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Protecting Distress Migrants' Right to Health in Ecuador: Are Legal Commitments Being Fulfilled?

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Abstract

Ecuador's legal framework promises equitable access to health care for all. However, gaps in coverage are being exacerbated by the nearly 500,000 Venezuelan distress migrants remaining in the country over the past decade. The purpose of our study was to examine how the Ecuadorian health system responds to the needs of migrant populations arriving in poor health conditions. We conducted 28 key informant interviews with government officials, health care providers, and representatives of international cooperation agencies and migrant organizations, and analyzed documents from a related Constitutional Court sentence. We find that despite Ecuador's commitments, significant gaps exist in the implementation of protection mechanisms for distress migrants. Systemic obstacles, such as documentation requirements and exclusion from benefits granted by law, remain. Discriminatory practices and concerns about the allocation of limited resources can further impede access. The Constitutional Court case underscores how the judicialization of health may prompt the government to address distress migrants' right to health and document its progress. Ultimately, more comprehensive approaches are needed to promote a more equitable health system that addresses the specific experiences and needs of distress migrants in Ecuador.

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Introduction

The protracted crisis of the past decade in Venezuela has led to the displacement of millions of people, forcing them to migrate to other countries in the region.[1] By the end of 2023, approximately 7.7 million distress migrants from Venezuela had sought refuge across the Americas.[2] Ecuador, in relative proximity to Venezuela, has felt the impact of this migration surge; an estimated 500,000 Venezuelan migrants—a majority of whom are in an irregular situation—have remained in the country. In addition to instances of discrimination and xenophobia, the lack of a legal status exposes them to various challenges (e.g., preventing them from reporting potential human rights violations).[3] The 2022 census did not register all foreign-born populations in Ecuador, capturing only 231,686 Venezuelans, 97,832 Colombians, 10,768 Cubans, 14,837 Peruvians, and 14,424 US citizens among the largest migrant groups residing in the country.[4] Similarly to Venezuelans, the number of Colombian nationals is estimated to be much higher than census figures; such under-registration of migrants hinders the planning and allocation of resources.

Following Jacqueline Bhabha, we use the term "distress migrants" to characterize migration that "stems from desperation, vulnerability, and need, from living circumstances that are experienced as unbearable or deeply unsatisfactory and that precipitate serious obstacles to a reasonable or tolerable life."[5] Like Bhabha, we understand distress migration to encompass refugee, survival, and forced migrants, together with "people who have no choice but to leave home, but who do not fall into those categories."[6]

In 2021, approximately 19 million Venezuelans worldwide lacked adequate access to health care, including 10 million who were living with chronic conditions.[7] After arriving in host countries, distress migrants face increased vulnerability to developing new illnesses or exacerbating preexisting health issues. In addition, their migration journey, marked by instability, discrimination, and xenophobia, and lack of knowledge about other countries' health and social service systems, can further compromise their health.[8] According to the Interagency Coordination Platform for Refugees and Migrants from Venezuela, there are significant challenges for Venezuelan migrants and refugees in accessing health care in the Latin American region.[9] In Ecuador, approximately 67% of all migrants lack regular migration status; 84% work in sectors that do not match their skills, experience, or qualifications; and 73% of Venezuelan migrant households report an average monthly per capita income of only US$86.[10] Also for this country, 27% of Venezuelan refugee and migrant respondents cite access to health services as their main need, while only 24% can afford health services.[11]

Ecuador has made efforts to uphold the rights of migrants in accordance with international and regional agreements, primarily through its legal framework, including the 2008 Constitution and the 2017 Organic Mobility Law.[12] For instance, Ecuador was the first Latin American country to incorporate the expanded refugee definition of the 1984 Cartagena Declaration into its national legislation.[13] Asylum seekers have 90 days to file a petition for refugee status once they arrive in the country. Moreover, Ecuador's Constitution guarantees access to care to all individuals regardless of immigration status.[14] Despite such protections, the reality on the ground is somewhat mixed. Recent research has found gaps in the implementation of the country's legal framework (from the national to the local levels) guaranteeing access to care for migrant populations.[15] Some patients have resorted to judicializing access to health care, including a Colombian refugee family in Ecuador (Constitutional Court case no. 983-18-JP/21, hereafter referred to as the *Ramirez* case).[16] According to the Ecuadorian Constitution, the right to health must be guaranteed by the state, and its realization is linked to the exercise of other rights, including the rights to water, food, education, physical culture, work, social security, a healthy environment, and others that support "good living" (*buen vivir* in Spanish) (art. 32).[17] Similarly, the Constitution mandates the health system with protecting and restoring people's capabilities for a healthy and integral life—both individually and collectively—and recognizing social and cultural diversity, in line with

the principles of inclusion, social equity, sufficiency, and interculturality (art. 358). The Constitution also states that the health system must ensure promotion, prevention, recovery, and rehabilitation at all levels (art. 359). However, there is evidence that the Ecuadorian government has systematically excluded civil society from decision-making processes, including in the health sector.[18]

Ecuador's health care system operates on constitutional principles that emphasize health as a fundamental human right.[19] Because less than 40% of the population is privately or publicly insured, approximately 60% of the population (including most migrants) depends on the Ministry of Health (MoH) network for free health services. However, the country has been experiencing a financial crisis since at least 2015, which has left the public system without the resources to provide needed services. As a result, out-of-pocket spending accounts for more than 32% of total health spending in Ecuador.[20] In addition, the public system prioritizes tertiary care, weakening the primary care network (whose gaps are expected to be filled by health personnel during their mandatory service year, particularly in rural and marginalized urban areas).[21]

Using a right to health approach (i.e., one seeking the highest attainable standard of health for all peoples), the purpose of our study was to examine how the Ecuadorian health system responds to the needs of distress migrants. To this end, we conducted interviews with government officials, health providers, and representatives of migrant, intergovernmental, and nongovernmental organizations and international cooperation agencies. Concurrently, we analyzed the *Ramirez* case, which prompted the MoH to make changes toward guaranteeing access to health care for all migrants in practice.

Methods

Analytical framework

The overarching framework of this study's parent project in the Andean region used a migrants' right to health framework, which guided the development of key informant questionnaires and the review of existing literature.[22] The right to health is a fundamental human right to "the enjoyment of the highest attainable standard of physical and mental health."[23] This includes respecting the principles of equality and nondiscrimination, which are essential to migrants' right to health. When access to health care is determined by legal status or when migrants are discriminated against in policy and practice, the right to health of migrants may not be realized.[24] Distress migrants often lack regular legal status, which puts them at greater risk of losing access to essential social determinants of health, thereby jeopardizing their right to health protection.[25]

For the present study, we used the Boli Peng and Li Ling framework to examine health services used by migrants.[26] This framework classifies migrants' determinants of health service utilization into three levels: (1) macro-structural or contextual factors, (2) characteristics of the health delivery system, and (3) characteristics of the population at risk. In our results section, we start from the micro (characteristics of the population at risk) and move to the macro (structural and contextual factors) to describe our findings.[27] Using a right to health lens, we analyzed the data at the three levels of the Peng and Ling framework.

Analytical sample

This study is part of a larger research project that examines the health of migrants in four Andean countries (Chile, Peru, Ecuador, and Colombia). Using interviews with key informants and documents from Ecuador's Constitutional Court, this study focuses on the right to health of distress migrants. The data collection process included 28 interviews with high- and mid-level decision makers from the national government and city governments and public sector medical practitioners from Tulcán and Lago Agrio (near the border with Colombia) and Huaquillas (near the border with Peru), as well as leaders of migrant groups and representatives of intergovernmental organizations, international cooperation agencies, and NGOs. The research team conducted a systematic mapping of informants by country borders, decision level and role, knowledge

of social service networks in border regions, and experience representing migrants through civil society associations. In addition, our study examined the *Ramirez* case and five associated documents describing the response of the MoH and other public institutions. The *Ramirez* case mandated the MoH to improve health services for all migrants.[28]

Content analysis. A thematic analysis, following Virginia Braun and Victoria Clarke's approach, was conducted using texts from transcribed interviews and documents related to the *Ramirez* case.[29] We systematically explored the content with specific key terms in Spanish, such as health, human rights, access to care, and health care provision. We also used terms consistent with the Constitution's emphasis on priority populations: child, boy, girl, adolescent, and family. Text segments containing the specified terms were extracted and assigned to thematic categories based on patterns identified using the analytical framework. The primary concepts were identified by recognizing recurring responses from the informants. Finally, informants' statements that encapsulated the dominant concept were highlighted.

Results

Characteristics of the population at risk

The informants agreed that the Venezuelan migrant population arrives in Ecuador in very poor health conditions due to the low level of health care in their country of origin and, subsequently, to the hardships of the extended migration journey under difficult conditions (including weather extremes and limited food and fresh water). They also highlighted that Venezuelan family members, from grandparents to young children, commonly migrate together. In their opinion, the hardships endured in their country of origin and during the journey, as well as mobilizing with women, children, adolescents, and senior citizens, increase the likelihood of being exposed to sexual and gender-based violence. In addition, respondents mentioned that most migrants are pregnant women, malnourished children, older adults with noncommunicable diseases without treatment, young people with psychoactive substance use disorders, and people with mental health issues.

> *The last waves of Venezuelans are people whose rights have been tremendously violated. They are very deprived in every way.* (civil society representative 1)

Another issue related to access to health care is the precarious economic situation of distress migrants. Although the right to health is guaranteed on paper in Ecuador, limitations in resources implicate high out-of-pocket spending (32.6% of all health expenditures), while most migrants cannot afford the cost of medicines, blood tests, specialized medicine, or even transportation to a health facility.[30] Finally, interviewees highlighted challenges in health care, such as migrants experiencing discrimination and a lack of sensitivity on the part of health care providers to recognize and respond to the specific needs and experiences of migrants.

> *You can train health workers, but if they do not have the sensitivity to put themselves in the other person's shoes and effectively recognize that this person … is a human being beyond* [their] *migratory status.* (international cooperation representative 2)

In the *Ramirez* case, a baby died 12 hours after birth due to a failure to transfer the patient to a higher level of care in the Ecuadorian health system. Following their request for a *tutela* (a constitutional injunction), the Constitutional Court ordered the MoH to issue a public apology, provide economic compensation to the family, and take steps to improve the delivery of care for migrant populations.

Characteristics of the health delivery system

Key informants, such as NGO workers and migrant leaders, agreed that primary care is a guaranteed right and should be free of charge. However, medical resources such as gloves, catheters, laboratory reagents, and drugs may become scarce in MoH facilities, meaning that many patients need to buy them themselves. Furthermore, there are limitations in access to specialized care, such as from a gynecologist or pediatrician; the public sector does

not have enough specialists to meet the demands of services from either the local or migrant population. These constraints have an impact on the quality of health services and are an obstacle to the right to health. NGO representatives mentioned that while emergency care may be guaranteed for migrants, there are times when health care workers discriminate against migrants based on their physical appearance or because migrants do not follow the "regular way" of making appointments. In other cases, health care workers do not provide services for the treatment of noncommunicable diseases because they do not trust migrants' declarations about their medical diagnoses and previously prescribed treatments. Finally, other services such as sexually transmitted disease screening programs, treatment for tuberculosis, and mental health consultations may not be provided because facilities do not have such capacity.

> *To get care, you have to make an appointment, unless it is an emergency. So, for example, we see that in many of the populations, especially those that are border crossers, migrants cannot schedule care because they are passing through [in transit]. So they need that care as soon as possible, and that has created a bit of a problem.* (intergovernmental organization representative 2)

Several interviewees mentioned that in some cases migrants find it difficult to access outpatient care because they are requested to provide an identification document even though there is no legal obligation to do so. Still, migrant leaders mention that they appreciate the health care services they receive because other countries in the region have more restrictions (eroding their right to health).

> *There is a lack of strength and resources. It is not that they do not want to take care of us, it is just that, for example, the hospitals do not have all the supplies and medicines that the specialists need to take care of our needs.* (civil society representative 5)

In response to the *Ramirez* case, the MoH was required to provide evidence of its ongoing progress toward disseminating the ruling among the health center staff in the areas responsible for providing urgent and emergency care to minors and pregnant women, and to issue a protocol for the health care of pregnant women and newborns within 120 days. In January 2022, the MoH reported that it had provided training in maternal and newborn care to 26,657 health professionals (nurses, general practitioners, and specialists). However, according to MoH data, the issue may lie not in the lack of training but in the short-staffed health facilities. In Ecuador, there are 1.35 obstetricians per 10,000 inhabitants and an estimated 23.44 physicians per 10,000 inhabitants.[31] This is a lower rate than in countries such as the United States (36.08), although similar to others in the region such as Brazil (21.42) and Colombia (24.51).[32]

MoH officials interviewed said that since 2018, the number of migrants has been growing at a faster rate, straining existing capacity, but that the government is working on improvements through increased cooperation between health institutions and NGOs, strengthening telemedicine, and opening specific health facilities at the border.

> *We want to strengthen telemedicine in Ecuador to avoid the barriers that sometimes exist in health facilities and to provide this option and avoid xenophobia.* (national government representative 1)

Migrant group leaders and NGO representatives mentioned that discrimination is a barrier to access, as locals' perception is that migrants take up their limited resources. Migrant leaders also report migrants experiencing rude behavior from doctors and nurses.

> *There is a perception among the local population that migrants take away their care and resources. But this is a general problem in Ecuador, which does not guarantee access to health care.* (civil society representative 3)

Discriminatory behavior was similarly addressed in the *Ramirez* case. As a result, the MoH developed a "Training Plan for Health Personnel of the MoH in Border Provinces" to build knowledge, skills, and behaviors contributing to a comprehensive health care based on theoretical and practical tools linked to the study of human rights and the human mo-

bility approach, with a target population of 9,780 health workers.[33]

Another barrier mentioned by informants is the difficulty in scheduling medical appointments, since this requires having a phone with prepaid airtime, internet capabilities and connection, or traveling to a different city to make an appointment in person—all options that most migrants cannot afford. In addition, communication about health services—especially information about the free availability of critical services such as vaccinations, prenatal checkups, and emergency care—is poor.

> *Currently, to get care, you must make an appointment, unless it is an emergency. So, for example, we see that in many of the populations, especially those who are crossing the border, people cannot schedule health care attention because they are crossing.* (intergovernmental organization representative 2)

Macro-structural and contextual factors

The Ecuadorian Constitution protects migrants, guaranteeing the right to equality and nondiscrimination (art. 11), the right to health (art. 32), the right to seek refuge (art. 41), the right to migrate (art. 40), and the right to humanitarian assistance (art. 42).[34] The relevance of constitutional protections was echoed in the interviews. Informants agreed that Ecuador has many laws that enshrine access to health care as a right for everyone in the country, regardless of nationality and migration status. Interviewees pointed to the Constitution, the Human Mobility Law, and programs and policies that acknowledge the importance of cultural-, mobility-, and gender-centered approaches when working with migrants.

National and local health authorities across the country agreed that the migrants should have the same rights as the local population, as guaranteed by the Constitution. Informants pointed out that, according to regulations, health services should be comprehensive (addressing issues such as health promotion, disease prevention, and sexual and reproductive health). However, some informants voiced the need for specific approaches to serve LGBTQIA+ people and pregnant women, and for specific recognition of the rights of children, adolescents, and older people among migrant populations.

> *We are trying to ensure that health, education, and other services are universal, regardless of whether you are Venezuelan, Colombian, or whatever, whether they have a valid identity document or not.* (local government representative 8)

Interviewees mentioned that in most cases, migrant populations are not aware that they can access health services for free, and thus there is a need for greater dissemination of information on the legal guarantees around accessing health care without restrictions within Ecuadorian borders. Distress migrants who may be familiar with the rules are often still afraid of being deported or imprisoned because of their irregular status, which prevents them from seeking care at public facilities. In addition, the primary care level may provide care without consideration for migration status or even the possession of an identity document; however, at the secondary and tertiary levels, the lack of any identity document or of a local identity document (which requires regular migration status) may become a barrier. For these reasons, informants noted that the active participation of the migrant community in health committees is essential to identify shortcomings and improve the public system. The regularization of migrants is seen as a method of expanding access to health care by facilitating the accurate identification of the health needs of this population, which can support better decision-making in the health care system.

> *Human mobility as a right should be worked on and policies should be changed because, although there is a Constitution that protects people in human mobility, the local policies are designed only for the local population.* (international NGO representative 2)

According to key informants, the right to health is similarly restricted due to the exclusion of migrants from policies such as disability certification, which is granted only to the local population, which has

exclusive access to subsidies with it. At the same time, several interviewees pointed out that some Ecuadorians believe that international organizations' focus on migrant populations is discriminatory against the host population and that the government's shifting of resources to give health coverage to migrants affects the right to health of the host population.

> *We would like for there to be a regulation to make the cooperation agencies take care of our nationals, because there is also extreme poverty, malnutrition, and people have learned that somehow there is more attention to the foreign population, and this triggers the social problem of discrimination.* (local government representative 8)

The *Ramirez* decision recognized the violation of several fundamental rights of the family, such as the right to health, the right to life, the right to migrate, the right to humanitarian assistance, the right to refuge, the right to a family, and the principle of equality and nondiscrimination based on ethnicity, place of birth, age, sex, and gender identity. In addition, the court stated that the MoH must establish a protocol to ensure that a similar situation does not take place again and must issue a public apology for failing to respond to the needs of the baby.[35]

Discussion

Using a right to health approach, our study drew on interviews with key informants and an analysis of the *Ramirez* case to examine how the Ecuadorian health system responds to the needs of distress migrants. Our findings show that access to health care for distress migrants in Ecuador depends on a complex interplay of legal protections, delivery system challenges, and specific vulnerabilities. While the country's legal framework promises extensive protections of the right to health of migrants, including access to health care, the translation of these rights into effective practice remains uneven, signaling gaps in the availability, accessibility, and quality of health services for distress migrants. Interviewees highlighted several challenges, such as migrants experiencing discrimination and a lack of sensitivity of the health care system to recognize and respond to their specific needs and experiences. Challenges in health care delivery, such as limited resources and specialized care, exacerbate the difficulties faced by migrants, who often arrive in poor health. Moreover, interviewees mentioned that in some cases migrants are requested to provide an identification document even though there is no legal obligation to do so.

Similar to several other Latin American countries, universal access to public health care services is legally guaranteed in Ecuador, regardless of nationality. However, in many countries in the region, migrants face challenges in accessing care, as well as limits in the kinds of services they can access. For instance, migrants may not have the necessary information on how to access health services or the necessary resources to buy medicines or to travel to a health facility. In countries such as Colombia and Peru, these types of complaints from migrants have also been documented.[36]

In our findings, there was consistent testimony from interviewees that the health of Venezuelan distress migrants arriving to Ecuador is significantly compromised. This may be due to a combination of factors, including poor health care services in their country of origin and the harsh conditions of the migrant journey, resulting in neglected chronic diseases and an increase in infectious diseases.[37] Similar findings have been described in Mexico, where one of the difficulties in addressing the health of migrants is the poor health conditions in which they arrive.[38] Among the Venezuelan population in particular, an increase in infectious diseases such as measles, malaria, and HIV has been documented on the Colombian-Venezuelan and Brazilian-Venezuelan borders.[39]

It is important to note that care for irregular migrants in Ecuador is limited to the public health system, since the social security system does not cover migrants without documentation and stable employment. Health care for the uninsured, under the MoH's responsibility, has limited resources and must strike a balance between not neglecting the local population and providing care to Venezuelan migrants. The limited resources available in the

public sector often result in patients paying out of pocket for services and medicines; further, a tertiary care focus erodes the capacity of primary care services to prevent disease and promote health. These conditions affect the most vulnerable Ecuadorian and migrant populations who cannot afford private services or secure medical appointments in the public system and who lack access to regular and quality preventive care services at free-of-cost facilities.[40]

Our study shows that discrimination and xenophobia are important barriers to accessing health services; this paper documents the discrimination against migrants in Ecuador, with health workers expressing negative views about migrants, while the local population is critical of the assistance provided by NGOs to migrant populations, which is not extended in the same way to them. Similarly, in countries such as Colombia, xenophobic attitudes toward low-income Venezuelans entering the country have been reported, and in Peru, higher levels of xenophobia toward Venezuelan migrant women have been documented.[41] It is worth mentioning that this phenomenon is not unique to health care. There are cases in which even government officials engage in discriminatory statements or practices. For example, in 2018, the Ecuadorian president made stigmatizing statements toward Venezuelans, blaming them for the increase in violence in the country and creating barriers for Venezuelans entering Ecuador, such as criminal record checks.[42] In April 2024, political disagreements between Ecuador and Venezuela escalated, leading to the closing of the Venezuelan embassy in Quito, further limiting consular support for Venezuelan migrants in the country.[43] All of these reinforce stigma against such migrants and in some ways may encourage discriminatory practices.

Furthermore, there is a need for comprehensive sexual and reproductive health care with a gender-sensitive approach that also recognizes the LGBTQIA+ population, as stressed by the interviewees. The continued lack of investment in and implementation of a gender-centered response can lead to the invisibility of distress migrant women's needs; sexual violence during migration and due to migrant status; and the exacerbation of the gender gap in the host population, as outlined in a recent International Organization for Migration and MoH report on sexual health and violence.[44]

Our research also evaluated the *Ramirez* case, in which Ecuador's Constitutional Court recognized the violation of several of the family's fundamental rights, such as the rights to life, health, equality, migration, and a family.[45] The Ramirez family had prior knowledge of the *tutela* mechanism in Colombia, where they had filed a *tutela* with the Unit for the Comprehensive Care and Reparation for Victims, a national entity under the Colombian executive branch. Leveraging this experience, the family found a way to defend their rights in Ecuador, which led to the first Constitutional Court sentence recognizing the right to health care for a migrant family in the country. This case marks a significant development in Ecuador, where the judiciary intervened in executive functions to ensure access to health care (similar to what is happening in Colombia, where fundamental rights such as health enshrined in the Constitution are enforced through the remedy of protection). The *Ramirez* case successfully applied existing legal frameworks and set a precedent that (as ordered by the court) applies to all migrant families.

This practice of filing a *tutela* to claim the right to health has been referred to in the literature as the "judicialization of health"—that is, the use of rights-based litigation to demand access to health care services.[46] While relatively rare in Ecuador, it is a more common phenomenon in other countries in the region, such as Colombia, Uruguay, Brazil, Argentina, and Costa Rica.[47] For instance, in Colombia, between January and September 2022, 109,825 *tutelas* related to the right to health were registered.[48] While *tutelas* can be an important instrument to protect the right to health, some argue their use can be counterproductive, running the risk of interfering with medical decisions, threatening the economic sustainability of the health system, and exacerbating inequities.[49] It has also been argued that the judicialization of health care can undermine efforts to expand coverage.[50] Others argue that litigation has helped fill "regulatory

compliance gaps" and bring down the prices of services and medications.[51] To our knowledge, the *Ramirez* case is the first "migrant/refugee health" case to date that the Ecuadorian Constitutional Court has selected for review to establish binding case law. This precedent-setting decision is significant for legal advocates seeking to defend migrant health rights in *tutela* proceedings before lower courts. However, the aforementioned criticisms to judicialization remain relevant. Four other Constitutional Court cases have addressed the right to access essential medicines for the treatment of HIV/AIDS and Laron syndrome.[52] Given the universal scope of the right to health in Ecuador, these cases are relevant for identifying roadmaps for services that should be extended to both migrant and local populations.

Similarly, the Constitutional Court underscored the need for the MoH to report on health and human resources providing maternal and perinatal care. In 2022, the MoH reported that there were 26,657 health care workers in the public sector (including the social security system) providing maternal and perinatal health services.[53] However, this figure is equivalent to 52% of the medical and nursing staff in the public network, which in 2020 included 29,586 doctors and 21,905 nurses.[54] Therefore, there is a discrepancy between the report and the reality of MoH, pointing to the limitations in capacity to effectively provide access to free, essential health services. These gaps could lead to fatal outcomes, as evidenced in the case of the refugee family.

Several limitations of our study must be acknowledged. First, the key informants were selected from people who agreed to participate in the study and may have specific interests that we did not identify. Second, although the judicialization of health emerged as an issue in the interviews, our interview guide did not include questions on the topic that would allow us to draw conclusions about the informants' related perceptions and opinions. Third, our qualitative analysis is susceptible to researcher bias, as the interpretation and coding of data are influenced by our preconceptions and perspectives. Fourth, while we interviewed informants working in the health system, government, international cooperation agencies, and representatives of migrant associations, we did not interview distress migrants directly. Fifth, future research could benefit from utilizing other right to health frameworks, such as the "availability, accessibility, acceptability, and quality" framework (the AAAQ framework), to evaluate the fulfillment of distress migrants' right to health in Ecuador and elsewhere in the region.[55]

Conclusion

Distress migrants escape from structural inequality and vulnerability that impede people's ability to fully enjoy their right to health. Once they arrive in their host country, they are often excluded from obtaining refugee or other forms of legal status that could allow them access to health care (but even then, it is not guaranteed, as depicted by the *Ramirez* case). Access to quality health services by migrant populations in Ecuador is significantly limited because the health system is not prepared to meet the needs of migrants. These challenges are exacerbated by low incomes among distress migrants, as well as family migration. Even though the Constitution protects the right to health of both migrants and Ecuadorians, the former face additional obstacles in the ability to make appointments, use regular health services, and purchase medicines and medical supplies. Also, distress migrants commonly lack documentation that may be demanded by health providers to provide care, even when such documentation is not required by law, thus constituting discrimination. There is evidence of difficulties in service provision due to limited coverage by the public health care system and a lack of medicines and other supplies, which implies the need for patients to make out-of-pocket payments. Finally, local populations may see migrants as competition for aid from the government and other organizations, which prevents them from supporting actions to protect migrants' right to health.

The *Ramirez* case and the ensuing responses by public health officials highlight the potential (yet not fully realized) role of the judiciary in ensuring compliance toward protecting distress migrants'

right to health. Concurrently, the judicialization of health access may not be able to address most challenges or to correct instances of discrimination. Overall, key informants agreed in their assessment of the health system and the needs of migrant populations. Among the challenges they identified are the resource limitations of the government to provide health care for the uninsured and discrimination against migrants. Nevertheless, there are potential pathways to health care access via social and nongovernmental organizations. Whether the public or the private health sector can provide adequate access, however, will depend on the promotion of a more inclusive and culturally sensitive approach to health care provision—one that acknowledges and responds to the specific experiences and needs of migrant populations.

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Ethics approval

Ethics committee approval (2022-048E) was obtained from the Institutional Review Board of the Universidad San Francisco de Quito in Ecuador.

Translation

All translations from Spanish to English were performed by the authors.

Consent for publication

All participants were adults (18 years of age or older); they participated anonymously and provided verbal consent after being informed in writing of the study's objectives, methods, and potential use. Documents related to Sentence 983-18-JP/21 of the Constitutional Court of Ecuador are publicly available at https://portal.corteconstitucional.gob.ec/FichaRelatoria.aspx?numdocumento=983-18-JP/21.

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