HHR Health and Human Rights

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A Primary Health Care-Anchored Migrant Right to Health: Insights from a Qualitative Study in Colombia

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Abstract

In recent years there has been a sustained rise in the number of international migrants, and scholarship and practice have increasingly focused on the relationship between health and migration. However, the entitlement to state-subsidized services for migrants with precarious or irregular legal status, often fleeing distressing living conditions, is typically limited to emergency lifesaving health treatment, with nonstate programs attempting to complement this constrained approach. This paper asks whether a primary health care (PHC) approach could serve as a blueprint for institutional priority-setting and for the realization of human rights obligations to help states meet their core international commitments regarding migrant health rights. I look at the multi-actor response in Colombia—where almost three million Venezuelans have sought to settle and many more have transited during the last nine years—as a case study to explore the possibility of a meaningful PHC-oriented right to health in the migration context. Using human rights law standards and commentaries, I suggest that, with some qualifications, this approach holds promise.

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Competing interests: None declared.

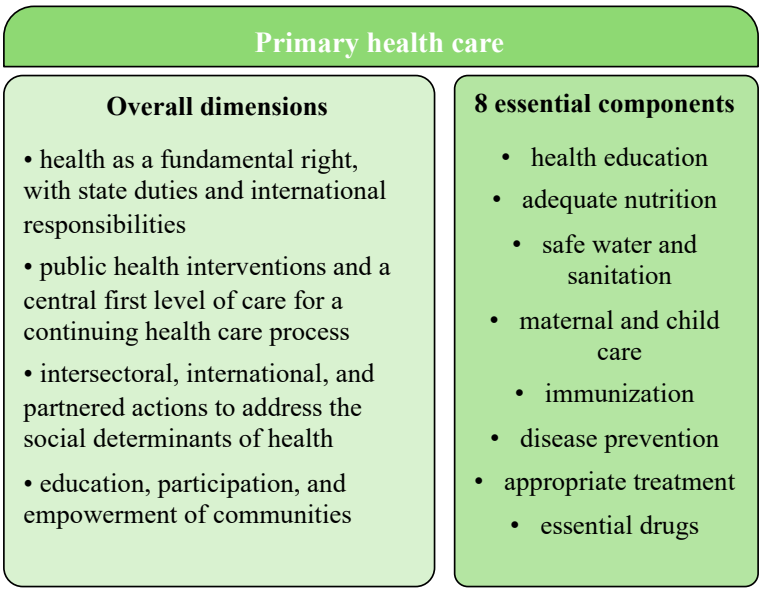
Introduction

With 281 million international migrants worldwide, the intricate link between migration and health has become a focus in both research and policy over the past two decades.[1] While migration can offer opportunities for improved well-being, migrants often confront serious health risks. They encounter violence, exploitation, and harsh living conditions, as well as family separation and systemic discrimination, challenges that are compounded by precarious legal status, threats of detention or deportation, and significant barriers to accessing health care. All these factors critically undermine migrants' health and well-being.[2] Society-wide responses to these unfavorable circumstances—including public health, humanitarian, and human rights interventions—offer potential solutions. Law is an essential tool for human rights advocates to hold states accountable for health-related rights violations.[3] However, international and regional human rights law are rather inconsistent and ambiguous on the nature of state obligations to migrants. They range from endorsements of a universal and nondiscriminatory right to health for all migrants to constrained approaches that limit the entitlement of people with irregular migration status to urgent (medical) care.[4] This fragmentation extends to domestic law, where migration status heavily influences access to health rights.[5] Public health evidence shows that medical care alone is insufficient to ensure health equity: the right to health for migrants must extend beyond emergency care to access to a broader range of health services and other key social determinants of health.[6]

This paper focuses on irregular migrants (non-nationals who do not meet legal entry or stay requirements) and migrants who, though lawfully present, have a precarious legal status (e.g., because they are awaiting decisions on their migration status, a "limbo" that can hinder access to welfare). Irregular migrants constitute a distinct subset of distress migrants, subject to state hostility and thus peculiarly exposed to vulnerabilities.[7]

The paper explores a proposal to address the gap between the universality of the right to health and its limited application to migrants with irregular or precarious status (from now on referred to as "irregular migrants"). The aim is to shift from a mere "bare survival" threshold to one that promotes "healthy subsistence."[8] The research question is, Would a stronger focus on a primary health care

FIGURE 1. The primary health care framework



Sources: International Conference on Primary Health Care, Declaration of Alma-Ata (1978); Global Conference on Primary Health Care, Declaration of Astana (2018).

(PHC) better fulfill the right to health for migrants? Related to that is the question of whether PHC should constitute a blueprint for priority-setting when seeking to realize migrants' right to health.

The authoritative 1978 Declaration of Alma-Ata defined PHC as an intersectoral approach to achieve health equity, with individual- and population-level interventions, grounded in the right to health and facilitated by national and international partnered actions.[9] Its essential components include health education, adequate nutrition, safe water and sanitation, maternal and child care, immunization, disease prevention, appropriate treatment, and the provision of essential drugs (see Figure 1). PHC has been recently recast by the 2018 Declaration of Astana, which, by contrast, emphasizes the need to implement integrated health systems with a central focus on the first point of contact with the health system (primary care) and public health interventions. It calls for multisectoral actions and the facilitation of community empowerment and participation.[10] Primary care in this framework is not the same as PHC; rather, the former "is the core of the *service*-fronting component of PHC."[11]

PHC is deemed a "cost-effective, equitable and accessible *route* to extending health services to *unreached* populations"—a key means to "materialize the right to health" without discrimination and a cornerstone of global efforts to achieve universal health coverage.[12]

It is thus unsurprising that PHC features as an essential element of health-related legal provisions in Convention on the Rights of the Child and the Additional Protocol to the American Convention on Human Rights, but it is also a benchmark in relation to state obligations on the right to health

FIGURE 2. The right to health: General and core obligations

Right to health

Overall framework

- progressive realization of the highest attainable standard of physical and mental health
- immediate duties to take concrete steps that ensure the realization of the right and to prevent discrimination
- availability, accessibility, acceptability, and quality of services and conditions (AAAQ)
- participation and accountability mechanisms

Priorities for action

Core obligations

- health services without discrimination (ensure access)
- safe and nutritious food and freedom from hunger (ensure access)
- basic shelter, housing and sanitation, and safe and potable water (ensure access)
- essential medicines, as defined by World Health Organization (provide)
- equitable distribution of health facilities, goods, and services (ensure)
- equitable national health plan of action (adopt/implement)

Obligations of comparable priority

- reproductive and prenatal and postnatal maternal and child health care (ensure)
- immunization for priority diseases (provide)
- epidemic and endemic diseases (prevent, treat, and control)
- health education (provide)
- appropriate training and education for health personnel (provide)

Sources: International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12; Committee on Economic, Social and Cultural Rights, General Comment No. 14, UN Doc. E/C.12/2000/4 (2000).

in the framework of the International Covenant on Economic, Social and Cultural Rights.[13] Despite varying interpretations across legal frameworks, the right to health in international law obliges states to promptly and effectively work toward its *progressive realization* for all. This entails establishing and enhancing health systems that provide preventive, curative, and palliative services, as well as implementing measures addressing the social determinants of health. States must also take *immediate steps* to ensure nondiscrimination against vulnerable groups in existing services and interventions and undertake "deliberate, concrete, and targeted" actions toward fully realizing the right to health.[14] PHC appears to have influenced a list of core obligations and duties of comparable priority in developing rights-compliant health systems and multisectoral governance (see Figure 2).[15] This relates to the much-debated yet authoritative legal concept of core obligations concerning the right to health, which serves as a "minimum floor" for the conduct or outcomes expected of state authorities.[16]

The intersection between PHC and the right to health seems therefore crucial for identifying priority areas of intervention for vulnerable people, such as irregular migrants and asylum seekers, which states are obligated to address.[17] Indeed, within the United Nations and Inter-American frameworks, all migrants are recognized as rights holders, with nondiscrimination applying on the grounds of nationality and legal status.[18]

The Colombian response to Venezuelan migration serves as a case study in this paper to answer the research question in a specific context, avoiding the perception of law operating in a social vacuum and exploring "human rights in action ... [through] engagement with communities' actual needs."[19]

The context in Colombia

This case study is particularly significant for several compelling reasons. First, Colombia has a strong Constitutional Court, and international human rights law has contributed to the development of health standards and statutory legislation that protect the fundamental right to health.[20] The Colombian health system operates through public and private providers, with services accessible via insurance: the state subsidizes coverage for those classified as poor or vulnerable, while others must pay through work contributions or privately.[21] However, only nationals and those with regular migration status can access comprehensive health and social services, while irregular migrants or people in the process of regularizing their status, who are ineligible for social security and health insurance, are generally limited to receiving urgent medical care (see Table 1).[22] Strategic litigation has led to many judgments extending migrants' health entitlements, some of which are referenced in the discussion below.[23] However, a significant gap exists between the law and how it is implemented.[24]

Second, over the past decade, nearly three million Venezuelans have settled in Colombia, (whose population was 52 million as of 2024), with hundreds of thousands of others (Venezuelan and other nationalities) transiting through its territory annually.[25] Although many Venezuelans—fleeing massive human rights violations—might in principle qualify for international protection under

TABLE 1. Entitlements for citizens and migrants

Legal status	Legal entitlements
Citizens and regular migrants (holding various visas, residence permits, or regularized through the Venezuelan temporary protection statute) and asylum seekers with certified status (SC2) lasting up to 180 days, renewable once.	Access to comprehensive health care if they affiliate with the social security system, are classified as "poor," and register with a health insurer. They may also be eligible for additional social services, such as nutrition programs. Non-nationals must report their residence every four months. Those with the capacity to pay must directly register with a health insurer to access care.
Uninsured populations, including irregular migrants and individuals in the process of regularizing their status. Regular migrants during the first month of health insurance.	Access to urgent care, which by law (Res. 5269/2017) extends beyond emergency services.

the Cartagena Declaration, which is incorporated into Colombian legislation, they are rarely granted refugee status.[26] Despite the low success rate, data collection in this study showed that many individuals still strategically apply for asylum, as asylum seeker status grants non-nationals eligibility for at least temporary health care affiliation. However, the vast majority of Venezuelans hold "liminal" statuses, such as temporary protection obtained through long-lasting regularization processes (especially during 2021–2023), or remain as irregular migrants.[27]

Third, state authorities have created partnerships with many dynamic international agencies and nongovernmental organizations (NGOs) to respond to the health and social needs of migrants who do not hold regular status.[28] Organizations operating in the health sector, largely coordinated by the Pan-American Health Organization and the Ministry of Health, appear to be guided by a PHC approach in what they coordinate and offer, and some subscribe to a human rights-based approach.[29] This unfolds in a political context of deep polarization, violence, and weak state presence in certain regions, despite institutional efforts toward peace and justice.[30] Polarization extends to health, where a strong tradition of social medicine coexists with a highly privatized health system resisting attempts at reform.[31] For instance, a recent health reform bill—aimed at introducing a greater focus on preventive and primary care, but which was silent on the right to health of irregular (uninsured) migrants—stalled in Congress for over a year before ultimately being quashed in March 2024.[32]

Methods

This paper combines a literature search and empirical data collection and analysis. The literature search covered judicial decisions, laws and policies, and secondary sources (scholarly analyses and commentaries of institutional bodies and NGOs) identified through relevant databases and institutional websites using a combination of keywords such as "primary health care," "human rights (law)," "right to health," "Venezuelan migration," "migrant," and "Colombia" in Spanish and English.[33] Empirical work, conducted in Spanish, had three elements:

- Diaries from two periods of participant observation during February–May 2022 with two humanitarian actors (Jesuit Refugee Service and the International Organization for Migration) in Bogotá, Cundinamarca, and Norte de Santander.
- Semi-structured interviews with 30 administrative, managerial, legal, and clinical staff across 20 public institutions and humanitarian and community organizations, held in person and online, in the same territories, during the period of May–December 2022. The sample started with the identification of key organizations via participant observations, and complemented with snowball identification (names of the organizations available from the author on request). Interviewees were 65% women and 35% men.
- Four in-person focus groups with 38 migrant and Colombian social leaders acting as community health workers (CHWs) in the cities of Bogotá, Soacha (Cundinamarca), Villa del Rosario (Norte de Santander), and Cúcuta (Norte de Santander). The focus group participants were 70% women and 30% men, as well as 60% Venezuelan and 40% Colombian.

During the semi-structured interviews and the in-person focus groups (see Annex), conversation, exercises, and prompts explored essential components, crosscutting principles, and challenges related to PHC and the right to health as applied to migrant communities in the country (with a focus on not-yet-regularized migrants, who were the majority of people during data collection).

I selected the aforementioned territories because, when the study design started in 2021, these were among the areas of the country with the highest concentration of migrant communities, whether settled, in transit, or of pendular migration. However, my research is limited by its geographical scope, as it excludes rural areas where health rights may be more neglected due to armed groups, limited infrastructure, and local budget

constraints. Additionally, the study's focus on Venezuelan migrants does not account for the growing number of migrants from other nationalities now transiting through Colombia.

Diaries and transcripts containing the opinions of participants were analyzed through qualitative thematic analysis using NVivo, which led to the identification of 300+ codes and the extraction of three macro themes (described below).[34] The findings are subsequently triangulated with the literature in the discussion section to assess whether a PHC approach could improve migrant health equity and rights.

Results: Three macro themes

My thematic analysis of empirical data found the following macro themes: (1) iterations of the human right to health and its facilitators; (2) the value of PHC in migrant-targeted actions; and (3) approach constraints. Given the breadth of the research question, this section aims to provide a short "thematic description of the entire data set"; however, a more detailed account is given for the dimensions of theme 2.[35]

Iterations of the human right to health and its facilitators

Study participants were particularly eager to share their views on the foundation and scope of the right to health (in general and in relation to migrants), as well as the mechanisms for ensuring its realization. Many emphasized "health and well-being" as the human *interests underlying* this right for everyone (e.g., FG1, I-9), further noting that "the right to health is functional to protect social determinants of health beyond urgent lifesaving medical care" because it is "framed as the highest attainable standard of health and well-being" (e.g., FG1, I-1). Others stated that this right is instrumental in protecting life, either a "dignified one" (FG-3) or in cases of "critical lifesaving situations" (e.g., FG4, I-9).

Regarding the *scope* and *nature* of rights and obligations, many participants, especially non-nationals, felt that state authorities were breaching their legal and moral obligations: "It cannot be that the right to health means 'I am dying, I have the right to health,' as in the case of uninsured migrants. This [right] should encompass timely care and services based on the patient's needs without engaging in discrimination" (I-7). Or, as one other participant stated, the right to health should encompass "at least some *essential* services for everyone regardless of nationality and status" (I-9, emphasis added). Others highlighted the "progressive nature of the right to health for migrants," emphasizing that there would be a "duty to provide emergency care to protect the right to life while gradually extending coverage" (I-4, similarly I-16).

All participants frequently reported that state and nonstate responses inadequately protected migrants' right to mental health, given the limited focus on one-time crisis management in emergency care and only limited mental health support through NGO-sponsored packages (I-2, I-9, I-18) (see Table 2).

Discussions further highlighted *how* irregular or not-yet-regularized migrants (the majority during data collection) enjoy the right to health. *Intermediaries* such as legal clinics, NGOs, and pro bono legal advisors are deemed "essential for their assistance in securing access to health services by engaging with ombudspersons, filing petitions, asylum applications, and protection writs" (e.g., FG1, FG-4). Additionally, the significant presence of development agencies with migrant health programs (mostly focused on primary care, children, and maternal care) also plays a key role, leading

TABLE 2. Mental health is a human right

A single mother of two participating in a focus group
"We arrived in Colombia with heavy hearts. Imagine watching your children and neighbors lose weight from hunger, walking for days through heat and cold, only to be treated as less than human because you're poor and foreign. Mental health must be recognized and actioned upon as human right" (FG-1).

many to feel that "[their] right to health is upheld by NGOs and agencies like the International Organization for Migration" (FG-1, similarly FG-3). However, some agencies caution that "it is not our function to realize human rights, but we do minimize risks of rights violations; we stay there, we support" (I-9), "within the limits of our projects that do not always ensure continuity of services, or as you want to put it, rights realization" (I-10).

The value of PHC in migrant-targeted actions

To evaluate whether a stronger focus on PHC could support the fulfillment of migrants' right to health, participants were briefly introduced to PHC dimensions and the eight essential components (see Figure 1) and asked to identify which should constitute a "minimum floor" in migrant-targeted actions and why. Below, responses are grouped into four sub-themes, consolidating the most referenced PHC elements.

Primary care, immunization programs, and essential drugs. While it should be reasserted that primary care, as the first level of care, is only one component of PHC, it was arguably identified by study participants as representing one of the biggest gaps in the institutional response to the right to health for irregular migrants in Colombia. A United Nations employee noted that "primary care provision would allow us not to move to a higher level of complexity and costs, … preventing complications and unnecessary suffering, so it can constitute *appropriate treatment* in the face of certain communicable and noncommunicable diseases" (I-17, emphasis added). For that reason, "many development actors resorted to purchasing primary care packages in private and public health centers for uninsured migrants" (I-10) and created "mobile units" (I-10, I-14). These complementary primary care services "typically also address psychological distress by offering psychological first aid, with or without the involvement of psychologists (I-9)" and "referrals to specialized or urgent services when available" (I-3).

Venezuelan nationals in focus groups, regardless of their legal status, overwhelmingly wished that state-subsidized care included access to *primary care clinics* for immunization programs and for screening, treatment, and check-ups for common communicable and noncommunicable diseases, in order to avoid suffering, worsened conditions, and service denials in urgent care. They viewed this as "a human right, which should, in turn, trigger accountability and redress mechanisms" (FG-1). Colombian nationals, who are entitled to comprehensive health services, were mostly concerned with the "real opportunity to have access to affordable *essential drugs*, which are often unavailable for free or at a subsidized price" (FG-3, emphasis added).

Institutional actors and community-based organizations working in the visited territories agreed that *immunization programs* have been "widely accessible in public hospitals and mobile units, at least since 2019" (I-5, I-18). Further, "six months after COVID-19 vaccines were available to insured populations, they were extended to irregular migrants … to mitigate public health risks" (I-14).

Community strategies and health education. Strongly related to primary and territorial care are community health interventions, which "target all communities without distinctions" (I-14) but which "are chronically affected by funding shortages" (I-17).[36] According to PHC, such interventions include the involvement of CHWs. Informants highlighted CHWs' contributions, including to "promote public vaccinations for children and against COVID-19" (FG-2); "close information gaps about healthy behaviors and procedures to access services" (I-10); and "facilitate psychosocial interventions" (I-9).

Feedback on the activities and potential of CHWs highlighted their crucial position as receivers and providers of both health and human rights education. As for *health education* (an essential component of PHC and a core obligation), institutional participants admitted that they "lack targeted efforts for migrants, relying instead on development actors as information and workshops

providers" (I-14, I-5). To address these shortcomings, NGOs and development organizations provide migrant and host CHWs with "training on disease prevention and health promotion, as well as on framing these as human rights issues" (FG-2). The latter includes training on "legal and practical protection mechanisms, which are vital for empowering [marginalized] communities and social justice" (FG-1). Such trainings also promise to strengthen the quality of *social participation* of these communities; however, participants in the focus groups admitted that "we have been invited to speak to public authorities only when the national health plan was underway; otherwise, we do not participate directly in policymaking" (FG-1, similarly FG-2).[37]

Children and maternal care. Study participants valued the PHC focus on maternal and child health and noted that "international funding dynamics prioritize these groups" (I-11) and that "the number of pregnant women and mothers traveling alone with young children [had] increased in recent waves of migration" (I-8). Many interviewees, especially in focus groups, expressed outrage over the limited antenatal and child care available to irregular (and thus uninsured) migrants outside humanitarian programs. Beyond childbirth, emergency care, and abortion services, hospitals offer little to migrants without legal status. As one social leader exclaimed, "Migrant children without regular status can only access urgent care, just like adults. I think this is completely inhumane and discriminatory" (FG-3).

Social determinants of health. Many interviewees raised compelling points about the impact of dire living and working conditions, as well as their underlying factors (e.g., legal status, poverty, and gender), on the health of vulnerable migrant communities. These concerns included reports of normalized trafficking, sexual exploitation, sex for the survival of women and girls (especially in border towns) (I-10), and dangerous housing and labor conditions (I-1, FG1). Regarding the latter, for instance, on several occasions, interviewees discussed these circumstances in terms of human rights; as one stated, "There is no right to health without *basic needs* and *decent employment*. Migrants in the informal job market earn between 10,000 pesos [US$2.5] and 30,000 pesos [US$8] per day. If they attend a medical visit, they risk not being paid or losing their job, so many, especially men, avoid checking their health conditions until they're severe" (I-12).

Regarding the *essential* components of PHC (and core obligations), migrants may access food, water, nutrient supplements, and emergency accommodation at humanitarian centers along major migration routes.[38] However, this assistance is often provided on a "once-off basis" (I-10), with "projects … not ensuring continuity of provision" (I-16), making it more of a charity than a right. Particularly concerning for participants was the right to access to water in shanty towns (I-10, I-4) and the management of malnutrition in children in irregular situations, which is limited to treating their acute malnutrition, giving rise to a "periodic revolving-door phenomenon" (I-12). All migrant children, for focus groups participants, should have access to the "comprehensive program against malnutrition of the Family Welfare Institute," which is currently an entitlement only for nationals and regular migrants (FG-1).

Perceived constraints of a PHC-anchored migrant right to health

Finally, some participants raised doubts about whether a stronger focus on PHC is desirable for fulfilling migrants' right to health (Table 3). These perceived constraints can be categorized as either "invisibilization risks" (where *selective* PHC approaches may overlook vulnerable individuals and certain essential services) or "business as usual" (suggesting that even a PHC-anchored migrant right to health may not help overcome the broader political, social, and economic factors underlying the operationalization of human rights).

Discussion

This section discusses the case study in relation to domestic and international human rights norms

and commentaries. Since the law in Colombia restricts entitlements to health care for migrants without regular status, it must also be part of the solution. The goal is to evaluate whether integrating PHC into a rights-and-obligations framework represents an equitable and practical step toward better realizing migrants' right to health and advancing universal health coverage.

From iterations of the right to health to compliance with international law

Most study participants viewed the right to physical and mental health as protecting "health and well-being" and requiring state obligations for prevention, treatment, and health promotion, aligning with international declarations on PHC and obligations reflected in constitutional and statutory law.[39] However, this sharply contrasts with the reality for migrants who are poor and have precarious legal status, as these factors prevent them from enrolling with a health insurer. In Colombia, *national law* restricts irregular migrants to accessing only *urgent* care, which participants identify as the primary barrier to their right to health: the legal framework ends up protecting their right to life in health care rather than the right to health.[40] Given the prominent role of international human rights treaties in Colombian law, and the resonance of international jurisprudence with judges, placing greater emphasis on PHC components as embedded in core obligations could help legal advocates foster the development of more protective normative standards for all.[41]

Diverse opinions emerged regarding the *nature of obligations* tied to migrant health rights. The progressive realization of socioeconomic rights was often misinterpreted to justify delays in fulfilling irregular migrants' health rights. Denying services based solely on irregular legal status, while other groups are entitled to them, is prima facie discriminatory under human rights law. Nondiscrimination is not subject to progressive realization and imposes an immediate duty to include migrants in health policies and ensure access to existing services, unless reasonable, objective, and proportionate justifications are provided to limit rights beyond their core content.[42] Distressed migrants in Latin America, including in Colombia, face multiple vulnerabilities to rights abuses.[43] Instead of imposing unjustified restrictions, human rights law compels states to devise special measures to promote this population's substantive equality.[44] Relatedly, this paper argues that essential PHC services and interventions, being highly valued and part of core obligations, should be considered special measures of priority realization, invalidating

TABLE 3. Perceived approach constraints

Risks of "invisibilization"	Business as usual
Vulnerable people who are not pregnant women or children "International agencies and NGOs focus mainly on migrant children and pregnant women, but this is insufficient" (I-20). "Selective PHC centered on children and maternal care risks overlooking the health needs and rights of other vulnerable groups" (I-2).	Political will "You can present technical, ethical, and human rights arguments, but if the government says no, change is hard. There was political will for the 2021 Venezuelan regularization scheme, and they still collaborate with humanitarian actors, but we don't see political space to extend state-subsidized care beyond emergencies or creating special routes" (I-17)
Inadequate access to urgent care "You speak of PHC, but we often need judicial orders to access our entitlement to urgent care, even for migrant children" (FG-1). "You need to insist, and we frequently ask the ombudsperson to intervene" (FG-2); "quality is also an issue; many are dismissed with just a blood test and acetaminophen" (FG-3).	Costs "Health care for migrants is costly, which is why the government doesn't cover it comprehensively or gradually extend services" (I-6). "We regularly transfer hundreds of millions of pesos to regional authorities for urgent care, which is already a big effort" (I-14).
Social determinants of health "PHC's essential components cover basics like water and nutrition, but we need more, migrants need more. The social determinants and the right to health go beyond that" (I-1). "It is hard to envision migrants' right to favorable health determinants in a middle-income country like Colombia, where 50% of the population is socioeconomically vulnerable or poor" (I-17).	Structural problems of the health system "Structural issues block measures for migrants: the system has improved but remains fragmented, privatized, underfunded, urban-centered and the national level lacks strong regulatory powers" (I-1). "Even if reforms extended migrants' entitlements, major barriers like high out-of-pocket costs, xenophobia, and discrimination from health care and security staff would still exist" (I-19).

any state justification excluding irregular migrants from their provision. Understanding these legal concepts is crucial for courts, nonstate actors, and humanitarian organizations to strengthen rights-based approaches and the capacity of duty bearers. Additionally, it is important for communities to understand international duties as tools for mobilization, empowerment, and contestation that allow them to advocate for social change in the treatment of marginalized individuals.[45]

Against severely constrained legal rights, numerous humanitarian actors, NGOs, and grassroots organizations in Colombia run programs targeting essential PHC components, focusing on the protection and promotion of the physical, mental, and social health and well-being of migrants (and other vulnerable communities).[46] This strategy is prima facie compatible with human rights law: article 2 of the International Covenant on Economic, Social and Cultural Rights demands that states adopt a broad array of measures "individually and through international assistance and co-operation," and partnerships for the right to health are deemed essential.[47] However, this case study reveals that program-based interventions for migrants often fall short of human rights standards. Common issues include the lack of geographic availability and continuity of services, neglect of accountability, and the unintended consequence of absolving the state of its obligations, effectively legitimizing the reduction of *public* safety nets for the most vulnerable.[48] It is particular concerning, as noted by an international organization employee, that "after years of complementary services, the Colombian government takes what we [humanitarian actors and NGOs] do for granted and is unwilling to extend health rights to irregular migrants beyond emergency care" (I-11). Even well-intentioned actors implementing rights-based approaches inevitably face trade-offs: "[They] operate like private entities; if funding dries up, the program ends, and the 'user' cannot expect their rights to be realized" (I-10).[49] This highlights the importance of *legally recognizing* essential PHC services and interventions for migrants as minimum standards to fulfill their right to health, which is vital for *institutionalization* and *accountability*.[50]

PHC components: From value to obligations

The results section flags how the components of PHC are widely valued across sectors for reducing health inequity, especially for irregular migrants. These components align with core obligations and state priorities for realizing the right to health.

The centrality of *primary care* for interviewees clashes against the fact that this level of care is accessible only via status regularization and enrollment with an insurer in Colombia. As the core service component of PHC, "it would be difficult not to consider it as key means for realizing a right to health for all" (I-16).[51] Studies estimate that primary care is adequate for 75% to 80% of cases when medical help is needed, and the United Nations Committee on Economic, Social and Cultural Rights specifies that such care, as well as immunization against priority diseases, must be accessible to all regardless of legal status.[52] Constitutional case law includes immunization programs for migrants within the right to *urgent* health care (to protect public health), with field feedback and gray literature describing these programs as a "success story in practice" (I-9) and an area where "institutions showed notable commitment and resource allocation" (I-8).[53] The same cannot be said regarding access to *essential* drugs (as defined by the World Health Organization), a core obligation of the right to health and an essential component of PHC, which are available to irregular migrants only if they are hospitalized for emergency services.[54]

Participants revealed the critical role of CHWs in "bridging the gaps" between health systems and marginalized communities.[55] As part of PHC and the right to health frameworks, *community strategies* help facilitate nondiscriminatory access to services and contribute to *disease prevention and control*—core state obligations.[56] Colombia has a long history with CHWs, dating back to rural pilot projects in the late 1950s.[57] Recently, development actors have been training CHWs to support migrant communities, fostering empowerment by equipping them

to advocate with communities for health rights and to participate in policymaking.[58] However, *social participation* remains an unfulfilled promise for migrants, as CHW engagement with health authorities is often mediated by humanitarian actors. State obligations for migrant health should include proper CHW training, funding, and integration into the health system, as recommended by World Health Organization guidelines.[59] A recent draft decree by Colombia's Ministry of Health proposes integrating CHWs as auxiliary staff but omits specific reference to (programs for) migrants.[60]

Participants unsurprisingly emphasized the importance of PHC components related to *maternal and child care* for migrants, highlighting these as the declared priorities of many development and humanitarian actors with whom they collaborate. State duties in these areas are reinforced by international human rights law and constitutional rulings, which highlight gender equality and the best interests of the child as taking precedence over migration policies.[61] Although Colombia's Constitutional Court has ruled in favor of providing *necessary* health services to uninsured children and perinatal care, access often comes only through litigation (I-6).[62] A legal expert noted that "progressive constitutional case law on individual writs would not be enough to influence policy as they normally have limited general validity" (I-2). A physician further pointed out practical challenges, explaining that while the Constitutional Court may mandate antenatal and children's services as urgent care, such services are not typically provided in urgent care departments: "ambulatory services like prenatal check-ups and pediatric care require migrant status regularization and enrollment with insurers under current normative and operational frameworks" (I-20).

If the "minimum floor" of health rights and obligations for irregular migrants were not framed as urgent care but around PHC components and core obligations, comprehensive care for migrant children and pregnant persons would be part of the standard package. Without implying equivalence between entitlement and access, legal recognition would arguably be the starting point to create "special service routes for irregular migrants" (I-10), as recently seen with abortion services, which eliminated the requirement of regular migration status.[63]

Finally, on numerous instances, *working and living conditions* were highlighted as key factors to fulfill the right to health of migrants. Clear data patterns were elusive except for the fact that targeted services for irregular migrants rely largely on humanitarian and development actors. However, international human rights law (incorporated into the Constitution) through core obligations embedding PHC elements could become the means for extending rights to basic nutrition, food, shelter, water, and sanitation for all.[64] While this minimal approach does not fully account for broader social and structural determinants of health, it offers a legal foundation for human rights advocates to pursue iterative advocacy and strategic litigation for ensuring that basic needs are addressed for all vulnerable groups, including irregular migrants.[65]

From constraints to legal literacy

While I am not suggesting that law should dominate discussions on social justice for migrants, I believe that expanding *legal literacy*—that is, as conceptualized by Murphy and Angeleri, fostering curiosity about both the potential and the limitations of human rights law as enacted by various intermediaries—is essential.[66] This approach could help address constraints, such as those identified in the fieldwork, that currently limit the contribution of PHC to reduce migrant inequity. The "risks of invisibilizing" certain *population groups* (with selective PHC focused primarily on child and maternal health) can be mitigated by adopting a human rights perspective, which mandates special legal protections and practical measures for *all* vulnerable people and groups facing discrimination.[67] For instance, addressing the concerns of several study participants, human rights-compliant PHC-based reforms and programs should ensure comprehensive sexual and reproductive care for all, including LGBTIQ+ migrants, and provide tailored support for transnational Indigenous populations and people with disabilities, regardless of legal status.[68] Furthermore, a PHC-based right to health does not

focus solely on primary and preventive care but also promotes "strong linkages with timely acute care and effective referral systems at all levels."[69] Nonetheless, this *service integration* dimension appears less apparent in how participants understood PHC as a framework for realizing migrant health rights. Access to urgent care should continue to be fought for in courts and through other accountability mechanisms when legal and practical barriers hinder it: PHC does not conflict with it, nor does domestic law or international human rights law.[70] *Continued* access to secondary care may present more challenges if equalized standards are not embraced, but in Colombia, some services—such as treatment for sexually transmitted infections and cancer—are already recognized as judge-made entitlements for uninsured migrants as "urgent" care.[71] This highlights both the strengths and limitations of the proposed approach: a PHC-anchored migrant right to health—with priority services and interventions constituting legal entitlements to meet core obligations—provides a meaningful "minimum floor" for health protection while working toward full coverage and universal human rights protections for migrants.

Given the challenges of costs, structural issues, and political will, this paper seeks to leverage human rights law (embedding PHC standards) to counter government resistance by proposing a *temporary* subset of cost-effective universal services and interventions for irregular migrants. Furthermore, legal literacy can attenuate "business as usual" concerns, urging diverse stakeholders working in migrant health response to understand how human rights law might help navigate the *resource scarcity argument* in realizing socioeconomic rights. While this argument may justify a slow progression in overall right to health implementation, it cannot excuse the failure to meet core obligations—embedding PHC components—or support maintaining discriminatory rules.[72] On this note, compelling feedback from the fieldwork included that "a rights-based approach to health and migration should require the government to estimate funds necessary to provide a basic to comprehensive PHC-based package to all migrants, including the undocumented, to protect their rights beyond survival" (I-16). If a differentiated approach based on migration status persists, there must be reasonable, objective, proportionate justifications, along with a plan to address discrimination through stable and partnered rights-based solutions.[73]

Conclusion

International norms have yet to clearly and consistently define the right to health as it applies to non-citizens or non-residents. Colombia's Constitution and Constitutional Court, though, have established robust standards for this right for irregular migrants (even if not fully equal to those for citizens); however, law is not consistently applied in practice. This qualitative study employed PHC to expose gaps in migrant health protections and envision a more robust minimum framework for outlining state duties to fulfill the right to health. Triangulating empirical data and the literature revealed that anchoring the migrant right to health to the essential components of PHC would clarify state obligations to provide preventive care, health and human rights education, essential medicines, sexual and reproductive services, and comprehensive child health care to all migrants. Focusing on these elements, particularly primary care, would aid in detecting, treating and controlling common communicable and noncommunicable diseases, including mental health conditions. This foundational level of care requires legal, budgetary, and operational measures to ensure its effectiveness, including the promotion and funding of CHWs, mobile health units, and psychosocial interventions.

Participants indicated that the fulfillment of migrants' rights to the social determinants of health was more complex, although the imperative to commit to collaborative and partnered solutions remained evident, especially with regard to adequate nutrition, safe water, and shelter, which constitute core obligations. As data revealed that humanitarian and development actors play a key role in health and social service provision for irregular migrants in Colombia, the analysis demonstrated that these actors should at least facilitate rather than obstruct

the participation of rights holders in health-related decisions and the accountability of duty bearers regarding human rights obligations concerning migrant health. Finally, there was a strong consensus that this "minimum floor" (PHC *essential components*) should not serve as a "protection ceiling."[74] Addressing deficiencies of urgent care and progressing toward more comprehensive PHC *overall dimensions* (see Figure 1) aimed at universal health coverage and promoting nondiscriminatory social determinants of health for everyone is deemed essential for legal, moral, and public health reasons.

The findings of this study cannot be fully generalized due to its specific focus, yet the analysis, grounded in international standards, could inspire human rights-centered reflection and actions in other contexts. Overall, this is a call for migrant grassroots advocates to mobilize human rights arguments and reclaim their role in health policymaking; for development actors to genuinely adopt a human rights-based approach; for policymakers to ensure that PHC models include all marginalized communities; for legal advocates to explore meta-legal standards and go beyond individual litigation; and for international human rights bodies to clarify state obligations on migrant health, potentially using PHC dimensions and components (as agreed-on means to reduce health inequity) as benchmarks for progressing toward universal and equal rights.

Funding

This research was supported by funding from the European Union's Horizon 2020 research and innovation program under Marie Skłodowska-Curie grant agreement no. 101032116–HEAVEN.

Acknowledgments

I am deeply grateful to Judith Bueno de Mesquita, Thérèse Murphy, Jacqueline Bhabha, and Carmel

ANNEX: List of interviews and focus groups

Citation	Description	Date
I-1	Interview with two development professionals at a UN agency's national office in Bogotá	May 2022
I-2	Interview with a physician and a lawyer at a community-based organization in Bogotá	June 2022
I-3	Interview with a physician and a project manager of a national NGO	June 2022
I-4	Interview with two health professionals at a UN agency's national office in Bogotá	June 2022
I-5	Interview with a high-level agent of a regional health unit in Cúcuta, Norte de Santander	June 2022
I-6	Interview with a former high-level agent of a regional health unit in Cúcuta, Norte de Santander	June 2022
I-7	Interview with a high-level agent of the Ombudsman's Office of Colombia	June 2022
I-8	Interview with the head of a religious national NGO	June 2022
I-9	Interview with an agent of an international NGO	June 2022
I-10	Interview with an agent of an NGO in Norte de Santander	Aug. 2022
I-11	Interview with an agent of a health-focused NGO in Norte de Santander	Aug. 2022
I-12	Interview with the head of a community-based organization in Cundinamarca	Sept. 2022
I-13	Interview with the head physician of a diaspora organization in Cundinamarca	Sept. 2022
I-14	Interview with two agents of the national health authority	Oct. 2022
I-15	Interview with a project manager of a humanitarian agency	Sept. 2022
I-16	Interview with an agent of an international NGO	Oct. 2022
I-17	Interview with a health professional at a UN agency operating in Cundinamarca	Oct. 2022
I-18	Interview with two agents of the health agency of Bogotá	Nov. 2022
I-19	Interview with a health professional at an international NGO	Nov. 2022
I-20	Interview with two nurses of a health center in Bogotá	Dec. 2022
FG-1	Focus group with CHWs in Soacha (12 people)	June 2022
FG-2	Focus group with CHWs in Bogotá (10 people)	July 2022
FG-3	Focus group with CHWs in Cúcuta (6 people)	Aug. 2022
FG-4	Focus group with CHWs in Villa del Rosario (8 people)	Aug. 2022

Williams, as well as the two peer reviewers, for their valuable feedback, which helped enhance this piece.

Ethical approval

The Research Ethics Committees at Queen's University Belfast and at Universidad del Rosario approved data collection and use strategies on February 11 and 17, 2022, respectively.

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