these territories.

In the framework of a nation-state, the binary construction of the citizen and the migrant as the non-citizen is at the core of the social provisioning systems. The reading of 'the other' as an outsider of a social and political construction reflects "the formal and ideological limits" of the political community (Sharma, 2015, p. 101), and therefore, the criteria used to define their exclusion of a particular system of provisioning.

However, in Turbo and Necoclí, transit migrants problematize this binary relationship since transit migrants as non-citizens do not constitute a homogenous identity. The demographic and socio-economic conditions of transit migrants define the types of risks that they face during their journeys through Turbo and Necoclí and allow them to be more or less prepared to minimize exposure to these risks. Particularly in 2022, the fact that Venezuelan migrants travel with less financial resources make their journeys to become more precarious (Díaz, Necoclí, 16th August 2022; Pupo, Necoclí, 9th August 2022; Zúñiga, Necoclí, 11th August 2022). Moreover, some transit migrants are Colombian or have a Colombian residence permit, which allows them to have a broader access to healthcare services in comparison with transit migrants without residence permit.

Once transit migrants without residence permit arrive to the Colombian territory, they face the limits of the principle of universality of the public health system, which are set by Law on the provisioning of emergency services (Arroyave, Ramírez and Abramovits, 2021, p. 39) and some low complexity services, such as vaccination and laboratory tests to prioritized populations (Carmona, Turbo, 2nd August 2022; Díaz, Necoclí, 16th August 2022). Thus, Laws 100 of 1993, 715 of 2001 and 1751 of 2015, which justify the provisioning of emergency services for all population in the Colombian territory, are not permeable to the changing realities and the differentiated risks and precarities that transit migrants carry with them. Furthermore, they do not respond to perceptions that government officials and public health providers have about the conditions and needs of this particular population. However, these realities and perceptions do motivate some changes in the way healthcare provision is organized for this population.

On the one hand, transit migrants arrive to local authorities and public hospitals with insufficient financial and physical resources to respond both to local and transit migrants' healthcare needs. When more migrants arrive to Turbo and Necoclí, public actors need to reallocate their resources in order to respond to emergencies and low complexity services offered to them. On the other hand, non-governmental actors provide technical and financial support to governmental actors, and therefore, define the capacity of the public healthcare providers to meet transit migrants' needs.

Non-governmental actors that provide humanitarian healthcare services to transit migrants assume two different roles in this provision: they support the state with its own responsibilities, and complement the services offered by it. Organizations such as the IOM, the Colombian Institute of Tropical Medicine, and the Colombian Red Cross provide low complexity services for transit migrants. These are characterized by a broader capacity to respond to the risks and precarious conditions of transit migrants. To do so, organizations such as the Red Cross and the Colombian Institute of Tropical Medicine limit access to their services to transit migrants, excluding residents in their eligibility criteria.

It is then important to highlight that residents of these two municipalities have reworked the political community in which they justify and legitimize the provisioning of healthcare services to transit migrants, prioritizing the shared identity as human beings over the Colombian citizenship. However, the fact that their citizenship does not guarantee social rights leads to problematize the citizen/non-citizen binary view. Residents' daily experiences are defined by the "fantasy of the 'full citizenship" (Hughes and Anderson, 2015, p. 2), since, as it was exposed through basic indicators, the performance of healthcare services is insufficient in comparison to the national level. This, although residents manifested they have had both positive and negative experiences with the healthcare system. In this context, transit migrants having access to low complexity services that are denied by non-governmental actors to residents can undermine the legitimacy and solidarity relations between them and host societies (Noy and Voorend, 2015, p. 608, 611), and generates feelings of xenophobia and exclusion that could deteriorate even more the precarious conditions of transit migrants.

Finally, this research provides a general overview of the way realities and perceptions about transit migration shape the politics and practices of healthcare provisioning for transit migrants in Turbo and Necoclí. In order to reach a broader understanding of this particular system of provisioning it is first necessary to hear the voices of formal actors that provide medical services but who did not participate in this research. Moreover, it is also important to include the views of transit migrants in relation to their perceptions and experiences with the healthcare system. Since the logic of transit migration through the Darien Gap remains in constant change, this research provides a picture of the situation of health provisioning in Turbo and Necoclí limited to July-August 2022.

Appendices

Appendix 1. Translations

T1

"dé esa vuelta tan grande para llegar a Estados Unidos, esa motivación tiene que ser, digo yo, la vida, cierto, porque hay mucho sufrimiento para pasar, la persona para llegar allá…" (Perea, Turbo, 2nd August 2022).

T2

"El único doctor que a mí me responde es Dios" (León, Necoclí, 12th August 2022). Translated by the author.

T3

"si es una urgencia vital, podrían acceder sin ningún tipo de documento, pero ya sí para toda la prestación del servicio ambulatorio sí se está requiriendo el permiso" (Carmona, Turbo, 2nd August 2022). Translated by the author.

T4

"Ellos vienen aquí y me dejan loca" (Padilla, Necoclí, 16th August 2022). Translated by the author.

T5

"porque no es lo mismo yo atender 10.000 adultos que están rebuscándose la vida, a que esa población de 10.000, son con 7.000 niños con 3.000 adultos que estén logrando sobrevivir con esos 7.000 niños" (Díaz, Necoclí, 16th August 2022). Translated by the author.

T6

"Sí nosotros no atendemos a estos pacientes y hay muchas personas enfermas, posiblemente en el hospital no las puedan atender. ¿Por qué? Por los convenios, de pronto porque no tienen la capacidad o cualquier cosa. Pero nosotros por eso es que estamos acá" (Hernández, Necoclí, 10th August 2022). Translated by the author.

T7

"César: Afortunadamente hemos contado con la Cruz Roja que créame que yo en todos los escenarios donde nos reunimos, siempre les reitero nuestro agradecimiento de parte de la administración, en nombre del alcalde, siempre les ratificamos que sin ellos no habíamos sido capaz…
Carolina: Ya …
César: Créame que no, es que es muy difícil, es que este pueblito es muy pequeño, mira, los servicios básicos de Necoclí no son suficientes ni para nosotros, con eso te lo digo todo" (Zúñiga, Necoclí, 11th August 2022). Translated by the author.

T8

"Pues precisamente tú sabes que las organizaciones no gubernamentales están prestando esos servicios. Estas organizaciones ofrecen pues lo que el Estado no puede garantizar" (Interviewee 1, 2022). Translated by the author.

T9

Frente a la pregunta por cómo vive él la migración en tránsito en su cotidianidad, señala que él sí ve que aquí llega mucha gente de todas partes todos los días (Lozano, Necoclí, 9th August 2022). Translated by the author (notes from the interview, no permission to record it).

T10

"Uno ve a la gente que se va es a sufrir mucho…uno arriesgando la vida, es duro" (León, Necoclí, 12th August 2022). Translated by the author.

T11

"son unas personas que vienen muy necesitadas" (Interviewee 1, 2022). Translated by the author.

T12

"Que ellos llegan y se aguantan 1 o 2 días máximo 3, pero es seguido, muy fluido, muy fluido, pero preocupa es el tema de la migración venezolana, porque por ejemplo, la migración transcontinental, África, Asia, y el mismo Europa, hasta acá del mismo continente, Cuba…llegan y ellos no tienen problema porque ellos traen sus recursos. En cambio los venezolanos, no, entonces ellos llegan, empiezan a trabajar en búsqueda de recursos, y aquí es un pueblito muy pequeño, donde difícilmente van a lograr…si se quedan en Medellín, ahí hay más forma de conseguir, en otras ciudades… pero en un pueblito es difícil para ellos, entonces se ponen a reciclar y a generar ese ingreso, y entonces o pagan comida y dormida o reúnen pal pasaje, pues es difícil para ellos" (Zúñiga, Necoclí, 11th August 2022). Translated by the author.

T13

"es el asunto del cambio en la condición socioeconómica de la migración actual. Durante casi todo el tiempo nosotros tuvimos migrantes con una no, buena condición económica, pero sí con unas condiciones de subsistencia digna en el territorio. En su época cuando los cubanos pasaban por aquí manejaban sus dólares, después cuando vinieron los haitianos pasaban por aquí

también tenían sus dólares, alquilaban y vivían, estábamos colapsados porque no tenemos las condiciones físicas para albergar tanta gente, pero ahora estamos en una condición que tenemos menos migrantes pero es una población que esta tirada en la calle, con niños mendigando, vendiendo dulces, con consumo de sustancias psicoactivas" (Díaz, Necoclí, 16th August 2022). Translated by the author.

T14

"No sé si te puedas dar una vuelta, no sé si ya hayas caminado por el muelle, es mi percepción que ahora es más difícil la situación que como, en su momento puede detonar, la población migrante venezolana que es la que está llegando más al municipio, ellos no traen recursos económicos, si-quiera los otros traían su presupuesto para trasladarse en su travesía, pero estos vienen, muchos se quedan y quedan también situación de mendicidad, se quedan acá en Necoclí y sea lo que sea, Necoclí es un pueblo pequeño, que no hay siguiera la oportunidad de trabajo, ni siquiera para los habitantes de acá, imagínese esta población que vienen también en esta situación, esto genera muchos problemas, que arranca con nosotros en salud, nos viene a afectar como hospital" (Pupo, Necoclí, 9th August 2022). Translated by the author.

T15

"Como tal no tenemos de pronto una oferta de vacunación abierta a migrantes en adultos porque, como sabes, la vacunación contra el COVID ha estado muy controlada por las dosis que manda el gobierno por una población a quien se le debe aplicar, es por eso como tal...que a los niños es a quienes estamos atendiendo sin ninguna restricción. En un tiempo se tuvo una atención abierta con un convenio que se tuvo con la Alcaldía pero desafortunadamente era tal la cantidad de gente que se atendía que desbordó el presupuesto y en este momento está cerrado, creo, que en estos momentos tiene una atención a niños y creo que a embarazadas, creo estas son la dos únicas poblaciones que se les está brindando atención de manera libre" (Díaz, Necoclí, 16th August 2022). Translated by the author.

T16

"Pues todo el tema de querer garantizarle la atención a la población y que uno se da cuenta que no tiene la capacidad económica por así decirlo para atender las necesidades que tiene la población y a veces tener que decir no espere un momentico, ya aquí toca como particular porque nosotros no tenemos los recursos y ya tampoco se les está garantizando algunos derechos que tenían antes en el tema pues del acceso a la salud y que uno sabe que es una población que es de escasos recursos" (Carmona, Turbo, 2nd August 2022). Translated by the author.

T17

"uno sin salud no es nadie" y se le debe prestar a todo el mundo… "uno como ser humano tiene derecho a la salud (Pérez, Turbo, 2nd August 2022). Translated by the author (notes from the interview, no permission to record it).

T18

"claro, ellos sí. Como seres humanos todos necesitamos tener salud y es un derecho de todos" (Mosquera, Necoclí, 10th August 2022). Translated by the author.

T19

Señala que los migrantes deben poder acceder a los servicios de salud porque "la salud es un dere-cho, todas las personas tienen derecho a salud" (Quejada, Turbo, 4th August 2022). Translated by the author (notes from the interview, no permission to record it).

T20

Ella "no se cree más" que los y las migrantes "todos somos iguales". Asimismo, considera que es muy importante que puedan acceder a los servicios de salud porque "todos somos humanos" y por eso "es importante que nos atiendan a todos" (Interviewee 4, Turbo, 2nd August 2022). Translated by the author (notes from the interview, no permission to record it).

T21

Además, indica que a ella no la atienden en la Cruz Roja porque es colombiana. De hecho, una vez fue a la Cruz Roja con su nieta y le indicaron que a ella no la podían atender por ser colombiana. En este orden de ideas, indica que los migrantes "tienen buena ayuda, a todo el mundo lo atienden bien mientras que a los colombianos no nos atienden" (León, Necoclí, 12th August 2022). Translated by the author (notes from the interview, no permission to record it).

T22

"Los atienden mejor que a uno por migrantes" (Quejada, Turbo, 4th August 2022). Translated by the author.

Appendix 2. Images

Photos taken by Federico Ríos Escobar for the New York Times

Migrants in Necoclí

Source: Ríos, 2022

Source: Ríos, 2022

Migrants in the Darien Gap

Source: Ríos, 2022

Source: Ríos, 2022

Source: Ríos, 2022

Photos of the *In Situ* Work in Necoclí


Pwen
pou bwè
unicef
¡Sevis gratis !


ESE
HOSPITAL
SanSebastián
De Urabá - Necoclí
Guia
GUIDE / GUIDER / GUIA
Consultorios 6- 8
Offices 6- 8 / Bureaux 6-8 / Escritórios 6- 8
Consultorio 9
Office 9 / Bureau 9 / Escritório 9
Oficina de Atención al Usuario
- Customer service office
- Bureau du service client
- Escritório de atendimento ao cliente
Archivo Clínico
Clinical File / Dossier clinique
Arquivo Clínico
Admisiones
Admissions / Entree / Admissões
Vacunación
Vaccination / Vaccination
Vacinação


LABORATORIO
LABORATORY
LABORATOIRE
LABORATÓRIO
TOME

Appendix 3. List of participants of the research

Formal actors

Name	Organization	Position	Municipality
Geiler Yair Miller Perea	Francisco Valderrama Hospital	General Manager of the Hospital	Turbo
Daniela Carmona Valencia	Francisco Valderrama Hospital	Social Worker at the Hospital	Turbo
Bladimir A. Rudas Gómez	Municipality of Turbo	Municipal Seer of Turbo	Turbo
Interviewee 1	No organization (Mercy Corps)		Turbo/Necoclí
Interviewee 3	Sumimédica	Chief of the Nursing Office	Turbo
César Zúñiga	Risk Management Office Necoclí	Director	Necoclí
Dayana Padilla	NecoFarma Jireh Pharmacy	Seller	Necoclí
Fernando Alexis Torres Díaz	Secretary of Health Necoclí	Manager of coverage, insurances and affiliation to the health system	Necoclí
Neyder Pupo	San Sebastián de Urabá Hospital	General Manager of the Hospital	Necoclí
Alejandro Díaz Ramos	San Sebastián de Urabá Hospital	Director of the Vaccination Office	Necoclí
Alexander Murillo	Farmacia Urabá	Seller	Necoclí
Luz Elena Hernández Díaz	Cruz Roja Internacional	General Practitioner	Necoclí
Míler Meza	Instituto Colombiano de Medicina Tropical	Consulting and Public Health Area Coordinator	Necoclí
Amanda Coral	NA (Expert)	Expert	Apartadó
Marisol Quiceno Valencia	Doctors Without Borders	Humanitarian Affairs Director	San Vicente/Panama
Informal conversations			
Diego	Orientation for Migrants' Service Point	N/A	Turbo
Doctor Fabián	Clínica Central Someba Urabá	N/A	Turbo
N/A	Migración Colombia	N/A	Turbo
María Lourdes	Orientation for Migrants' Service Point	N/A	Necoclí
N/A	UNICEF	N/A	Necoclí
Sandra Milena Zuleta	UNLAB	N/A	Necoclí

Residents of Turbo and Necoclí

Name	Occupation	Municipality
Ana Milena Pérez	Independent. Patient of the Francisco Valderrama Hospital who was having a drink at the cafeteria of the hospital at the moment of the interview	Turbo
Marisol Rincón	Independent. Her mother had an appointment at the Francisco Valderrama Hospital. Both were having a drink at the cafeteria of the hospital at the moment of the interview	Turbo/Carepa

Leonardo Quejada	Stretcher handler at the Francisco Valderrama Hospital. He was having lunch at the cafeteria of the hospital at the moment of the interview	Turbo
Ruth Fuertes	Independent. She was having lunch with her 5 years old child at the cafeteria of the Francisco Valderrama Hospital at the moment of the interview	Turbo
Rosalba Morales	Security Guard at the Francisco Valderrama Hospital	Turbo
Interviewee 4	Cooker at the Cafeteria of the Francisco Valderrama Hospital	Turbo
José Alejandro Lozano	Seller at the cafeteria of the San Sebastián de Urabá Hospital	Necoclí/San Pedro de Urabá
Interviewee 2	Informal seller. She was selling stuff for camping close to one of the docks and in front of the UNICEF center.	Necoclí
Luis Javier Arteaga Romero	Businessman. He was having a drink at a cafeteria next to the Hotel.	Necoclí
Ernestina Mosquera	She is the owner of the hotel where I stayed	Necoclí
Graciela León	Informal seller. She was selling stuff for camping just in front one of the docks.	Necoclí
Juan Aleixo Patiño Giraldo	Informal seller. He is sitting in his family store, where they sell cloths and products such as toys, tappers, among others.	Necoclí

Appendix 4. Interview guide

Actores formales

Consideraciones iniciales

1) Presentación personal
2) Explicar el propósito de la entrevista
3) Presentar los resultados esperados con la entrevista
4) Mencionar que la información va a ser utilizada exclusivamente para los propósitos de esta investigación y que será anonimizada en caso de que sea deseado.
5) Preguntarle a la persona si continúa interesada en participar en la entrevista.
6) Preguntar por el consentimiento para grabar la entrevista. Entregar el consentimiento informado.
7) Mencionar que si en algún momento quiere que pare la grabación o no quiere que algún apartado de su respuesta sea considerada, me lo haga saber.
8) Preguntar si tiene alguna inquietud antes de comenzar.
9) Mencionar que va a tener acceso al documento final una vez este esté listo.

Preguntas

1) Presentación inicial: Nombre, formación, organización a la que representa, cargo, tiempo trabajando en ella.
2) ¿Quiénes están migando en este momento por la Selva del Darién con relación a su nacionalidad, edad, género? ¿Cómo ha cambiado este perfil en los últimos años?
3) ¿A qué públicos se encuentran dirigidos los servicios de salud/saneamiento que su organización presta? ¿Son estos solo para migrantes o para residentes? ¿Cuánto tiempo lleva prestando estos servicios?
4) ¿A qué servicios de salud/saneamiento pueden acceder los/as residentes de Turbo/Necoclí a través de su organización y a qué servicios pueden acceder los/as migrantes en tránsito? (Depende de pregunta 2).
5) ¿Bajo qué lineamientos su organización presta servicios de salud/saneamiento en Turbo/Necoclí?
6) ¿Cuáles son los requisitos que un/a migrante en tránsito debe cumplir para acceder a los servicios de salud/saneamiento en su programa/proyecto? ¿Cuáles son los requisitos para un/a residente de Turbo/Necoclí?
7) ¿Es necesario que los/as migrantes en tránsito cumplan alguna condición una vez estén vinculados/as al programa para poder seguir participando del mismo?
8) ¿Es necesario que los/as migrantes en tránsito paguen para acceder a los servicios de salud/saneamiento que presta su organización? ¿Es necesario que los/as residentes paguen por estos servicios?
9) ¿Cuál es la cobertura de salud/saneamiento para los/as residentes de Turbo/Necoclí y cuál es la cobertura para los/as migrantes en tránsito?
10) ¿Cómo se financian las actividades de su organización? ¿Con qué otros recursos cuenta su organización?

11) ¿Qué organizaciones trabajan con su organización? ¿Cómo se organiza el trabajo articulado entre organizaciones?
12) ¿Qué otras organizaciones están prestando servicios de salud/saneamiento en Turbo/Necoclí a los/as residentes y a los/as migrantes en tránsito?
13) ¿De qué manera ha influido la migración en tránsito la provisión de salud/saneamiento a los/as residentes de Turbo/Necoclí?
14) ¿A qué retos se ha enfrentado su organización en la provisión de servicios de salud/saneamiento para los/as residentes de Turbo/Necoclí y para los/as migrantes en tránsito?

Consideraciones finales

1) Preguntar si quiere agregar algo que haya quedado por fuera de las preguntas de la entrevista.
2) Preguntar cómo se siente con la entrevista.
3) Recordar que, si no desea que algo se mencione en el informe final, se pueden comunicar conmigo para no incluirlo.
4) Preguntar por referencias a otros actores en Necoclí y Turbo

Actores informales de Turbo y Necoclí

Consideraciones iniciales

1) Presentación personal
2) Explicar el propósito de la entrevista
3) Presentar los resultados esperados con la entrevista
4) Mencionar que la información va a ser utilizada exclusivamente para los propósitos de esta investigación y que será anonimizada en caso de que sea deseado.
5) Preguntarle a la persona si continúa interesada en participar en la entrevista.
6) Preguntar por el consentimiento para grabar la entrevista. Entregar el consentimiento informado.
7) Mencionar que si en algún momento quiere que pare la grabación o no quiere que algún apartado de su respuesta sea considerada, me lo haga saber.
8) Preguntar si tiene alguna inquietud antes de comenzar.
9) Mencionar que va a tener acceso al documento final una vez este esté listo.

Preguntas

1) Presentación inicial: Nombre, dedicación, edad, género.
2) ¿Qué atenciones en salud o en saneamiento le ofrece usted a los/as migrantes en tránsito o a los/as residentes de Turbo/Necoclí? ¿Estos servicios los ofrece tanto a residentes como a migrantes en tránsito o solo a uno de estos grupos?
3) ¿Cuánto tiempo lleva prestando estos servicios? ¿Cómo comenzó?
4) ¿Qué lo/la motiva a usted a prestar estos servicios? ¿Cómo lo hace? ¿Alguien le colabora?
5) ¿Cuáles son los requisitos para que un/a migrante en tránsito pueda acceder a los servicios de salud/saneamiento que usted presta? ¿Cuáles son los requisitos para un/a residente de Turbo/Necoclí?
6) ¿Es necesario que los/as migrantes en tránsito cumplan alguna condición una vez estén vinculados/as a sus servicios para poder seguir participando del mismo?
7) ¿Es necesario que los/as migrantes en tránsito paguen para acceder a los servicios de salud/saneamiento que usted presta? ¿Es necesario que los/as residentes paguen por estos servicios?
8) ¿Con qué recursos cuenta usted para prestar los servicios de salud/saneamiento?
9) ¿De qué manera ha influido la migración en tránsito la provisión de salud/saneamiento a los/as residentes de Turbo/Necoclí?
10) ¿A qué retos se ha enfrentado usted al momento de prestar servicios de salud/saneamiento para los/as residentes de Turbo/Necoclí y para los/as migrantes en tránsito?

Consideraciones finales

1) Preguntar si quiere agregar algo que haya quedado por fuera de las preguntas de la entrevista.
2) Preguntar cómo se siente con la entrevista.
3) Recordar que si no desea que algo se mencione en el informe final, se pueden comunicar conmigo para no incluirlo.

Residentes de Turbo y Necoclí

Consideraciones iniciales

1) Presentación personal
2) Explicar el propósito de la entrevista
3) Presentar los resultados esperados con la entrevista
4) Mencionar que la información va a ser utilizada exclusivamente para los propósitos de esta investigación y que será anonimizada en caso de que sea deseado.
5) Preguntarle a la persona si continúa interesada en participar en la entrevista.
6) Preguntar por el consentimiento para grabar la entrevista. Entregar el consentimiento informado.
7) Mencionar que si en algún momento quiere que pare la grabación o no quiere que algún apartado de su respuesta sea considerada, me lo haga saber.
8) Preguntar si tiene alguna inquietud antes de comenzar.
9) Mencionar que va a tener acceso al documento final una vez este esté listo.

Preguntas

1) Presentación inicial
2) ¿Por qué cree usted que las personas están transitando por Turbo/Necoclí?
3) ¿Cree usted que es importante que los/as migrantes en tránsito puedan acceder a servicios de salud/saneamiento?
4) ¿Cómo vive usted la migración en tránsito en su cotidianidad?
5) ¿Cómo es su experiencia con el sistema de salud/saneamiento en Turbo/Necoclí?
6) ¿A qué servicios de salud/saneamiento pueden acceder los/as migrantes en tránsito? ¿Usted podría acceder a estos servicios?
7) ¿Cómo percibe usted los servicios de salud/saneamiento a los que pueden acceder los/las migrantes en tránsito en términos de calidad?
8) ¿De qué manera cree usted que ha influido la migración en tránsito la provisión de salud/saneamiento a los/as residentes de Turbo/Necoclí?

Consideraciones finales

1) Preguntar si quiere agregar algo que haya quedado por fuera de las preguntas de la entrevista.
2) Preguntar cómo se siente con la entrevista.
3) Recordar que si no desea que algo se mencione en el informe final, se pueden comunicar conmigo para no incluirlo.

Maestría en Estudios del Desarrollo

Tesis de grado

Consentimiento Informado

Lugar: _____ Fecha: ___/___ /_____Hora: ___:___ AM/PM

Esta entrevista hace parte de las actividades necesarias para el desarrollo de la tesis de maestría *Provisión social de salud y saneamiento básico para migrantes en tránsito en Turbo y Necoclí*, la cual tiene como objetivo comprender las gestiones y prácticas alrededor de la provisión de salud y saneamiento básico a los y las migrantes en tránsito, así como las percepciones sobre estos servicios por parte de los y las residentes de estos municipios. Esta tesis es un requisito para optar al título de Magíster en Políticas Sociales para el Desarrollo en el Instituto de Estudios Sociales de la Universidad Erasmus Rotterdam, el cual se encuentra ubicado en La Haya, Países Bajos. En consecuencia, el fin de esta tesis es meramente académico.

Confidencialidad
Su identidad será incluida en el documento de la investigación solo si usted lo permite.

Acepto que mi nombre sea utilizado _____No acepto que mi nombre sea utilizado _____

Compensación y participación voluntaria
Esta entrevista no tiene una compensación económica. Su participación en esta investigación es completamente voluntaria. Si en cualquier momento usted no desea que sus aportes sean incluidos en la investigación, esto no traerá ningún perjuicio para usted.

Si tiene alguna inquietud luego de participar en esta entrevista, se puede comunicar con Carolina Aristizábal a los siguientes números (+57) 3217108395/(+31) 613884365

¿Desea participar en la entrevista? Sí _____ No_____

_____
Firma del/ de la participante

Yo, Carolina Aristizábal Saldarriaga, estudiante de la Maestría en Estudios del Desarrollo del Instituto de Estudios Sociales de la Universidad Erasmus Rotterdam, certifico que la información de la presente investigación será usada meramente para fines académicos y que los resultados de la investigación serán socializados una vez esta haya terminado.

_____
Firma de la estudiante

Appendix 5. Informal actors

During the *in situ* work it was possible to identify three different actors that provide informal access to health. However, it was not possible to have interviews with neither of them.

a) Club de nutrición Luna Mosquera

This person offers Herbalife products at her house and has a nutrition club based in these products. When I asked her for an interview she said that migrants do not participate at her club and therefore, that she did not understand why I was asking her for an interview.

b) Cecilia Cartagena

Cecilia Cartagena puts injections at her house. The 15th of August I went to her house and she asked my what product I was going to have. When I told her that I did not want an injection but instead an interview she asked me to go the next day to the San Sebastián de Urabá Hospital, where she also works. The 16th of August I went to the hospital and I met her at the entrance and she told me that the Director of Vaccination Services was waiting for me. I told her that I wanted the interview with her and she responded that she did not want to dismiss the regular conduct. In consequence I had an interview with Alejandro Díaz Ramos and not with her.

c) Médico de Pies

The services of Médico de Pies are offered at a house close to the beach. When I came in I realized that they do not provide health services but instead they offer manicure and pedicure.

Appendix 6. Security Concerns

Autodefensas Gaitanistas de Colombia
AGC
Por una Colombia, Madre Patria para todos

COMUNICADO

El Estado Mayor de las Autodefensas Gaitanistas de Colombia, comunica a la opinión pública en general:

1. Por fin termina el régimen del saliente presidente Duque, el cual es representativo de todas las cosas que deben cambiar en un país para el logro de la esquiva paz. No más abusos en contra de la población inerme, no más atentados en contra del liderazgo social, no más condenas a muerte contra nuestra base social, nuestras familias y nuestros combatientes.

2. El 7 de agosto, que esperamos sea el inicio de una era distinta para nuestra atribulada patria, levantaremos todas las medidas extremas que hemos debido ejecutar, como ya lo anunciamos en un comunicado en los días previos.

3. Consecuentes con estas fechas históricas, decretamos también un cese unilateral de hostilidades ofensivas, como expresión de buena voluntad con el gobierno que inicia y su amplia disposición de búsqueda de caminos de paz para todos los actores del conflicto, a partir del 7 de agosto.

4. Tenemos la mejor buena voluntad de sumarnos a los diálogos exploratorios de paz que ha anunciado Gustavo Petro desde el momento de su elección. Creemos que es la mejor decisión para la Colombia olvidada que representamos.

Dado en las Montañas de Colombia el 7 de agosto de 2022

ESTADO MAYOR
Autodefensas Gaitanistas de Colombia

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Notes

[1] The provision of social protection by formal actors correspond to the state, market and organisations, while informal actors refer to interpersonal networks (Serra Mingot and Mazzucato, 2018, p. 2128).

[2] In the framework of this research, politics is understood as the beliefs and activities related to the exercise of power (de Vera, 2005, p. 58), which refer in this particular case to the underlying reasons that justify social provisioning to a particular population.

[3] Due to the informal nature of this migration, these data could underrepresent the number of migrants that are going through the Darien Gap.

[4] Based on Lister (1994), defamilialism refers to the degree on which individuals can have socially acceptable living standards independent from their family relationships. In that order of ideas, familiarization refers to the dependency on these types of relationships to reach wellbeing standards.

[5] The concept of 'transit migrant' has been problematized since it hides the "various unsteady, non-linear, flexible and mobile migrational biographies" (Hess, 2012, p. 435). In fact, authors such as Düvell and Vollmer (2009 cited in Basok et al., 2015, p. 9) it is not even clear after how long a migrant is not considered as a transit migrant anymore. Missbach (2015 cited in Méndez, 2021, p. 195) claim that the concept does not refer to a particular type of migration but instead to a stage in the migration process. However, Méndez (2021, p. 195) recognizes that this differentiation does not clarify some of the concerns about the concept. Without disregarding these critics, the concept is still going to be used to refer to migrants that arrive to Turbo and Necoclí to cross the Darien Gap. In this order of ideas, it is important to recognize that migrants' intentions to continue their journeys to Panama are challenged by individual and structural factors that affect their following steps.

[6] Apartadó is the capital municipality of the Urabá region and was the place where I was staying since an acquaintance of mine lives there and it takes around 35 minutes to go from there to Turbo.

[7] Universality: guarantee of protection for all people, without any type of discrimination on any stage of their lives (Ley 100 de 1993, p. 1)

[8] Solidarity: mutual practice of help among generations, economic sectors, regions, and communities, based on the principle of support from the stronger to the weaker (Ley 100 de 1993, p. 2).

[9] The Special Populations are people who due to vulnerability, marginality, discrimination or weakness are potential beneficiaries of the Subsidized Regime, according to the Law (Dirección de Aseguramiento y Garantía del Derecho a la Salud-Alcaldía de Bogotá, no date, p.2).

[10] Commodification occurs when a service is rendered through the market instead of being considered as a matter of right. The consequence is that in order to maintain a livelihood, a person needs to rely on the market (Esping-Andersen, 1990, pp. 21-22).