Duazary / Vol. 20, No. 3 – 2023 / 164 - 174
DOI: https://doi.org/10.21676/2389783X.5199

Article of scientific and technological research

Social determination of health in access to vaccination: a qualitative study in Colombian migrants

Determinación social de la salud en el acceso a vacunación: un estudio cualitativo en migrantes colombianos

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How to cite this article: Sotelo-Daza J, Herrera-Zuleta IA. Determinación social de la salud en el acceso a vacunación: un estudio cualitativo en migrantes colombianos. Duazary. 2023;20(3):164-174. https://doi.org/10.21676/2389783X.5199

Received on May 03, 2023
Accepted on September 15, 2023
Posted online September 25, 2023

ABSTRACT

Introduction: Vaccination represent a cost-effective strategy in public health, however, access in migrant population continues to be a persistent problem and limitedly understood from its social nature. **Objective:** To understand from the social determinants of health (SDH) the dynamics of access to vaccination in migrant children under five years of age in Popayán, Colombia. **Method:** Qualitative, ethnographic study. It used semi-structured interviews, focus groups and field diaries in 19 caregivers of children susceptible to vaccination. The SDH approach was used to understand the phenomenon as a social process from singular, particular and general domains. **Results:** Where children live, there are precarious conditions that limit access to vaccination. Lifestyles are determined by sociocultural, political, economic and health system dynamics. From the point of view of lifestyles, vaccination is considered a protective activity for health. Good care, free of charge, proximity to hospitals, good information, affiliation to the health system and the absence of queues favor vaccination. **Conclusions:** Access to vaccination in children with migratory status is determined by sociocultural, political and economic aspects. The SDH approach broadens the understanding of public health phenomena from their social reality.

Keywords: Social determinants of health; Immunization program; Access to health services; Internal migration.

RESUMEN

Introducción: la vacunación representa una estrategia costo-efectiva en salud pública, sin embargo, el acceso en población migrante continúa siendo un problema persistente y limitadamente comprendido desde su naturaleza social. **Objetivo:** comprender desde la determinación social de la salud (DSS) las dinámicas del acceso a vacunación en niños migrantes menores de cinco años en Popayán Colombia. **Método:** estudio cualitativo, etnográfico. Se utilizaron entrevistas semiestructuradas, grupos focales y diarios de campo en 19 cuidadores de niños susceptibles de vacunación. Se asumió el enfoque de la DSS para comprender el fenómeno como un proceso social a partir de dominios singular, particular y general. **Resultados:** existen condiciones precarias donde habitan los niños, que limitan el acceso a vacunación. Los modos de vida están determinados por dinámicas socioculturales, políticas, económicas y del sistema sanitario. Desde los estilos de vida, la vacunación se considera una actividad protectora para la salud. La buena atención, gratuidad, cercanía a hospitales, buena información, afiliación al sistema sanitario y la ausencia de filas, favorecen la vacunación. **Conclusiones:** el acceso a la vacunación en niños en condición migratoria está determinado por aspectos socioculturales, políticos y económicos. El enfoque de DSS amplía la comprensión de los fenómenos en salud pública desde su realidad social

Palabras clave: determinación social de la salud; programa de inmunizaciones; acceso a servicios de salud; migración interna.

INTRODUCTION

Vaccination is the best tool for preventing vaccine-preventable diseases, significantly impacting the reduction and control of childhood infectious diseases[1]; it also plays an essential role in promoting health equity[2]. Between 2006 and 2011, thanks to the vaccination of children under five years of age, approximately 174,000 deaths were avoided in Latin America and the Caribbean[3]. Based on these achievements, the World Health Organization (WHO) designated 2010 to 2020 as the "Decade of Vaccines" in recognition of the outstanding advances; however, the established global goals were not achieved[4].

The WHO has recognized that currently, five of the ten main threats to global health correspond to diseases that can be prevented by vaccination. These diseases include pandemic influenza, diphtheria, meningitis, yellow fever, and cholera[5]. In addition, there is growing global concern due to the risk posed by the re-emergence of vaccine-preventable diseases. An example of this is what happened in 2016, when several measles events were reported in 11 countries in America, with a total of 5,004 confirmed cases and 68 deaths. It is essential to highlight that the first 55 cases occurred in the migrant population[6].

In Colombia, vaccination coverage close to 90% has been achieved[7]. However, achieving immunization in the entire susceptible population constitutes a constant challenge for the country's public health[8], considering the characteristics and dynamics of the populations that have a significant impact on access and care in the system. health[9]. A clear example of this is the populations that live in contexts of social inequality, in which various barriers that limit access to health care services have been documented[10]. These barriers include lack of familiarity with the health system[11], culturally inappropriate care, religious considerations[10], lack of knowledge of rights[12], health system barriers[13], low educational levels, origin, age, marital status, occupation, geographic accessibility, opening hours, and unfavorable attitude of health personnel[14].

In addition to the barriers mentioned above, it is essential to highlight that disparities in access to vaccination are accentuated to a greater extent in populations in migration situations[15], where vaccine coverage is usually lower[16]. Similarly, when analyzing the level of health, differences have also been observed that affect the migrant population compared to the non-migrant population[12].

The effects on access to vaccination vary according to places, contexts, and the sociocultural dynamics of the populations[17]. Therefore, it is essential to understand the contextual determinants influencing the vaccination process, especially for local communities in vulnerable situations, such as the migrant population[18]. It is important to note that this topic of interest in public health has been addressed in a limited way from qualitative perspectives in Latin America[8]. Therefore, it is essential for health research to recognize both individual and collective influences that can strengthen actions in the field of public and community health. This will allow the development of effective strategies to overcome barriers in the vaccination process[19].

The social determination of health refers to thinking about the health-illness-care process (HICP) from a critical logic. This approach challenges the positivist paradigm and seeks to eliminate the boundaries between biological and social aspects, as well as understand the relationship between nature and society[20].

The central element in this perspective is related to the subsumption of the biological into the social, and health and illness are processes shaped by the sociohistorical process in which they occur[21].

In the analyses that conceive the social determination of health, economic, political, environmental, social, and cultural aspects influence the distribution of the disease and mortality process. These aspects are related to the living conditions and material circumstances in which people carry out their daily lives. These conditions are mediated by social reproduction[22], which leads to understanding health as a dialectical process in which power relations, capital accumulation, consumption, and work patterns intervene.

The social determination of health focuses on understanding how communities assume social representations and responses to face the challenges that arise as sociohistorical facts. In this sense, the approach addresses three domains of reality[21], where multiple interrelationships are carried out: general, particular, and singular. In the general domain, the relationships of the PSEA are analyzed according to

the historical and political moment, the economic processes, and the social environment in which they develop. In this particular domain, the variations in the health-disease profile are explored depending on the social stratification of population groups. Here, factors and processes are identified that can protect and harm health that operate in individual lifestyles and lifestyles that are susceptible to modification. In the singular domain, reference is made to forms of organization, individual behaviors, and exposures to risk factors. It is recognized that social and biological processes are subsumed in producing health or disease.

Understanding the dynamics of access to vaccination in the migrant population alludes to a fundamental input for decision-makers, health policymakers, and health care providers[23]. In this way, the objective of this research was to understand from the social determination of health the dynamics of access to vaccination in migrant children under five years of age in Popayán, Colombia.

METHOD

Kind of investigation

A qualitative study with an ethnographic approach[24] allows describing interpretations of people to reveal meaning structures with which they act in different everyday scenarios[25] through a description of the phenomena, which are a portrait of the facts to make interpretations of cultural dynamics.

Participants

The study population was fathers, mothers, or caregivers of children under five years of age from Popayán in internal migration status (Colombian displaced for different reasons), susceptible to vaccination according to the expanded immunization program. Purposive or purposive sampling was used[26]. The inclusion criteria were being a Colombian internal migrant, residing in the municipality of Popayán (for more than a year), and being a caregiver for a child under five—exclusion criteria: being an international migrant. The decision was not to incorporate more participants into the study, as redundant data were found[27].

Information collection techniques

A semi-structured interview incorporated sociodemographic data, conditions and lifestyles, social organization, family socioeconomic structure, availability of public services, production space, and workplace. A second interview was carried out with the focus group, through which dynamics of community organization, employment, knowledge and attitudes towards immunization, migration, preventive practices, ethnicity, and gender were investigated. The information is complemented with the field diary in which relevant elements were linked to the extent of contact with the territories and people.

Procedures and information collection

The immersion in the scenarios where the migrant population lives took place between May and November 2021. Nineteen semi-structured interviews and three focus groups were carried out. Participants were contacted directly in low-complexity hospitals (vaccination centers) and their homes. The people freely agreed to participate in the study and expressed their endorsement through informed consent, which they read and signed. The interviews, as well as the focus groups, were recorded and subsequently transcribed into Microsoft Word. Then, conceptually recover the knowledge and practices [28] related to access to vaccination. The information collected was processed in Atlas Ti version 8.1. Categories were coded according to a coding manual, and thematic analyses and matrices were carried out that facilitated cross-sectional comparison of the data.

Analysis

The research incorporated the analytical categories of the social determination of health proposed by Breilh[20]. These categories allow the understanding of health and illness as a dialectical process, where individual and collective health are linked in a complementary way. Different domains and dimensions of analysis were addressed, including singular, particular, and general elements. These elements refer to how people interact in their daily lives in a social context that influences the lifestyles of different population groups. These lifestyles, in turn, have an impact on people's health.

Breilh[20] focuses his analysis on the processes of social organization and the socioeconomic structures where group identities are structured. In the analysis of these dimensions, spaces of social reproduction are incorporated that contribute to the construction of the identity of a community and the generation of links between its members. These social ties generate interactions that involve power relations, which, in turn, have a significant impact on the production of health outcomes or the emergence of unfavorable health conditions in the community.

To understand the phenomenon studied, predefined analytical categories of the general, particular, and singular domains were defined[21]. These categories included living conditions, productive social forces, ways of life, community identity, and lifestyles. As the stories and data collected were analyzed, subcategories emerged that complemented the understanding of the phenomenon. Subcategories were incorporated into the three domains of social determination of health. Category comparison processes were carried out following methodological rigor techniques for qualitative studies[27].

The concept of health disease was assumed as a socially and historically determined process, from the perspective of Latin American critical epidemiology. This approach is based on three dimensions: social reproduction, society-nature metabolism, and social determination[22].

These dimensions are interrelated and encompass different components in the general, particular, and singular domains[21]. The starting point was the premise that the vaccination program does not respond to an action restricted to individuals but instead involves complex interactions between different social aspects and processes on which public health must be thought.

By addressing the social determination of health from qualitative research, it is possible to enrich the understanding of the complexity of health and disease phenomena. In doing so, categories are revealed beyond the limits of the positivist paradigm, which results in a strengthening of political action from various scenarios, including academia and social movements, in order to strengthen the fight against fragmentation, inequality, and inequality.

Statement on ethical aspects

The research considered the guidelines of the Declaration of Helsinki[29]. It was approved by the ethics committee of the Universidad del Cauca according to Minutes Number 6.1-1.25/53 of June 30, 2020, who considered it to be of minimal risk according to Resolution 8430 of 1993[30]. Under the principle of confidentiality, in order to protect the privacy of the participants and safeguard the information in the execution of the study, they were assigned an alphanumeric code for their identification and differentiation from the conduct of the interviews and focus groups, until the information processing and analysis stage according to the following structure: SSA: active social subject; 1003: interview number; 25A: age in years; Fem or Mas: gender).

RESULTS

Nineteen caregivers of children under five years of age who were in internal migration and resided in Popayán, Colombia, were linked to the study (Table 1).

Next, the research results are described, following the structure proposed by Breilh[20], which covers the general and singular domains of the social determination of health.

Access to vaccination from the general domain

Regarding the category of living conditions, the people who participated in the study expressed that, despite belonging to populations in vulnerable situations and being protected by

The State, through public policies aimed at migrants, still experiences restrictions in guaranteeing their rights in access to housing, health, education, and the labor market. In this domain, a subcategory related to low income emerges, which limits the possibilities of satisfying the basic needs of both individuals and their families. Many of these families have limited access to formal jobs and depend mainly on jobs in the domestic sector, construction, "motorcycle taxis," and assistance with auto mechanics to obtain resources.

Table 1. Characterization of the participants.

No.	Age (years)	Gender	Income	Civil status	Education level	Occupation
1	32	Female	1	Single	Secondary	Saleswoman
2	24	Female	1	Free Union	Secondary	cook
3	27	Female	2	Married	Technical	Motorcycle taxi driver
4	19	Female	1	Separate	Secondary	Domestic works
5	28	Male	1	Married	Primary	Motorcycle taxi driver
6	41	Female	1	Widower	Primary	construction worker
7	3. 4	Female	2	Single	Secondary	Businessman
8	25	Female	1	Single	Primary	Domestic works
9	22	Male	1	Free Union	Secondary	Driver
10	36	Female	1	Widower	Primary	Automotive mechanic
11	25	Female	2	Single	Technical	Domestic works
12	29	Female	1	Married	Secondary	General services
13	37	Male	1	Free Union	Secondary	Construction worker
14	27	Female	1	Married	Primary	Domestic works
15	20	Male	1	Free Union	Secondary	Construction worker
16	26	Female	2	Single	Secondary	Various trades
17	30	Male	1	Single	Secondary	Automotive mechanic
18	26	Female	1	Married	Technical	General services
19	29	Male	3	Free Union	Secondary	Automotive mechanic

"[…] *what you work at is difficult, that is not enough for you at all, and everything is expensive… the Government should give you what you need as a displaced person because it is challenging to have small children…" (SSA* 1003-25A -Fem).

These types of occupations are related to the social forces that define precarious jobs, initially intended for people with technical profiles but which are now assumed mainly by migrants. This has a negative impact on the living conditions of migrants due to the low income they receive, widening the gap in access to health services, education, and economic resources. Along the same lines, low education emerges as a subcategory, a common condition in the study participants. This low education limits their opportunities to access jobs that allow them to satisfy their basic needs.

"[…] *my parents could not afford to get me to study… I only did up to fifth grade, and with that, they do not give you a good job, you have to do whatever it takes…" (SSA* 1007-23A-Fem).

Study participants considered vaccination a traditional practice to prevent infectious diseases rooted in culture, as an aspect contributing to childcare. This cultural subcategory favors access to vaccination.

"[…] *they had me vaccinated when I was a child, and I have my children vaccinated because it helps keep them healthy… we have always believed that vaccines are good…*" (SSA 1009-24A-Fem).

Supported by field diaries, it was possible to observe various characteristics of the places where people

reside, as well as the dynamics surrounding care in vaccination services. The places where people live have limitations in terms of basic sanitation, access to drinking water, and waste management. Study participants perceive these conditions as a risk to children's health since they can lead to the appearance of diseases. Most migrants reside in settlements with unstable soils, homes built with low-quality materials, and unpaved streets. Through the participants' stories, a subcategory stands out that refers to an adverse environment in which children reside. This situation, to a certain extent, makes access to vaccination services complex, primarily due to the limited presence of government institutions in the area. These aspects are considered determinants of access to vaccination from a social perspective.

"[…] *living here is hard, look at this house one has to struggle to get water to drink or cook, those hoses are for water that comes from the stream…*" (SSA 1017-29A-Fem).

The main reason for the displaced population to migrate to Popayán is the armed conflict that prevails in their territories of origin due to political, military, and economic confrontations. This situation forces them to abandon their place of origin. This subcategory emerges from the reports as one of the aspects that generate interruption in the continuity and compliance of vaccination schedules in children.

"[…] *we left the town because there were guerrilla takeovers all the time and they threatened us, the best thing was to come here, but here it is tough to survive, in the city things are more difficult…* and vaccination is screwed up…" (SSA 1019-36A-Fem).

Access to vaccination from the private domain

In this domain, in the category of lifestyles, a subcategory arises related to care for children in health services. Although, in most cases, access to these services is fluid, challenges arise related to bureaucracy and verification of affiliation to the health system, which can limit vaccination due to long waits, billing of activities, and service congestion. Additionally, at some vaccination posts, participants described situations in which they could not access vaccination due to shortages of supplies and vaccines, as well as poor care.

"[…] *there they take a long time to attend to him, they do not have databases of displaced people, and they do not find him quickly, and they cause problems, they turn him away if he does not have a card…" (SSA 1005-30A-Mas*).

Affiliation with the health system (or insurance) restricts access to vaccination for study participants when they are not affiliated. This is due to the perception that they are from another municipality or territory; the vaccination service cannot be guaranteed in Popayán.

"[…] *my children were not vaccinated because they did not have a card, they said they were from another municipality, and that could not be attended to here*…" (SSA 1001-27A-Fem).

Taking care of children falls mainly on women heads of households, who must balance their work and the responsibility of ensuring family well-being. This situation arises due to several circumstances, among which is the loss of their husbands due to the armed conflict. This situation has led these women to migrate to rebuild their lives elsewhere. However, work schedules do not allow them to attend the vaccination service on time, which has led to the postponement of appointments.

"[…] *I leave work at six in the afternoon, and at that time no vaccination post is open, it is difficult for me to go during the day*…" (SSA 1014-24A-Fem).

In relation to community identity, migrants expressed that social and community organizations exercise weak action in supporting access to vaccination. There needs to be more communication between people, and due to migration, relationships between neighbors and community leaders have been weakened. Furthermore, vaccination of children is not considered a priority in community meetings, where other topics related to different diseases are discussed.

"[…] *here in this neighborhood, there is no community leader to help us with vaccination, that is not discussed in the meetings, and they talk about other things, but little is said about the vaccination of children…" (SSA* 1009-27A -Fem).

A relevant aspect that emerges from the participants' stories is the inclusion of children in the educational system, which serves as a favorable environment for

vaccination. The health system and the education system work together to ensure that vaccination schedules are adequate. However, migrant children are often forced to interrupt their studies due to constant mobility between territories, resulting in a loss of continuity of vaccination.

"[…] *at school they help a lot to vaccinate the children, the doctors go there to vaccinate them, but imagine one with these little children from one place to another… that is complicated* … they cannot study well…" (SSA 1011-36A- Fem).

According to the interviewees, perceptions about community dynamics, the institutional framework, and family typology act as hostile local social forces that limit access to vaccination.

Access to vaccination from the singular domain

Within the scope of the lifestyle category, participants highlighted the importance of vaccines as a fundamental tool to prevent diseases in children. Therefore, they feel the need to go to hospitals to ensure that their children receive the necessary vaccines.

"[…] *they prevent many diseases, those viruses that are happening now, the vaccines help them to have more strength so that the children can go through their stages well…*" (SSA 1004-37A-Mas).

In family dynamics, members agree on activities to take children to be vaccinated. They establish the daytime and organize the necessary transportation to access the vaccination service. Many of the interviewees have vaccination cards in which the immunobiological application is recorded; however, the interpretation of this card can be complicated, and they often require the assistance of a technician or health professional to understand the situation of fully vaccination their children.

"[…] *we take the children on the day they were given the appointment, and we attend for the vaccine, the mother always takes it or sometimes the uncle*…" (SSA 1008-29A-Mas).

Deciding to vaccinate children is influenced by several factors. These include the belief in the effectiveness of vaccination to prevent diseases, the service being free, having a nearby vaccination center, not having to wait long, availability of clear and accurate information, and the experience of receiving friendly attention from part of the health personnel.

"[…] *of course, I believe in vaccines so that my children do not get sick… hospitals should treat them well, the other day I went, and they treated me poorly, they almost did not vaccinate my child… I stood in a long line to check in and that it was just a vaccine* …" (SSA 1013-27A-Fem).

The age of the children at the time of accessing vaccination emerged as a relevant subcategory in the participants' reports. It was observed that several children did not receive vaccines at the recommended ages, which resulted in the impossibility of providing them with adequate protection against morbid agents. This delay in vaccination is due to the delay in attending the consultation by parents, caregivers, or the vaccination center.

"[…] *we took the girl late, and they did not give her any vaccines, they told us that they could not be given because she was already big and that worried me a lot*…" (SSA 1015-26A-Fem).

According to the study participants, a lack of information was identified about the vaccines, the necessary doses, and the administrative procedures to access the vaccination service. Those who had more children and previous experiences with immunization processes found the vaccination process easier.

Regarding gender, women showed greater involvement and knowledge about vaccines and were generally the ones who took children to the vaccination service. When questioning some male participants, they recognized that women had more excellent knowledge about the topic of vaccination and that they had less familiarity with these issues.

"[…] *the mother is in charge of the vaccines, I do not know anything about that; she has always taken him to the health post*…" (SSA 1007-28A-Mas).

DISCUSSION

The research describes elements related to access to vaccination in the migrant population. It recognizes

that achieving this access and achieving adequate coverage depends on a series of factors of a social, cultural, political, and economic nature. These aspects are framed in a complex historical context where various social forces interact to influence the determination of health. The findings of this study are consistent with previous research conducted by Arsenault *et al*[9] and Doornekamp *et al*[10,] who also explored the determinants of vaccination.

The study's findings reveal that the structural conditions of life, such as economic and political aspects, are linked to people's behaviors. These individuals are influenced by social forces that determine life plans and influence access to vaccination. Previous studies by Narváez *et al*[7] and Byrne *et al*[31] support these findings by highlighting that deprivation, including poverty, lack of adequate housing, and low literacy[32], negatively impacts access to vaccination. Likewise, Obrist *et al*[18] and Letley *et al*[33] highlight the psychological, social, contextual, and administrative obstacles in the health system that also hinder access to vaccines.

Living conditions in the context of migration are socially stigmatized due to the armed conflict and the history of violence in the migrants' place of origin. These findings are consistent with what was described by Escobar-Díaz *et al*[8] in their study on reasons for non-vaccination in children under five years of age in Colombia.

According to the participants' opinions, there is a negative perception of the limited compliance of national and local governments regarding their responsibility to protect people's rights, particularly in public health. This perception resembles what Knights *et al*[34] found in their research, which described a lack of trust in the health system and health policies.

Acceptance and access to vaccination by participants refer to living conditions where cultural influence favors the purpose of the health system to achieve helpful coverage. These findings coincide with Solís-Lino *et al*[16] and the WHO[17] in research related to sociocultural aspects of vaccination.

From a lifestyle point of view, administrative limitations are evident in childcare since the vaccination program tends to assign a significant part of the management (administrative procedures) to parents or caregivers to achieve access. Similarly, if the local government does not guarantee children's affiliation with the health system through insurance, limitations may arise in accessing health services. These findings are in line with the results reported by Ruiz-Rodríguez *et al*[35] in their analysis of coverage in the displaced population, as well as with the findings of Carrasco-Sanz *et al*[13] in their research on health problems, the needs of care, and inequalities of migrant children.

On the other hand, individual behavior, free availability, and the availability of vaccination centers facilitate access, as Kusuma *et al*[11] and Habersaa et al[36] in their studies on the analysis of access to vaccination.

According to the study participants, a limited expression of community identity is observed in the vaccination process. One of the main factors that contribute to this situation is the constant mobility of people in the neighborhoods and settlements where they reside. This mobility makes it difficult to monitor the children and the work of community leaders. On the contrary, research carried out by Buttle *et al*[19] and Letley *et al*[33] have found that community support from leaders strengthens access to vaccination.

Regarding lifestyles, participants consider that vaccines promote children's health. For this reason, they manage processes to access the vaccination service. However, if they encounter restrictions from the health system, vaccination may be compromised. These restrictions may be due to inadequate care by health personnel, as pointed out by Solís-Lino *et al*[16]; or inadequate information for vaccination, similar to what Doornekamp described *et al*[10]. In addition, there may be delays in the provision of services and shortages of supplies, categories that coincide with what is described by the WHO[17] in the study on the prevention and response to shortages of vaccine supplies.

It is essential to highlight the fundamental role that women play in child health care, particularly concerning vaccination. It is women who, for the most part, assume the primary responsibility for managing immunization activities, which not only contributes to feminizing the process but also accentuates gender-social differences in this context. This observation coincides with the findings of studies conducted by Arsenault *et al*[9] and Oztas *et al*[37] on implementing effective vaccination strategies.

Understanding access to vaccination from the perspective of the social determination of health is essential to managing and defining comprehensive strategies that involve various social actors. This involves adopting a collective approach to public health with the aim of overcoming the limitations of the health system through an organized socio-political response. In the study of this phenomenon, it is crucial to understand the perceptions of the participants and their context. To achieve this understanding, it is essential to strengthen public health actions, especially regarding primary care and health promotion. These are elements of great relevance that have been highlighted in the reform processes of the health system in Colombia as fundamental pillars to guarantee access, continuity, and the right to health, in addition to promoting equity, especially in a system where Economic and financial considerations often prevail over a health process focused on the needs of individuals, families, and communities.

The implementation of these actions can allow the creation of responses at the local level that take into account the particularities of the social group in question. This can be achieved through intersectoral action, reorientation of health services, and community participation.

CONCLUSIONS

Sociocultural, political, and economic aspects influence access to vaccination in children in migration. The social determination of the health approach expands the understanding of public health phenomena from their social reality.

ACKNOWLEDGEMENT

The authors thank the Universidad del Cauca for allocating the time to conduct the research.

STATEMENT ON CONFLICTS OF INTEREST

The authors declare that does not exist an interest conflict.

CONTRIBUTION OF THE AUTHORS

The first author contributed to the conceptualization and design of the study, data collection, qualitative analysis, bibliographic review, writing, and final approval of the manuscript.
The second author made the bibliographic review, data collection, qualitative analysis, writing, and final approval of the manuscript.

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