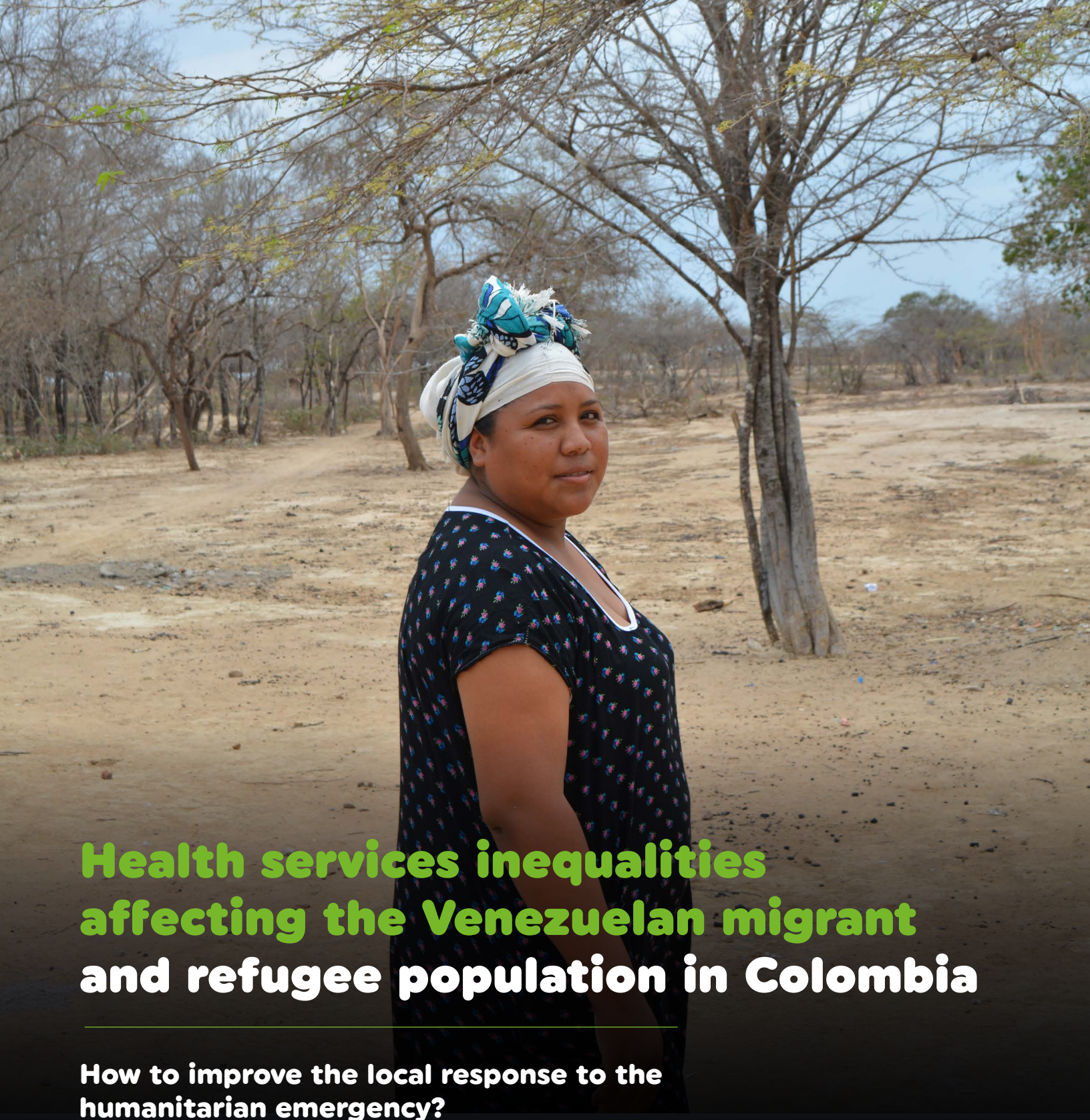

Health services inequalities affecting the Venezuelan migrant and refugee population in Colombia

How to improve the local response to the humanitarian emergency?

USAID
FROM THE AMERICAN PEOPLE

Profamilia

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How to improve the local response to the humanitarian emergency?

Bogotá D.C., Barranquilla, Cartagena,
Cúcuta, Riohacha y Santa Marta

USAID
FROM THE AMERICAN PEOPLE

Profamilia

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PRESENTATION

In 2019, Profamilia in partnership with the Office of US Foreign Disaster Assistance Abroad (OFDA-USAID) started the Humanitarian crisis: Health and the guarantee of rights of the migrant population project. This project aims to increase the provision of health services to the Venezuelan migrants and refugees, as well as the host communities in 12 departments of Colombia.

Between November 2019 and March 2020 the project evaluated the needs, expectations, and inequalities regarding access to health services for Venezuelan migrants and refugees. The research focused on six prioritized cities with high immigration flow: Bogotá, Barranquilla, Cartagena, Cucuta, Riohacha, and Santa Marta. In order to improve the response of the health system locally, this research also inquired about the use of services and inequalities within the host community.

The Colombian health system has set out to ensure basic health care for the migrant population. However, running a complex health system and pandemic response present difficulties such as the absence of healthcare guidelines established for migrants and refugees, high migration flows affecting geographic areas that already have inadequate services, and social exclusion. Thus, this offers an opportunity to develop strategies that ensure universal health coverage nationwide, and to reform the preparedness and response of the health system to the needs of migrants, refugees. and the host community.

Marta Royo
Executive Director Profamilia

The results of this research are intended to support safe, effective, and non-discriminatory migration, while simultaneously improving health coverage in the host communities during Covid-19. In particular, this research highlights the need to direct financial resources to the territories, as well as mobilize the strategies and resources of international agencies and NGOs. These actions play a fundamental role in guaranteeing universal health coverage as a human right, not only to the Colombian population, but also to migrants and refugees – a catalytic goal of sustainable development by 2030.

This book, divided into five chapters, focuses on health outcomes particularly, sexual, reproductive, maternal, child, adolescent, and mental health, communicable and noncommunicable diseases, and violence against women. The first chapter describes the research motivation and methodological approach. The second chapter describes the socioeconomics of the migrant and refugee population in Colombia. The third chapter identifies the perceptions of migrants and refugees regarding coverage, needs, barriers, and health expectations. The fourth chapter presents data on the use of health services by migrants and the host community.

ABBREVIATIONS INDEX

HCA: High Cost Account

NHPC: National Housing and Population Census 2018.

DANE: National Administrative Department of Statistics

AD: Acute Diarrheal Disease

HPS: Health Promoting Entities

NIH: National Institute of Health

ARI: Acute Respiratory Infection

STI: Sexually Transmitted Infections

MHSP: Ministry of Health and Social Protection

WHO: World Health Organization

SPS: special permission to stay

PROFAMILIA: Profamilia Association

RIPS: Individual Registry of Provision of Healthcare Services

GSSHS: General System of Social Health Security

SISPRO: Integrated Social Protection Information System

SIVIGILA: National System for Public Health Surveillance

SRH: Sexual and Reproductive Health

BMC: Border Mobility Card

HIV: Human Immunodeficiency Virus

EXECUTIVE SUMMARY

Needs	**1.8** migrants and refugees	**1 million** migrants and refugees in six departments	**2 out of 10** migrants and refugees attended health services in Colombia in the last year
Identities	**300** Yukpa Natives on the Colombia-Venezuela border	**333** Trans people	
Circumstances	**737 thousand** undocumented migrants and refugees	**346 thousand** migrants and refugees in transit	**4.3 million** with border mobility cards
	67% childbearing-age migrants and refugees	**573** migrant and refugee victims of sexual violence	**12 thousand** migrants and refugees with disabilities

Chapter 1 Research motivation and methodological approach Pág. 11 - 15	Three main reasons motivated this research: i) migration is a structural determinant, which has a differential impact on health throughout the life of an individual; ii) the need to evaluate the use of health services; and iii) the opportunity to use the information available on the health of migrants and refugees.	The research incorporated three quantitative and qualitative methods: the review of information sources, measurement of health inequalities, and focus groups of discussion. The research focused on the analysis of sexual, reproductive, mental, maternal, child, and adolescent health, communicable and noncommunicable diseases, and violence against women. The geographical areas analyzed included Barranquilla, Bogotá, Cartagena, Cucuta, Riohacha, and Santa Marta.
Chapter 2 Sociodemographic characteristics of migrant, refugee, and host communities Pág. 16 - 21	In order to adapt the response to the needs and circumstances of migrants and refugees in Colombia, it is necessary to identify and describe their sociodemographic characteristics.	The research and data collection focused on information from different national and local sources. The last Colombia Migration report detailed the evolution of the humanitarian emergency. In addition, the National Population and Housing Census of 2018 allowed for the demographic characterization of the host communities, and migrant and refugee population.
Chapter 3 Health system's response to the perceptions and experiences of migrants and refugees Pág. 22 - 31	Focus groups of discussion sought to hear the voice of migrants and refugees emphasizing health care coverage. Six cities with high migration flow were prioritized to conduct the focus groups. Each focus group was separated by gender and consisted of migrants and refuges over 18 years of age.	Analysis on the perspectives and experiences of Venezuelan migrants and refugees focused on coverage, needs, expectations, and barriers in access to health services.
Chapter 4 Use of health services Pág. 32 - 83	Strengthening the humanitarian response demands identifying and describing the health situation for both, migrants and refugees and the host community.	The sources of information used included the system of public health surveillance (In Spanish Sivigila) and Individual Registry for the Provision of Health Services (In Spanish RIPS).
Chapter 5 Conclusions and recommendations Pág. 90 - 92	Proposed recommendations based on the evidence gathered to improve the local health system's response to the migration phenomenon.	

GLOSSARY

Universal health coverage: It implies that all people have access to comprehensive, adequate, timely, and quality health services according to their needs and without financially burdening the users [1].

Host community: it refers to the population of the destination country receiving the migrants and refugees [2].

Social determinants of health: a set of circumstances that conditions most inequities and inequalities that individuals and communities face when addressing and responding to their health needs. Migration is a structural determinant of health [3].

Inequalities in health: refers to healthcare disparities within a society that are caused by various determinants. Health inequalities are divided into two groups: i) inevitable, and ii) unjust and preventable (inequities) [4].

Migrant: a person who for various reasons moved away from their place of habitual residence, either within a country or across an international border, temporarily or permanently.

Irregular migration: migration to a host country through unauthorized points of entry, which results in migrants without documents to verify or clarify their immigration status [2].

Regular migration: Legal migration into the host country so that immigrants have documents that confirm their migration status and facilitate the control of authorized stay times [2].

Refugee: a person fleeing conflict and persecution. International law defines their status, and legal protection, and opposes their expulsion or being returned to situations where their lives and freedom are at risk [5].

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Special thanks to Venezuelan migrants and refugees who devoted some of their time to share their stories, interests, and needs regarding access to healthcare services in Colombia. We appreciate those who decided to support and participate in this research despite the challenges associated with migration (e.g. search of livelihood and opportunities, exposure to risks).

Special thanks to Profamilia clinics in Bogotá, Barranquilla, Cartagena, Cucuta, Riohacha, and Santa Marta; the fieldwork for this research would not have been possible without their logistical help. Likewise, we thank the Centro de Atención Integral para al Migrante in Bogotá, the Fundación CORSOLUZ in Barranquilla, the Pastoral Social in Riohacha, and the Centro de Adoración Familiar in Soacha, for facilitating the outreach to and organization of migrants.

The information presented here is the result of fieldwork and data collection by Johan Sebastian Ariza, Angela Cifuentes, Mariana Calderon, and Sandra Marcela Sanchez. Mariana Calderon and Angela Cifuentes managed ethical issues and gender considerations. Johan Ariza, Angela Cifuentes, Mariana Calderon, Juan Sebastian Arteaga, Danny Rivera, Julieth Medrano, Rocío Murad, Andrés Gómez and Juan Carlos Rivillas conducted the analysis on healthcare results and health inequalities. Rocio Murad, Sandra Marcela Sanchez, and Camila Vera contributed significantly to the technical and administrative support of the research. Juan Carlos Rivillas, Angela Cifuentes, Carlos Gomez, Diana Moreno, German Lopez, Mariana Calderon, and Rocio Murad revised each version of the document and validated data. Juan Carlos Rivillas coordinated the design and implementation of the study.

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PURPOSE OF THIS REPORT

REPORT

The existence of inequalities for migrants and refugees in Colombia regarding their healthcare needs and use of healthcare services.

IDENTIFY

Opportunities to implement innovative and equitable healthcare service accommodations that reach the most vulnerable migrants and refugees in this humanitarian emergency and during COVID-19 response.

INFLUENCE

The preparedness and response of the healthcare system at a local and regional level when dealing with a humanitarian emergency and pandemic.

CHAPTER I

MOTIVATION FOR RESEARCH AND METHODOLOGICAL APPROACH

MOTIVATION FOR RESEARCH

The migrants and refugees who arrive in Colombia as a result of the deprivation in healthcare and education in Venezuela overwhelm the existing social support structures in Colombia, especially the healthcare system and public and private health institutions. The most vulnerable groups include children who are separated from their parents or alone, nursing mothers and pregnant women, itinerants, indigenous people, Afro-descendants, seniors, individuals with disabilities, and LGBTQ individuals, due to discrimination, lack of information, and access difficulties [6].

In 2018, an assessment regarding unmet sexual and reproductive healthcare needs of Venezuelan migrants and refugees in Colombia was completed [7]. The results identified the most urgent needs related to access to contraception, teen pregnancy prevention, gender violence prevention and management, and comprehensive sexuality education in a humanitarian crisis. The research also helped understand the obstacles that migrants experience in the use of services, and proposed recommendations to improve interinstitutional and intersectoral coordination. However, when dealing with a humanitarian migration crisis, a further assessment of the healthcare needs of migrants and refugees is essential in order to improve the preparedness and response of the social support structures in Colombia. Accordingly, the most urgent health needs include maternal, child, adolescent, and mental health, communicable and noncommunicable diseases, and violence against women.

Migration as a social determinant of health throughout life

Migration is a structural determinant that has a differential impact on health throughout the life of an individual. Migration flows can increase inequalities in the use of health services, as well as expose people to risks of communicable diseases and many forms of violence; in particular women and girls, adolescents, persons with disabilities, LGBTQ people, and indigenous and afro-descendants [8].

The relationship between migration and health before, during, and after mobilization is complex; whether the migration is forced, voluntary, regular, irregular, or circular. The health and welfare of migrants represent a human rights issue on morality and equity at the center of the humanitarian response agenda. Actions that guarantee the dignity of individuals, prevent and reduce the morbidity and mortality related to migration, and decrease the differential impact on health outcomes are crucial. More specifically, the differential impact between men and women, between the migrant and refugee population and the host community, and within different core health indicators.

Utilizing data about the health of migrants and refugees

The health institutions of Colombia are experienced in gathering information on the health of migrants and refugees. In particular, regarding the use of health services and public health surveillance. In 2017, the Individual Registry of Provision of Healthcare Services (RIPS) and public health events were improved in response to the humanitarian emergency. This allowed for better monitoring of the health of migrants and refugees, as well as that of the host communities.

Overall, 21.94% of regular Venezuelan migrants are affiliated to the General System of Social Health Security (GSSHS), of which 66.4% are enrolled in the contributory coverage and 33.9% in the subsidized coverage. Between 2017 and 2019, the information that the SIVIGILA recorded indicated five health conditions affecting migrants that require attention: malaria, violence, gestational syphilis, severe maternal morbidity (SMM), and HIV/AIDS [9]. This represents a research opportunity regarding health services in an effort to better meet the needs of migrants and refugees, and to model the behavior of infectious diseases and predict emerging epidemics in a humanitarian emergency.

Urgency to provide health services for adolescents, trans people, individuals with disabilities, indigenous people, elders, and women victims of gender violence, regardless of their immigration status

Approximately 184,455 Venezuelan migrant and refugee girls are particularly exposed to age and gender inequities. These inequities can jeopardize their safety and trigger discrimination scenarios where they become victims of physical and psychological violence such as malnutrition, neglect, trafficking, sexual exploitation, and various forms of sexual violence [10]. Similarly, 475 women victims of gender violence, including pregnant teens, require mental, sexual, and reproductive healthcare assistance and restoration of rights [11]. There are also 333 trans people prone to violation and discrimination because of their sexual orientation and gender identity. These individuals can be stigmatized, and for lack of information, live with HIV/AIDS without proper treatment [12].

On the other hand, 38,416 elderly migrants and refugees require specific and continuing healthcare for health conditions, comorbidities, and access to medicines. Also, about 12,000 people with disabilities have special needs given the humanitarian emergency [13]. Finally, it is urgent to consider the more than 300 Yukpa natives that are not recognized as binational citizens, face language barriers, and are particularly vulnerable to extreme poverty in border cities. These are some amongst other vulnerable migration groups.

METHODOLOGICAL APPROACH

Overall objective

Identify the most common health inequalities, barriers, and experiences in access to healthcare services by Venezuelan migrants and refugees in six Colombian cities with high immigration flow.

Specific objectives

- Identify the needs, barriers, and circumstances of Venezuelan migrants and refugees regarding the use of healthcare services.
- Describe the use of healthcare services by Venezuelan migrants and refugees, and the host community.
- Generate evidence that guides healthcare services to better meet the needs and circumstances of migrants and refugees in response to the Venezuelan humanitarian emergency.

The research used a mixed methodology in order to take advantage of different information sources and evidence that the MHSP and Migration Colombia have begun to generate on the subject. The research focused on the analysis of the health situation in six Colombian cities and their respective departments: Barranquilla and Atlántico, Bogotá, Cartagena and Bolivar, Cucuta and Norte de Santander, Riohacha and La Guajira, and Santa Marta and Magdalena. The selected cities form a part of the ten departments in Colombia with the highest number of Venezuelan migrants and refugees, and high flow migration corridors [14].

Research methods

The research combined three tools described below: i) review of information sources, ii) measurement of health inequalities, and iii) focus group discussions.

I. Review of information sources

Data on Venezuelan migrants and refugees and the host communities were obtained from several open access information sources.

Individual Registry of Provision of Healthcare Services RIPS (2018-2019)

Health care data were obtained from the RIPS data cube and Circular 029 data cube for the Colombian and migrant population, respectively. Both information hubs provide data regarding healthcare provision and access. The Ministry of

Health and Social Protection manages this source of information. Consultation period: January 1, 2018 to September 30, 2019.

National Population and Housing Census (2018)

Sociodemographic characteristics were derived from the analysis of the Colombian National Population and Housing Census, which included migrants.

Migration Colombia (2019)

The Colombian national government records the number of migrant men and women from Venezuela in the six prioritized cities.

National System for Public Health Surveillance - SIVIGILA (2018-2019)

Epidemiological data on public health events concerning the Venezuelan migrant population and their host communities were obtained from the National Institute of Health (NIH) of the Ministry of Health and Social Protection (MHSP).

II. Focus group of discussions

Focus groups allowed to interpret the realities that the Venezuelan migrant population encounters at the time of using health services in Colombia. These were divided into four sections: health needs, barriers in access to health care, universal health coverage, and outcomes, experiences, and expectations.

The pilot test took place in the municipality of Soacha (Cundinamarca) on November 6, 2019, with two groups of Venezuelan migrants (13 women and 12 men). The focus groups lasted on average two hours and thirty minutes.

A total of twelve focus groups were conducted between the 19th and 29th of November, 2019. The groups consisted of Venezuelan migrants and refugees over 18 years old and separated by gender. Each municipality conducted two focus groups with a total of 153 participants (men n = 79 and women n = 74).

N-Vivo software was used to record, transcribe, and encode the discussions from the focus groups. The encoding process was separated into the same four sections as the focus group discussions. Participants in the focus groups were convened through the network of humanitarian aid across the cities of interest, which included covered shelters, health care stations, comprehensive care centers for migrants, and Profamilia clinics.

Ethical and gender considerations

The Ethics and Research Committee of Profamilia approved this research, on October 22nd of 2019 through record CEIP-2019-19. Although the research is safe, it explores the health problems of the migrant population, which can elicit painful situations of discrimination, stigma, and xenophobia for the migrants. For this reason, and in order to achieve an atmosphere of trust and confidence amongst participants, the focus groups consisted of adults and were separated

by gender. The research team applied an informed consent to safeguard the confidentiality of participants, and guaranteed the freedom to withdraw consent and participation at any point of the study. This research did provide financial incentives to its participants.

Topics discussed in the use of services

The numbers of Venezuelan migrants and refugees and host community individuals who used health services were obtained from the RIPS. The health fields presented in the following table were considered:

Table 1.1. Sheet - variables determined for the analysis of quantitative data.

Topic	Health event	Indicator	Numerator	Denominator	CIE Code X
SRH	Contraception	Percent (%) people who consulted for contraception	Number of people served by CIE X codes related to contraception	Women of childbearing age	Z30 - Z39
Maternal health	prenatal care	Women + number 18, who accessed health services for prenatal care.			Z340 - Z369
	Care delivery	Number of women + 18 years who accessed health services for care delivery.			O800 - O849
	Maternal morbidity extreme (MME)	Number of women + 18 years who accessed health services by MME.			O081, O120, O141, O151, O152, O159, O265, O678, O679, 0710, O711, 0730, O731, O995
	gestational syphilis	Number of women + 18 who accessed health services for gestational syphilis			O981
	Congenital syphilis	Number of girls / children - 5 years who accessed health care for congenital syphilis			A500 - A509
Child's Health	Acute respiratory infection (ARI)	Percent (%) girls / boys who have made use of health services by IRA	Number of girls / children served by the CIE X codes related to IRA	Girls / children 0 to 5 years	J00 - J22; Z251
	Acute diarrheal disease (EDA)	Percent (%) girls / boys who have made use of health services by EDA	Number of girls / children served by the CIE X codes related to EDA	Girls / children 0 to 5 years	A00 - A09; Z110; Z221; Z270
	Child cancer	Percent (%) girls / boys who have made use of health services for Childhood Cancer	Number of girls / children and adolescents attended by CIE X codes related to childhood cancer	Girls / children and adolescents aged 0 to 19 years	C710; C820; C859; C910; C920; C923; C926; C928; D330; D332; Z130
Infectoius diseases	HIV AIDS	Number of people + 18, who accessed health services for HIV / AIDS			B200 - B232, B238, B24X
	viral hepatitis	Number of people + 18, who gained access to health services for viral hepatitis			B15; B19; Z205; Z225; Z246
	Malaria	Number of people + 18, who gained access to health services for malaria			B500; B54X; Z116; Z119
Non Communicable diseases	SIST diseases. circulatory (ESC)	Percent (%) people who have made use of health services by ESC	Number of persons served by CIE X codes related to ESC	Person + 18 years	I00 - I99; Z034 - Z035; Z135
	Diabetes	Percent (%) people who have made use of health services for diabetes	Number of persons served by CIE X codes related to diabetes	Person + 18 years	E00 - E07; E10 - E14; E15 - E16; E20 - E35; E70 - E90; Z131
	Cervical cancer	% People who have used health services for cervical cancer	You number of women + 18, attended by CIE X codes related to cervical cancer	Women + 18 years	C51 - C58; D060 - D073
	Breast cancer	% persons. who they have made use of health services for breast cancer	You number of women + 18, attended by CIE X codes related to breast cancer	Women + 18 years	C500; C509; D057; D059; D486.
	Prostate cancer	% People who have used health services for prostate cancer	Number of men + 18, attended by CIE X codes related to prostate cancer	Men's + 18 years	C61X; D075; D2991; D400; Z125
Violence against women	sexual violence	Number of girls and women who accessed health services for sexual violence			T742; Y05; Y059
	physical violence	Number of girls / women who accessed health services for physical violence			T41; T48 - T49; X850 - Y049; Y070 - Y099; Y10 - Y34; Y35 - Y36
	psychological violence	Number of girls / women who accessed health services psychological violence			T743; Z601 - Z613; Z617 - Z659
Mental health	Suicide attempts	Number of people + 18, who gained access to health services for suicide attempts			X60-X84.
	Depression	They number people + 18, who gained access to health services for depression			F320 - F339
	Anxiety	They number people + 18, who accessed health services anxiety			F400 - F419

Sources. in consultation migrants and refugees was revised Cube Circular 2018 00029; and Colombian people attended the Cube RIPS, of the Information System ISPSIS Social Protection of the Ministry of Health and Social Protection (MHSP). Reference period: 2018 until September 2019. Consultations in November 2019 and February 2020. For the denominators in migrants and refugees report Migration Colombia consulted, of the Ministry of Foreign Affairs, 31 October 2019 Colombian population for the National population and Housing Census 2018 of the National Administrative Department of Statistics.

CHAPTER II

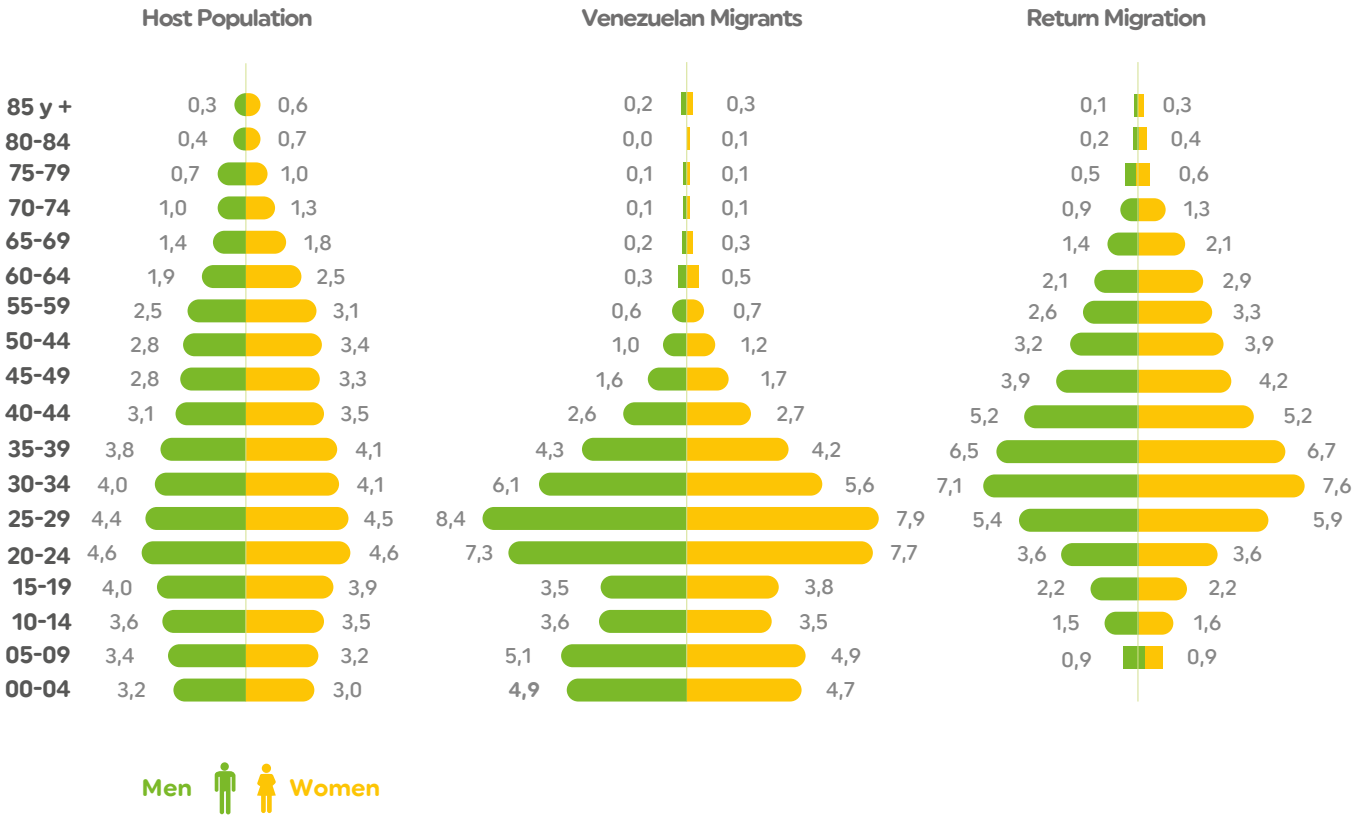
SOCIODEMOGRAPHIC CHARACTERISTICS OF MIGRANT, REFUGEE, AND HOST COMMUNITIES

This section describes the sociodemographic features of Venezuelan migrants and refugees and the host community in the six prioritized cities (Barranquilla, Bogotá, Cartagena, Cucuta, Riohacha, and Santa Marta) and their respective departments (Atlántico, Bolivar, Norte de Santander, Guajira, and Magdalena except for Cundinamarca). Accordingly, Table 1.1 describes the Venezuelan migrant and refugee population in the departments of interest, the types of migrants in the country, and the use of health services in 2019.

The National Population and Housing Census (NHPC) of 2018 provided an estimate of the characteristics of the Venezuelan migrant and refugee population, which allowed for a differential analysis with the host community. According to the results, a total of 10,476,358 people live in the six cities studied, representing approximately 22% of the country's population. In these six cities, 94% are Colombians who have not migrated, 3% are Venezuelan migrants and refugees, 0.6% are Colombians who returned from Venezuela, 0.5% are migrants from other countries, and 1.6% provided no birthplace information. Furthermore, the highest percentages of Venezuelan migrants in relation to the population of the city, are in Cúcuta (7.9%), Riohacha (7.7%), Santa Marta (5.4%), and Barranquilla (3.6%). These percentages were derived from the 2018 NHPC, which takes into account the place of residence for the previous five years and for the year prior to the census.

The sociodemographic distribution of the host community in all six cities was representative of the national distribution, and corresponded to a population with a large youth population (15-29 years old) (Figure 2.1).

Figure 2.1. **Age distribution of Venezuelan migrants and refugees and host community individuals in six Colombian cities (Barranquilla, Bogotá, Cartagena. Cúcuta, Santa Marta, and Riohacha), 2018.**

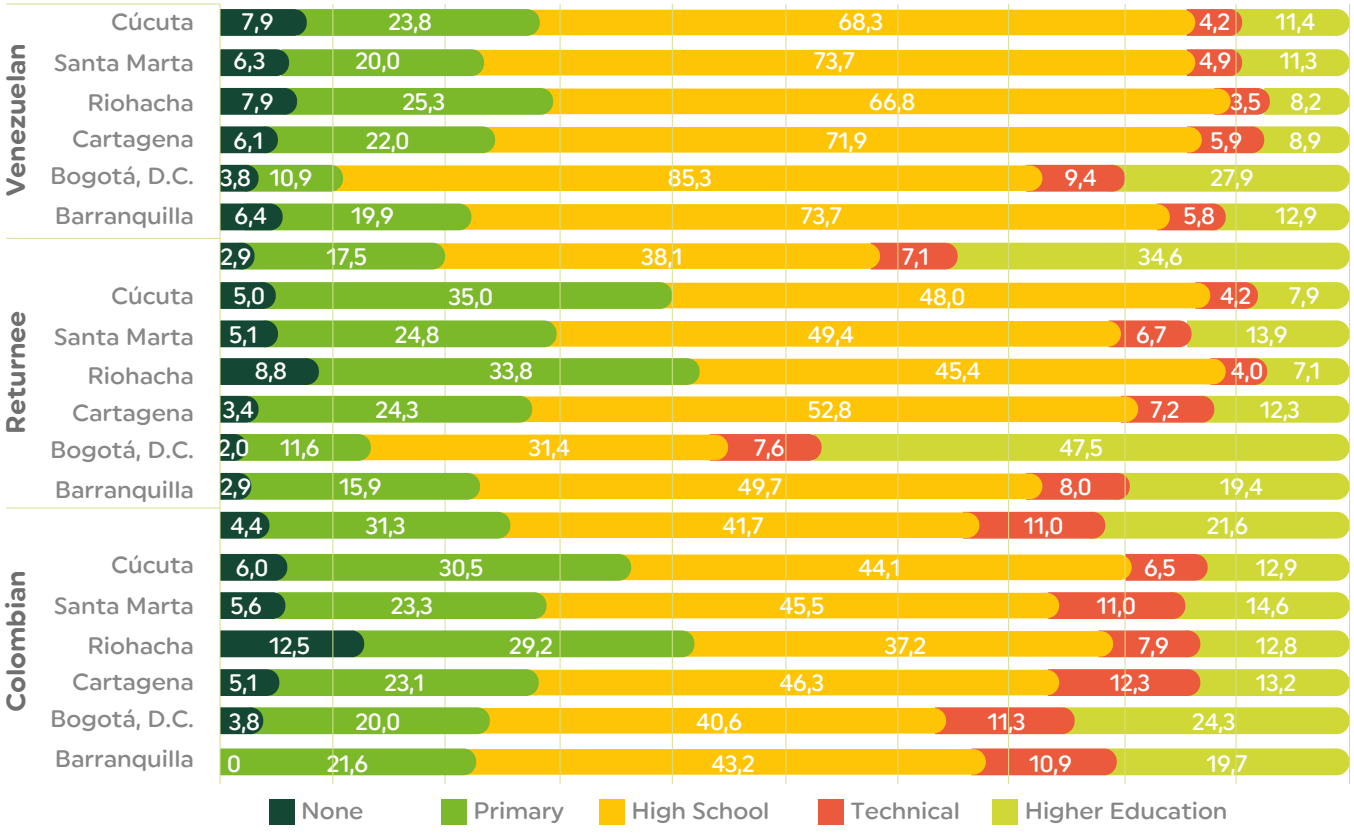


Source. National Administrative Department of Statistics DANE, National Population and Housing Census of 2018.

According to Figure 2.1., the age distribution of the Venezuelan migrant and refugee population in the six cities was similar to that reported by the 2018 CNPV for the whole country. Additionally, it corresponded to the distribution obtained from the records of migrants in the 2018 national population census, where the largest volumes of migrants were between ages 20 and 34, and under 10 years old. On the other hand, the largest percentage of repatriates were between ages 30 and 39 years, and the relative weight of adults was greater than that found in the Venezuelan migrant and refugee population.

In relation to the Venezuelan migrant and refugee population distribution, the demographic dependency rate indicates that in Cartagena, Cucuta, and Riohacha there were approximately 57 dependents (ages 0 to 14 and over 64) per 100 working-age migrants (ages 15 to 64). In Santa Marta and Barranquilla there were 47 dependents per 100 working-age migrants, and in Bogotá DC, 28 dependents per 100 working-age migrants. This study regards individuals between ages 0 and 14, and over 64 as dependents, and individuals between ages 15 and 64 as working-age.

Figure 2.2 Distribution of the educational level of Venezuelan migrants and refugees and host community individuals in six Colombian cities (Barranquilla, Bogotá, Cartagena. Cúcuta, Santa Marta, and Riohacha), 2018.

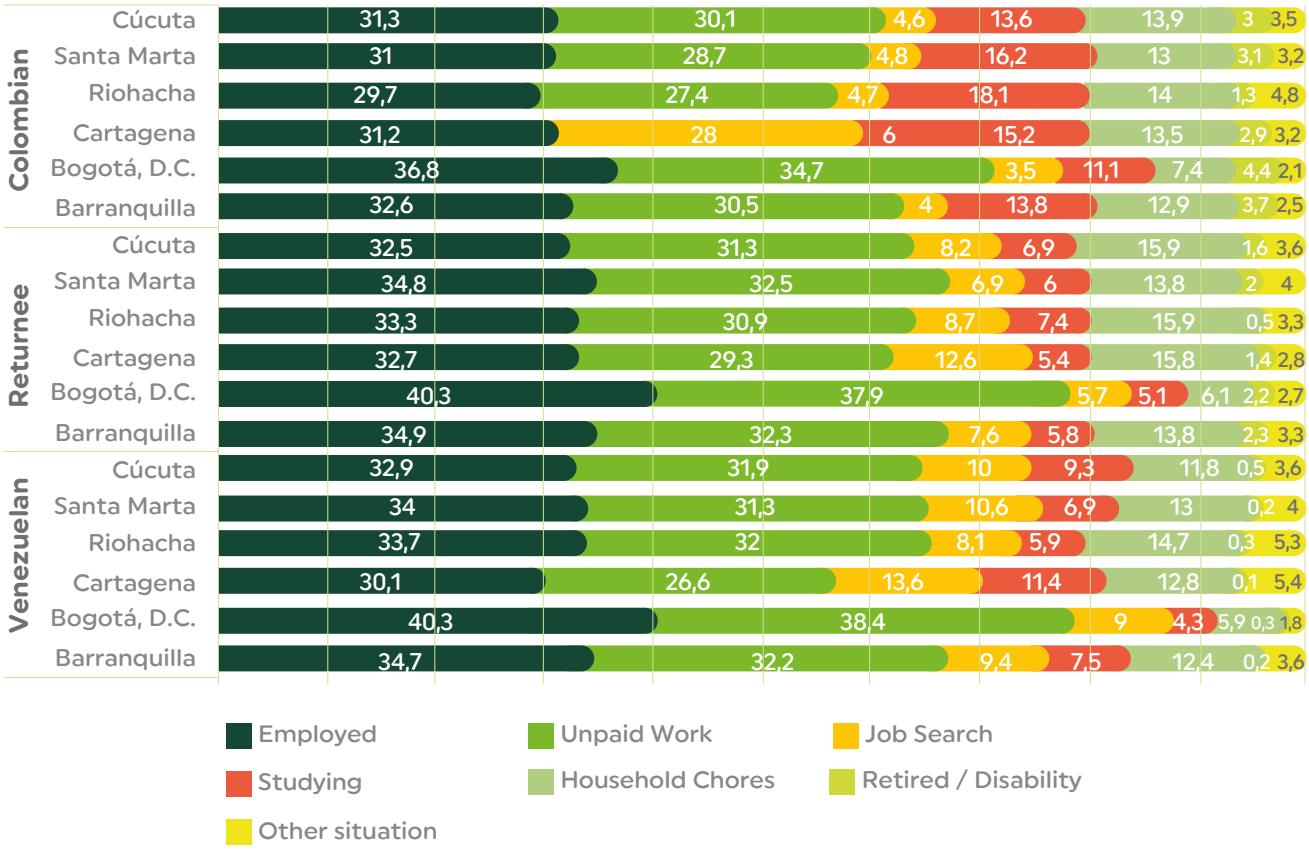


Source. National Administrative Department of Statistics DANE, National Population and Housing Census of 2018.

Regarding the educational level, significant differences were evident between Colombians, repatriates, and Venezuelan migrants as depicted in Figure 2.2 In general, a higher percentage of repatriates completed a higher education degree compared to Venezuelan migrants, except for in Cucuta and Riohacha. On the other hand, a higher percentage of Venezuelan migrants completed high school compared to host community individuals.

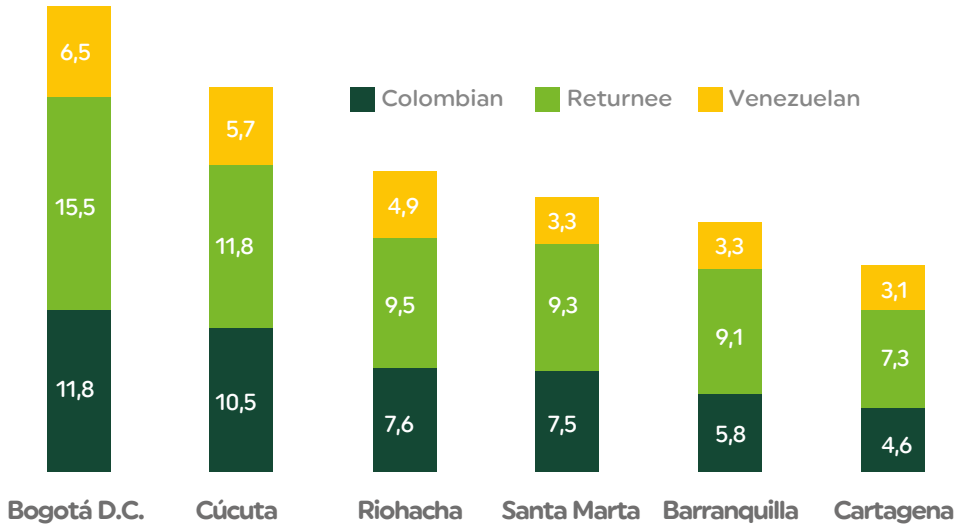
Bogotá recorded the highest percentage of Venezuelan migrants and repatriates who completed a bachelor's degree or higher; 47.5% repatriates and 27.9% Venezuelan migrants. On the other hand, Riohacha recorded the highest percentage of Colombians and repatriates with no education; 12.9% and 8.8%, respectively. Also, Cucuta and Riohacha reported comparable percentages of Venezuelan migrants with no education; 7.9% and 7.8%, respectively. The highest percentages who completed only elementary school corresponded to Colombians (30.5%) and repatriates (35%) in Cucuta, followed by Venezuelan migrants in Riohacha (25.3%).

Figure 2.3. **Percentages of employment for the population 10 years and older for migrants and refugees, and host community individuals in six Colombian cities for the year 2018.**



Source. National Administrative Department of Statistics DANE, National Population and Housing Census of 2018.

Figure 2.4. **Percentage of Venezuelan migrants and refugees and host community individuals who had an outpatient health issue in the past month in the six prioritized cities (2018).**



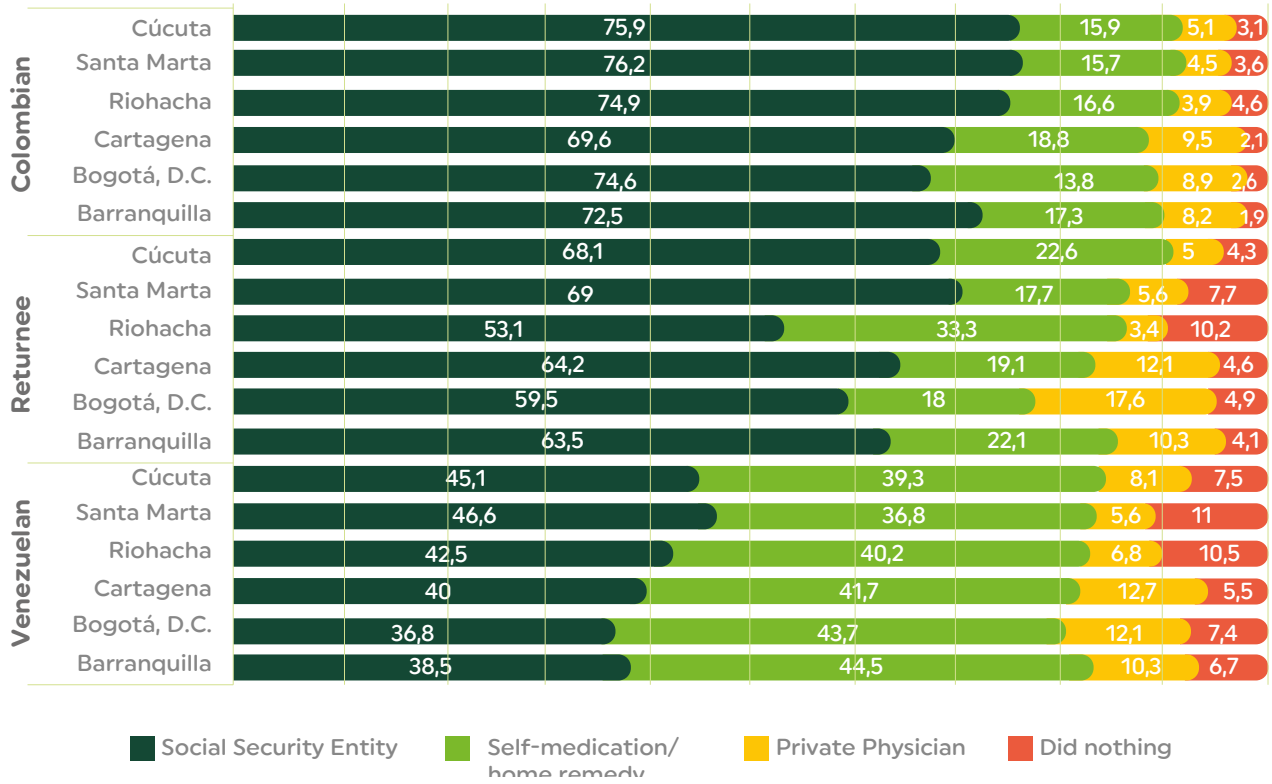
Source. National Administrative Department of Statistics DANE, National Population and Housing Census of 2018.

According to Figure 2.3, the percentage of people who worked last week was similar across the three population groups, and highest in Bogotá. At the same time, the proportion of people who worked but did not receive payment for their work in Bogotá was greater among Venezuelan migrants and repatriates compared to Colombians.

Figure 2.4 indicates whether people had some illness, accident from external causes, dental problems, or any other health problem that did not involve inpatient services, in the last 30 days. Overall, repatriates experienced the most outpatient health issues in the previous month, with higher percentages in Bogotá and Cucuta.

According to Figure 2.5, over 50% of the host community and repatriates turned the Social Security Health System (GSSHS) to treat health problems. In addition, a higher percentage of Venezuelan migrants self-prescribed medications or used home remedies, the drugstore, alternative treatments or did nothing to treat their health condition compared to repatriates and Colombians. These percentages were significantly higher in all six cities, except between Venezuelan migrants and repatriates who did nothing in Riohacha (less than 3% difference).

Figure 2.5. Percentage of Venezuelan migrants and refugees and host community individuals who had a health problem in the previous month based on their treatment approach, in the six prioritized cities (2018).



Source. National Administrative Department of Statistics DANE, National Population and Housing Census of 2018.

Furthermore, the CNPV provided an assessment of the social disadvantage regarding opportunities for Venezuelan migrants and refugees, as well as for repatriates. In particular, low-paid work, no access to education, and limited use of health care services; further explained in Chapter four.

CHAPTER III

RESPONSE OF THE HEALTH SYSTEM AS PERCEPTIONS AND EXPERIENCES OF THE MIGRANT POPULATION AND REFUGEES

Every health system ultimately aims to achieve universal health coverage through the following goals: i) improve health and health equity; ii) fair financing; iii) improve the use and efficiency of available resources; and iv) improve access to health interventions and coverage without jeopardizing the quality of service and safety of the patient [15]. Therefore, in response to the humanitarian migration crisis and in order to achieve universal health coverage, local and regional healthcare systems need to focus on the needs and circumstances of both, the migrant and refugee population and the host community.

This chapter encompasses the perceptions and experiences collected from twelve focus groups of Venezuelan men and women who are migrants and refugees in six major Colombian cities. The purpose of these talks was to gather information of their personal health needs, and identify barriers and outcomes in the use of health care services. This evidence can serve as a guide to reform the response of the health care system at local and regional levels.

Universal Health Coverage

Universal health coverage encompasses equal access to quality health services for all individuals and communities, regardless of nationality, age, and location. The services include prevention, diagnosis, treatment, rehabilitation, and palliative care, and must not impose financial difficulties (i.e. individuals do not suffer impoverishment for the sake of using health services) [16].

Universal coverage incorporates three strategic dimensions. Foremost, health insurance, consisting of programs within institutions that guarantee access to health services. Second, the provision of health care, meaning the portfolio of health services covered under the health insurance. Third, financial protection, involving mechanisms that reduce out-of-pocket expenses resulting from access to these services [15].

Nonetheless, in humanitarian emergencies, migrants and refugees face difficulties in accessing basic and essential health services in host countries. For instance, in Colombia:

-Only 21.94% of regular migrants are affiliated to social and health security.
-Of the total number of migrants and refugees, only 5% are affiliated [17].

This chapter is divided in three sections, starting with a description of the three issues that impede the provision of universal health coverage for Venezuelan migrants and refugees. These are health insurance, access to health services, and financial protection. A description of the needs and barriers when using health services follows. Lastly, people's expectations regarding the health services offered at the local level in response to the humanitarian crisis.

Figure 3.1. describes the most urgent and immediate needs resulting from the triangulation of sources. The most urgent needs relate to access to primary care services, including diagnostic tests for major public health concerns. This is followed by prenatal controls and postpartum care. Thirdly, access to information regarding the provision of health services, especially the location of such services. Finally, in Cucuta and Riohacha timely vaccination programs are essential to continue to successfully respond to the humanitarian emergency.

Figure 3.1. Top ten unmet health needs, according to migrants and refugees in six prioritized Colombian cities with high migration flow.

	Bogotá	Barranquilla	Cartagena	Cúcuta	Riohacha	Santa Marta	
1	Access to primary health care services and diagnostic testing						MOST PRESSING NEEDS
2	Attention to chronic and high-cost diseases (Cardiovascular)	Information of demand and supply of health services for migrants and refugees		Antenatal and post-natal care		Information on health service provision and healthcare pathways for migrants and refugees	
3	Prenatal and post-natal care		Attention to chronic and high cost diseases (Cardiovascular - Cancer - Diabetes)	Timely vaccination programs. Maintain current response initiatives.		Attention to chronic and high cost diseases (Cardiovascular - Cancer - Diabetes)	
4	Effective access to mental health services through a differential focus on the migrant population	Attention to chronic and high-cost diseases (Cardiovascular - Cancer - Diabetes)	Prenatal and post-natal care	Attention to chronic and high-cost diseases (Cardiovascular - Cancer - Diabetes)	Free access to quality contraceptives at any time	Care of prenatal controls and postpartum controls	URGENT NEEDS
5	Child health with priority given to pediatric and nutritional care			Free access to quality contraceptives anytime	Child health with priority given to pediatric and nutritional care		
6	Effective access to medicine and health supplies	Combined response to communicable diseases		Child health prioritized in pediatric and nutritional care	Attention to chronic and high cost diseases (Cardiovascular - Cancer - Diabetes)	Effective access to mental health services through a differential focus on migration	
7	Combined response to communicable diseases	Effective access to mental health services through a differential focus on the migrant population	Free access to quality contraceptives when needed	Combined response to communicable diseases		Free access to quality contraceptives when desired	
8	Free access to quality contraceptives when needed		Effective access to medicine and health supplies	Provision of Sexual and reproductive services for adolescent migrants and refugees		Combined response to communicable diseases	OTHER TOP NEEDS
9	Prevention and case management of sexual, physical and psychological violence	Effective access to medicine and health supplies	Prevention and management of sexual, physical and psychological violence			Effective access to medicine and health supplies	
10	Timely and non -discriminatory emergency services	Prevention and management of sexual, physical and psychological violence	Timely and non -discriminatory emergency services	Effective access to mental health services through a differential focus on the migrant and refugee population		Effective and comprehensive care for victims of sexual, physical and psychological violence	

Table 3.1. summarizes some of the actions that the Colombian health system has implemented in response to the humanitarian emergency, along with the challenges and problems perceived and experienced by the interviewed migrants and refugees regarding these actions.

Table 3.1: Responses and challenges in providing universal health coverage in Colombia for the migrant and refugee population from Venezuela.

Universal Coverage Health Dimension	Response Colombian health system	Challenges and problems in practice
Health insurance **Who do I cover?**	**Affiliation to the General Social Security System in Health (SGSS)** Foreigners, migrants or refugees must register a company Promotora EPS Servicing and have some document legal stay in Colombia, to access the SGSS. If you are employed, self-employed or have ability to pay, you must join and pay into the tax regime; to join the subsidized scheme the SISBEN survey should apply and be classified at level I and II. In case of not having the above should approach an Immigration office Colombia.	• Inability to join the health system, including even regularizing their immigration status. • Lack of quality information on how to navigate through a complex Colombian health system: some of the migrants and refugees in fair condition and has the possibility to join the subsidized or contributory scheme, does not have the information necessary to advance the procedures corresponding to membership. • Venezuelans refer migrants and refugees who do not have social security conditions that the employer should provide them.
	Guidelines for membership in health. Circular 025 of 2017 MSPS asked the local and regional governors to carry out actions to ensure migrants and refugees from Venezuela and determine levels of health care.	• Lack of guidelines for membership in the health system at local and regional level.
	Right to health from local authorities Any national or foreign person is entitled to receive emergency care, and if they do not have capacity, attention should be covered under supply resources of the respective territorial entity where the provision of the service is performed.	• Lack of guidelines for membership in the health system at local and regional level; and violation of the right to health by the same local authorities. • Lack of knowledge by the territorial entity of the flow of resources from the national government to address the health of migrants and refugees.

Universal Coverage Health Dimension	Response Colombian health system	Challenges and problems in practice
Provision of health services presto What services?	Four components of service delivery. **1. Urgent Care:** Article 168 of Law 100 of 1993, in accordance with Article 67 of Law 715 of 2001 and Law 1751 of 2015 states that foreigners who entered Colombia without a health insurance policy that allows them to cover any contingency health, they were guaranteed the initial emergency care. **2. Epidemiological Surveillance:** - Containment of diseases of public health interest. - Cerco national vaccination: vaccines extend from under one year to control vaccine-preventable diseases. **3. Guarantee increasing health insurance:** - Strategy affiliation returned to the SGSSS (Subsidized) - Strategy population recorded PEP (advancing affiliation subsidized regime and characterization of the SISBEN). **4. Care Strategy priority groups and events:** -Intensify institutional strengthening actions and vaccination) -Loader strengthen support for ETS SIVIGILA extramural, P & B management and clinical nutrition and maternal and child care and HIV Attention priority.	Insufficient ownership of the guidelines of the government to ensure emergency care. • It is not clear what is meant as an emergency in the Colombian health system barriers are created as a result of access. • There xenophobia and discrimination by providers who correspond to the emergency services. • It should reinforce epidemiological surveillance in health situations, mainly in infectious diseases of children, gender violence and mental health of migrants and refugees. • While it has covered access to vaccination programs for children, it is necessary to strengthen primary care for this population to meet needs for nutrition, infections and mental health. • Migrants are unaware of the guidelines and the provision of health services (where, what and how to effectively access). • • Lack access to diagnostic tests and early diagnosis for migrants, particularly those in irregular status. • Need to implement preventive health activities: early detection and also specific protection between migrants and refugees. Social exclusion in access to diagnosis, treatment and ongoing care.

Universal Coverage Health Dimension	Response Colombian health system	Challenges and problems in practice
Provision of health services presto What services?	Right to health care in the jurisprudence of the Constitutional Court "It is not confined to maintain the vital signs of individuals, but also covers medical services necessary to avoid or diminish risks of disability and death from physical alterations and / or mental." (T-210/18) "The State has the obligation to provide maternal health services related to pregnancy, childbirth and post-partum to all women who need them for free, whether they are national Colombian or foreign regular stay or irregular. Health services pregnant women and newborns require urgent attention. (SU677 / 17).	• Ignorance of the jurisprudence of the Constitutional Court at local and regional level. Therefore, violations of the rights of health care particularly for pregnant migrant women, adolescents, adults and seniors. • Human talent requires training for health care from the appropriation and knowledge of the right to health and Colombian jurisprudence. • There remains a lack of access to medical supplies and medicines. • Maternal health have provided the necessary services for care delivery. However, there is a big gap in access to antenatal and postnatal services for migrants and refugees, mainly women irregular. • Adjust services maternal and child health needs and specificities of pregnant women who are in the process of migration. Additionally, eliminating all forms of barrier and stigma.
Financial protection **What proportion of the costs can change?**	Right to health in the jurisprudence of the Constitutional Court "Foreigners staying irregularly in the country are entitled to receive basic care and emergency under the subsidized regime when they lack economic resources, under the protection of their rights worthy life and physical integrity. "(SU677 / 17).	• Lack of job opportunities, pocket health spending and impoverishment; despite having regularized immigration status. • Charges for primary care. • Charges for diagnostic tests. • Charges for medical supplies or drugs. • Proceeds from nutritional supplements.

Source. Investigations Directorate, Profamilia, 2020. From the analysis of focus groups and jurisprudence review from the Faculty of Law of the Universidad de los Andes, 2019 [115], and guidelines of the Ministry of Health and Social Protection for Health Response Plan for Venezuelan Migrants in Colombia [17].

Health insurance

The focus groups identified health insurance as a main challenge for universal health coverage of the migrant population. In accordance with Table 3.1. the following perceptions and experiences of migrants and refugees regarding health services in Colombia were concluded:

Inability to join the health system, even for documented migrants.

Most migrants and refugees who participated in the focus groups shared similar experiences that account for limited health coverage and SGSS insurance problems. The most critical situation involved the lack of coverage for undocumented migrants, which is related to the lack of SPS and the difficulties to enroll in the contributory and subsidized plans:

> *Here, those who do not have SPS are denied health care; you can lie dying there, you die because while you do not have. Even those with SPS are denied health care if they are not in the SISBEN. Here they ask for the SISBEN, if you do not have it, you are not attended.*
>
> *Participant – women's focus group in Barranquilla.*

Although people who have SPS have the option to enroll in the health system (public, private, and/or both), most reported feeling overwhelmed by bureaucracy and administrative procedures involved with the enrollment process. Therefore, in many cases Venezuelan migrants prioritized seeking jobs and opportunities instead of investing time and money, which most cannot afford, in health insurance enrollment processes.

Limited information on how to navigate through the complex Colombian health system

Moreover, the unfamiliarity among Venezuelan migrants and refugees regarding the operation of the Colombian health system exacerbated the above situation. Focus group participants widely criticized the complexity of and extensive misinformation on insurance processes, resulting in confusion about the operation of the local health system and how to navigate it. Consequently, migrants and refugees often interpreted the system as discriminatory, inefficient, inequitable, and unreliable. In addition, many individuals with SPS or SISBEN encountered administrative obstacles during these processes:

> *Because if there is a human quality issue in the health systems, I do not know if their feelings are cauterized or they have seen so many things that they lose sensitivity, but they are masters at handling the regulations; handling the fine print of the law, and they deny you service or enrollment.*
>
> *Participant – men's focus group in Santa Marta*

Several factors affected the ability of migrants and refugees to enroll in health insurance and have effective access to care. These included barriers in regularization of undocumented migrants and refugees, limited information in each municipality about enrollment processes, administrative obstacles within the health systems, and lack of care that comprehends the migration and refugee crisis.

Provision of health services

Most migrants and refugees agreed that there is limited healthcare coverage, SGSS insurance issues, lack of useful information to navigate the health system, and insufficient financial protection plans.

Universal health coverage not only aims to ensure minimum essential coverage, but also a progressive expansion of health services and financial protection [16]. The availability, accessibility, and configuration of the health system at all levels determines the provision of health services. The focus groups identified the following challenges in the provision of health services at the local level:

Insufficient government regulations to ensure emergency care

Even though the Colombian government declared that all emergency care is mandatory based on international standards, the focus group participants identified challenges regarding access to emergency, basic, specialty, continuing, and comprehensive health care. The reconstruction of experiences highlighted the lack of information about access to emergency services, what constitutes an emergency, and where these services are provided:

'Off the top of your head, do you know your rights about access to health services in Colombia?
- No.
-Well, the only rights that they [providers] say are covered are emergency ones, and non-emergency ones are not covered.
- The detail is knowing who to call in an emergency [...] and that they [government and private sectors] determine what is an emergency; because if I go in for headache, because I cannot see, I am going to faint, I am throwing up, to me that is an emergency.

Participants – women's focus group in Bogotá.

In accordance with the existing legal frameworks, emergency care should be provided without requesting documents and payment of services. However, some people said that on occasion they had been denied emergency services for not having SPS or some kind of insurance. In addition, those who managed to be cared for in the emergency department had to pay for the services when it was determined that the level of urgency was not high enough.

Need to implement prevention activities: early detection and specific protection for Venezuelan migrants and refugees.

A significant number of the Venezuelan migrants and refugees who were interviewed shared several concerns about the lack of access to basic health services. This concern was elevated among people who migrated with children, senior citizens, people with disabilities, or people with preexisting conditions. For undocumented migrants, restricting healthcare access exclusively to emergency care prevented access to comprehensive, adequate, timely, free, and quality health services. This pressured people to seek other solutions, such as self-medication:

[...] we were in line to be attended because [my child] was very phlegmy and they told us: "- Do you have SPS? - No. - Bye, Goodbye dad. "
I bought a remedy and gave it to [my child], I asked at the pharmacy, it is called Mucosina, the doctor sold it to me, that one that provides service...
E: The one from the drugstore?
Q: The one who provides service, he says, "Give it to [the child] these many hours, these many drops." And thank God [my child] got better.

Participant – men's focus group in Bogotá.

Many people reported not having prior information on what is considered an emergency, how it is determined, and where these services are provided, making it difficult to get timely care.

A major concern among those who had experienced inappropriate medical care and treatment was that without proper care to address early symptoms, the situation may worsen and lead to greater damages and complications. Thus, as noted by the Venezuelan migrants and refugees, free and quality medical evaluations should cover basic health needs, without discrimination, and beyond what is interpreted as emergencies.

Social exclusion in access to diagnosis, treatment, and continuing care

Furthermore, the Venezuelan migrant population faces numerous difficulties in accessing specialty, continuing, and comprehensive care. Although many people have migrated to Colombia for health services and medical treatments inaccessible in Venezuela, the Colombian health system lacks the strategies to ensure access to these services. Many focus group participants indicated they had been unable to access medical specialists or diagnostic support services. In these cases, when additional tests were requested outside the emergency department or not covered within it, people were asked to bear the costs:

> *[...] we have no way to get a mammography, cytology; if we are sick, for example, I, got sick about a month ago and went to the doctor and was not attended because I am Venezuelan, I had to pay for the consultation.*
>
> *Participant – women's focus group in Barranquilla.*

Similarly, although people recognized that different humanitarian agencies or nonprofit entities have projects that cover some medical conditions, the coverage was insufficient. Oftentimes, general practitioners referred migrants to specialty services, which migrants could not access due to either the costs of care or lack of insurance. Nonetheless, primary care along with specialty, continuing, and comprehensive care are all essential to ensure the health of the migrant population. In the long-term, refusal of these services has negative consequences on the lives of the migrant population, as well as on the health of the general population.

Therefore, to ensure that care is provided in the most appropriate context, it is necessary to reorient health services to provide a fair balance and improve coordination between outpatient and inpatient care. Health services, including traditional and complementary medicine, should be organized according to the general needs and expectations of individuals and communities. This will help ensure that migrants and their communities play a more active role in their health and health system.

Financial protection

In order for the government to determine what services are covered within the humanitarian response, it is essential to have different funding mechanisms and sources [16] The focus group discussions identified challenges in guaranteeing financial protection.

Shortage of job opportunities, out-of-pocket health expenses, and impoverishment

Obstacles in access to health services include the socioeconomic and labor conditions of migrant and refugee populations, along with their illegal status and lack of economic resources:

> *And that is a trauma, then, if they see [the child], yes, but since "it is nothing serious mam, you have to pay $ 18,000, just for the consult, plus the drugs that the child needs and if he stays hospitalized it is another amount of money. And one here has no work because one has no papers, no physical work and from where one gets, so for an emergency at a minimum you must have at least $ 50,000 COP, for an emergency.*
>
> *Participant – women's focus group in Barranquilla*

There are limited financial protection mechanisms that explain out-of-pocket expenses related to health care, from photocopy payments to copayments of 50,000 COP for basic health services, as well as emergency care, which is a right

A section of the migrant and refugee population had out-of-pocket expenses for health without receiving information explaining these charges. On many occasions, people paid for drugs, medical supplies, and hospitalizations from out-of-pocket. Different humanitarian response actors have helped alleviate out-of-pocket costs for the migrant population through subsidies, individualized service packages, and establishing guidelines for emergency and maternal and child health care.

NEEDS AND CIRCUMSTANCES IN ACCESS TO HEALTH SERVICES

Table 3.2. describes the needs and circumstances in access to seven specific health services experienced by the Venezuelan migrant population. It is important to clarify that the needs relate to sexual, reproductive, maternal, adolescent, and mental health, communicable and non-communicable diseases, and violence against women. On the other hand, the circumstances refer to situations that result in a disadvantage or vulnerability for an individual, such as their age, immigration status, gender identity, and education, among others. This information is the result of focus group discussions in the six prioritized cities.

Table 3.2. Health needs and circumstances of migrants and refugees participating in focus groups in six prioritized cities in Colombia, 2020.

Topic	Needs	Circumstances
Sexual and Reproductive Health	Reversible contraception with modern methods, long-term and emergency at all levels (emergency, outpatient, extramural activities). Adhesiveness and cost-effective access to services. Information and comprehensive sexuality education.	Adolescents and young irregular without support networks People with disabilities, indigenous people and non-binary Sexual working people, victims of sexual violence and / or sexual exploitation.
Maternal Health	Basic laboratory tests. Induce demand for prenatal checkups. Care delivery Access to high complexity. Human talent trained in emergency obstetric care Post obstetric event contraception.	Pregnant women and adolescents without support networks Women without completing prenatal checkups pregnant women at high risk of morbidity and mortality Nutritional deficiencies in pregnant women. Pregnant women who suffer physical or psychological violence Risk trafficking.
Child's Health	Primary Health Care in IRA to minors. Mental health care, nutrition, dentistry and optometry Access to nutritional information and immunization programs Disease prevention related to the management of water and food	Children with nutrition problems; which stopped their school; without support networks; which have been neglected or family breakdown Children living in shelters or settlements without access to potable water and sewerage.

Topic	Needs	Circumstances
Adolescent health	Access to reversible contraceptive methods and long-lasting Access to counseling and care and reproductive sexual health Nutritional health care Comprehensive sex education and prevention of violence (irregular status).	Teenagers who have started their sexual life Teens who are pregnant. Teenagers abandoned or family breakdown, without support networks Adolescent victims of different types of violence. Adolescents and youth in labor exploitation.
Non-communicable diseases	Controls general medicine and diagnostic tests (cancer, diabetes, renal failure, etc.) Access to medicines and supplies	pregnant women Elderly men and women; dependents of others People with a history of chronic diseases and co-morbidities
Communicable diseases	Screening, management and treatment of HIV and viral hepatitis combination prevention to contain growing epidemic behavior migrants. Promote campaigns to prevent risk behaviors to health	People with STIs; Pregnant and Children and teenagers women without support networks People with economic difficulties accessing screening Victims of violence and / or sexual exploitation
Violence against women	Intersectoral management and prevention (health, education, protection, justice). Psychosocial support services, Reference and counter information.	Women and girl victims of sexual exploitation or sexual violence. Women and men sex workers.
Mental health	Primary care mental health (stress, anxiety, fear and worry) Access to specialized mental health services Information on supply and routes comprehensive mental health care Mental health programs aimed at migrants and host community to generate awareness of the risks that generates migration on mental health	migrants and refugees who have failed to resolve their immigration status without support networks. People traveling with children, seniors, people with disability or some kind of disease. People who have faced barriers to access to health services. Girls and children separated from family members of his product migration. Women and girl victims of gender violence and economic violence (trafficking, labor exploitation, etc.).

Source. Investigations Directorate, Profamilia, 2020.

EXPECTATIONS OF THE VENEZUELAN MIGRANT POPULATION REGARDING THE HEALTH SERVICES IN COLOMBIA

It is a question that makes sense, because whether we are Venezuelans, Colombians, health, should be good, be it, in this country, wherever [...]

Participant – men's focus group in Santa Marta

This section analyzes the expectations of migrants and refugees as an opportunity to improve Colombia's health system. In addition, it serves as a first step to understand how to strengthen the health system and build resilience.

Table 3.3. **Expectations and opportunities in health care for migrants and refugees.**

Expectations of health care, according to migrants and refugees	Opportunities attention focused on the expectations of migrants and refugees.
Receive high quality information on how to ensure the SGSS and the right to health	Key generating information on the guidelines and mechanisms to join and avoid red tape.
Receive information without discrimination and stigma free	Ensure that personnel of the health system provides transparent information free of stigma and seek a sensitive accompaniment.
Achieving assurance to the health system quickly and effectively.	Advantage to the maximum the first contact with migrants seeking information on health insurance, to ensure it is timely and effective.
Find providers of health care appropriate guidelines in practice. Ejm. knowledge of emergency care and knowledge of maternal and child health care. Knowledge of jurisprudence in health.	Ensure that health personnel involved in activities related to the legal aspects of migration and training processes centered humanitarian response.

Source. Investigations Directorate, Profamilia, 2020.

Regarding patient experience, some participants mentioned the lack of insurance coverage, high costs to access health services, discrimination by the health provider, waiting times, insufficient patient information, and lack of installed capacity in the institutions that provide health services and are accessible:

> *I've heard that, yes, that they need to attend the Venezuelans, that is, through social work they always have to help us, but in reality I feel that it is like, like to look good. Because of an experience that I had with my husband and he has permission, he got permission [SPS] and he became ill, he got a pneumonia and he was told to go to Barranquilla, and one goes trusting the information given, that one could go there and be attended. When we went, cool, he was attended there, when he was going to be discharged, [they said] he had to pay three million pesos [...]*
>
> *Participant – women's focus group in Barranquilla*

The previous experience highlights several aspects associated with the expectations of migrants and refugees. Perhaps the most common expectation was being able to access emergency services without being asked for the SPS or affiliation documents. Moreover, migrants and refugees expect emergency care, and when necessary physical exams, free of cost.

Aside from that, people noted the importance of upholding certain vital aspects once they have accessed health services: dignified treatment, availability of supplies and services, and good care provided by public institutions and humanitarian agencies. Even though the participants mostly shared negative aspects from their experiences, the fact that they mentioned the previous issues allows to interpret the expectations of the migrant population from a different angle:

> *The way the doctors, nurses, maternal-fetal medicine specialist treated me, it was three days with a 40 [°C] fever. She [the newborn] was checked very well during the pregnancy, they were very attentive of the pregnancy because of that, everything, everything. When I gave birth I was treated very well, all was well treated, I have no complaint of (silence)… What am I going to say? That they treated me? They never treated me poorly for being Venezuelan, never discriminated against me for being Venezuelan, just how they treated a Colombian they treated me.*
>
> *Participant – women's focus group in Cúcuta.*

Service availability and access to health coverage, ultimately require improving communication, guaranteeing continuing care, and increasing trust in health care providers. Figure 3.2 depicts a word cloud of the most common words associated with the expectations of the Venezuelan migrant population regarding health services. In it, health is at the center of the expectations surrounded by words like services, care, and support, which highlight the importance of eliminating barriers in access to health services.

Figure 3.2. Word cloud of expectations of Venezuelan migrants and refugees regarding health services.

Source. Investigations Directorate, Profamilia, 2020.

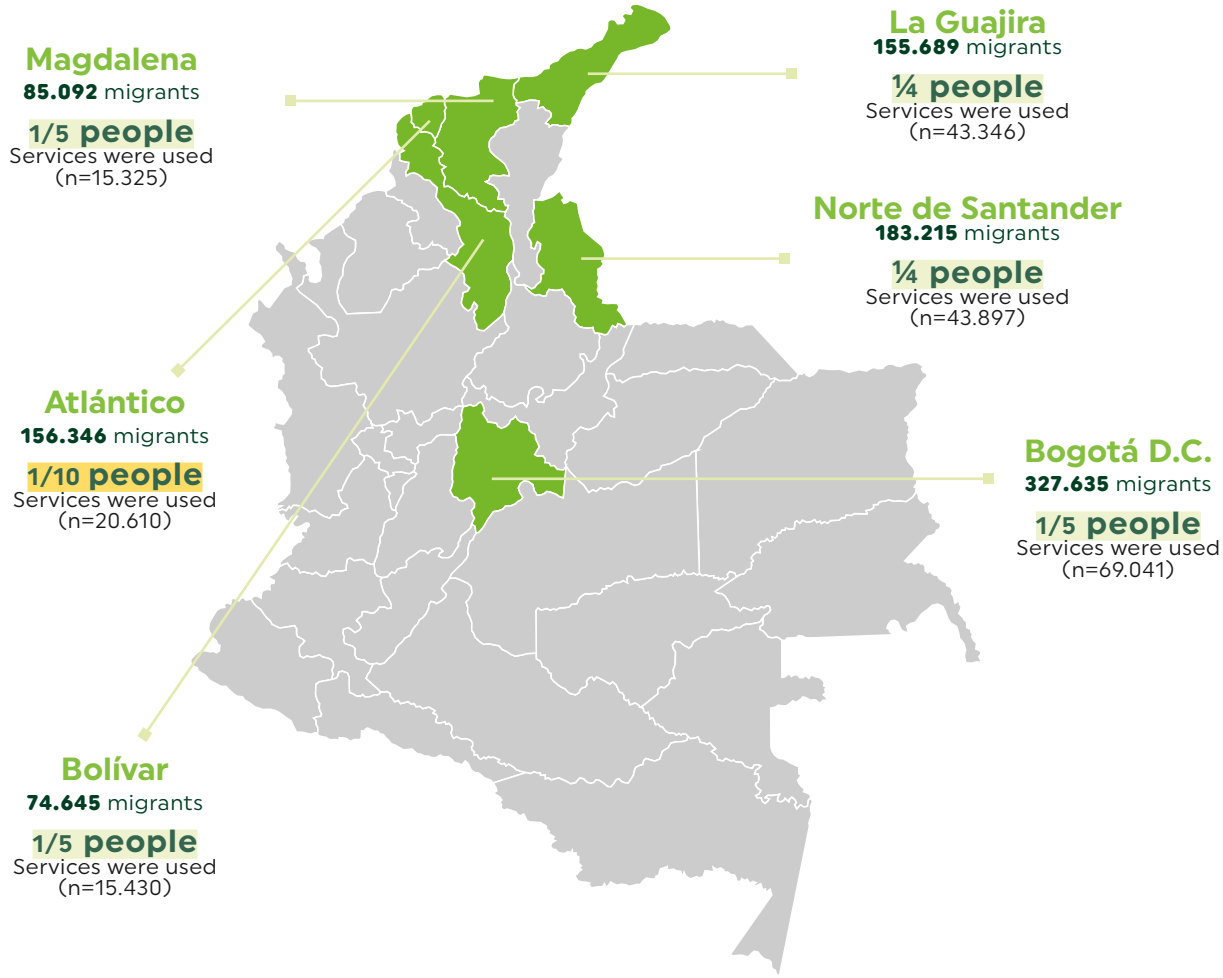
CHAPTER IV

USE OF HEALTH SERVICES AMONG THE MIGRANT POPULATION AND HOST COMMUNITY

Gender, ethnic and racial origin, religion, sexual orientation, age, ability to pay, or immigration status should not determine or restrict the use of health services under any circumstance. In the midst of a migration and refugee crisis, health services should not be interrupted and should adapt to the needs and circumstances of this population group, especially to those who face social disadvantages or vulnerable situations.

The principles of solidarity and equity define Colombia's health system. Accordingly, in 2018 the Ministry of Health and Social Protection issued guidelines to guarantee access to health care for pregnant women and children. Moreover, in 2019 the Ministry issued a resolution to ensure that the migrant population has access to all emergency services, which the insurance program would eventually cover through subsidies [18]. The latest developments of the Integrated Information System for Health Protection (SISPRO) provide data management on the provision of health services for the migrant, refugee, and host communities. This chapter describes how both populations agreed and used health care services in the eight health priority issues: sexual and reproductive, maternal, child, adolescent, and mental health, communicable and non-communicable diseases, and violence against women.

Map with use of health services in six cities with high migration flow in Colombia, 2020



Number of Venezuelan migrants and refugees in Colombia

1.630.903	719.189	911.714	52% Men 48% Women
Venezuelan migrants	Regular migrants	Undocumented migrants	

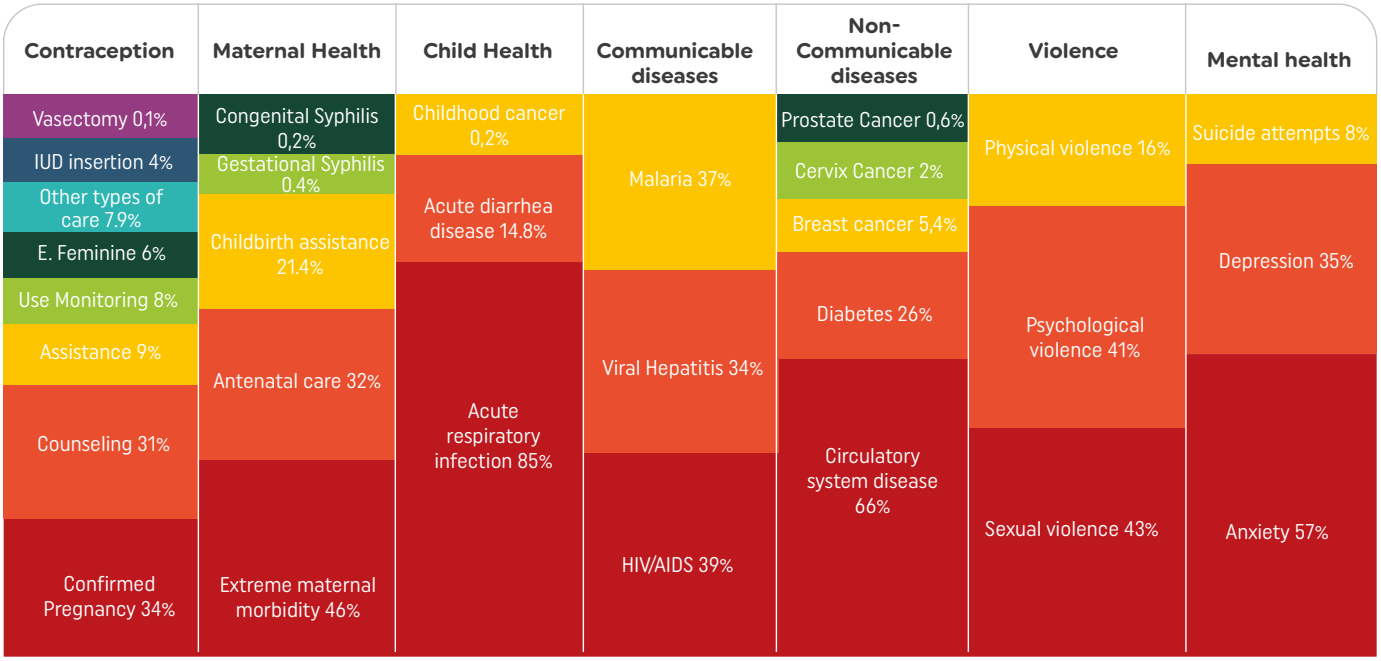
Between 2018-2019, the use of health services by the migrant and refugee population increased by:

249,5% in health care related to gestational syphilis.	**15,8%** in health care associated with communicable diseases (HIV / AIDS and viral hepatitis).	**134%** in medical services to manage and control cardiovascular system diseases	**114%** in breast cancer care **99%** % in health services for adolescents	**96%** contraceptive care **80%** in prenatal care

Source. Migration Colombia; Cube Individual Registration Service Delivery (RIPS) - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Consultation on 30 September 2019 during the month of November the same year.

Figure 4.1. Presents the distribution of migrants and refugees who sought access to health services according to seven health groups. For the contraception group, the top three services provided were to confirm a pregnancy, advice on contraception, and assistance on contraception methods. For maternal health group, the top three services provided were severe maternal morbidity (SMM), prenatal care, and childbirth. For the child health group, 85% of services were related to acute respiratory infection (ARI) and 14.8% to acute diarrhea. The majority of the communicable disease services were for HIV/AIDS (39%) and Hepatitis (34%). While for non-communicable diseases the most common services were for cardiovascular disease (66%) and diabetes (26%). Sexual (43%) and psychological (41%) violence comprise the majority of services for violence against women. Finally, over 90% of mental health services were for anxiety (57%) and depression (35%).

Figure 4.1. Proportion of the use of health services by migrants and refugees in Colombia



Source. Investigations Directorate, Profamilia, 2020, based on RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health (SRH) addresses the physical, psychological, and social well-being associated with the reproductive processes, functions, and system. These include for instance, the ability to pursue a satisfying and safe sexual life, when and how often to procreate, or not, and access to contraceptive methods [19]. The WHO recommends that to ensure SRH anyone wanting contraceptives can readily obtain accurate and quality information, as well as medical and psychosocial support [20].

Migration increases the vulnerability of people, particularly women, exposing them to risks of sexual and gender violence, unwanted pregnancies, early pregnancy (women between 10 and 14 years old), sexually transmitted diseases, and SMM, among others [21, 22]. This is a result of insufficient and inequitable access to essential sexual and reproductive health services. This section describes the use of contraceptive services by Venezuelan migrants and refugees, and the host community.

Figure 4.2. Distribution of SRH services used by migrants and refugees in 2019.

Source. RIPS data cube - Migrants. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. CIE X: Z30 - Z39.

Guidelines for local health services

- Increase care coverage in SRH services in the Colombian-Venezuelan border.
- Ensure effective and easy access to information regarding contraceptive methods, especially for Venezuelan migrants and refugees, and contraception methods for men.
- Encourage men in the migrant, refugee, and host communities, to use sexual and reproductive health services. Particularly in the departments of Bolívar and Magdalena, which recorded the lowest number of men seeking contraceptive methods.
- Implement strategies to recognize social and cultural differences in SRH between migrants and refugees. This, in order to transform SRH stereotypes and stigmas, gender-based care, and contraception.
- Strengthen the implementation of differential approaches that address SRH needs, ensuring that both regular and undocumented migrants have access to contraceptive care and SRH.

Access to contraceptive services

Use of contraceptive services in Colombia, 2019 and variation 2018-2019

Migrant population

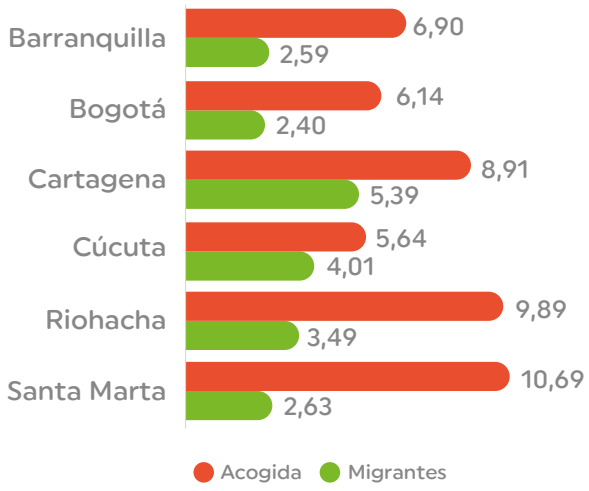
46,675 people
96% from 2018

Host community

1,732,569 people
-7% from 2018

- In 2018, around two million people accessed contraceptive services; comparable to the number for 2019. However, the number of Venezuelan migrants and refugees who sought such services, doubled between 2018 and 2019.
- A higher percentage of migrant and refugee women accessed contraceptive services than men.
- Bogotá reported the most migrants who sought contraceptive services (around four thousand people in 2018, and over six thousand in 2019).

Figure 4.3. Percentage of people who sought contraceptive services in the migrant and host communities, 2019



Source. RIPS data cube – Migrant population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

In general, migration generates obstacles in access to health care for women, and a limited availability of contraception exists in places of passage and arrival [7]. In a humanitarian emergency, sexual and reproductive health care should be guaranteed, even in the most difficult and complex cases [2, 3]. However there are still many unmet needs for Venezuelan migrants and refugees to access contraceptive services, particularly in Colombia-Venezuela border.

Colombia – Venezuela context

According to ENDS 2015, 7% of fertile women in a relationship and who did not want to become pregnant were not using contraception due to limited access to it. This percentage reveals inequities and barriers in access to contraception. For instance, percentages of those deprived from these services included: 19.3% of women aged 15 to 19 years old, 13.9% of those with lower education levels, 10.1% of the poverty-stricken, 10.1% of residents in the Caribbean, Amazon, and Orinoco regions, and 8.8% of rural residents. While Bogotá had an unmet need for contraception of 3.7%, the five departments studied exceeded the national level: 8.1% in Norte de Santander, 8.4% in Bolivar, 9.2% in Magdalena, 10.0% in Atlántico, and 13.7% in La Guajira [24].

Venezuela, does not count with updated figures for unmet contraceptive needs. The humanitarian crisis in Venezuela has led to drug shortages affecting access to contraception. For 2018, the Scarcity Index for Contraceptive Methods in pharmacies (IEMA) exceeded 75% in five Venezuelan cities, with the exception of condoms [24].

Use of contraceptive services

In 2018, around two million individuals accessed contraceptive and SRH services countrywide; similar to the 2019 numbers. However, the number of Venezuelan migrants and refugees who accessed contraceptive services countrywide increased from 23,764 in 2018 to 46,675 in 2019. In Bogotá and the five departments studied, contraceptive services registered and treated approximately 400,000 host community individuals in 2018 and 2019. On the other hand, for the same regions, 14,534 Venezuelan migrants and refugees accessed contraceptive services in 2019; a 69.7% change from 2018.

In 2019, Atlántico and La Guajira registered the largest numbers of migrants and host community individuals accessing contraceptive services (over 96,000 and 53,000, respectively). Except for in Atlántico, the number of Venezuelan migrants and refugees who sought contraceptive care in the other four departments increased between 2018 and 2019. More specifically, Bolivar (213.9%), Magdalena (133.5%), and Norte de Santander (133.3%) documented significant increases. For the same years, the number of people treated from the host community increased by 40.1% in Magdalena and by 5.9% in Norte de Santander. Atlántico and Bolivar were the departments with the highest numbers of host community individuals who used these services.

For the cities, Bogotá recorded the most Venezuelan migrants and refugees accessing contraceptive care; about 4,000 people in 2018, and 6,000 in 2019. Likewise, in the host community Bogotá recorded over 600,000 contraceptive consultations, the highest number by far.

Based on gender, more women in both population groups accessed contraceptive care in 2019. Bogotá, Norte de Santander, and Atlántico reported the largest numbers of migrant and refugee women who used these services. Similarly, Bogotá and Atlántico documented the highest numbers of women from the host community who accessed these services, along with Bolívar. Even though less men accessed contraceptive services, the number of Venezuelan male migrants and refugees who had a vasectomy in the prioritized departments increased from 102 in 2018 to 165 in 2019. This increase was higher in Atlántico (1 to 26) and Norte de Santander (36 to 75). Furthermore, the increase in Norte de Santander took place in municipalities other than Cucuta, highlighting the need for humanitarian assistance in other border municipalities, such as Villas del Rosario and Los Patios.

MATERNAL HEALTH

Maternal health includes all aspects of women's health from pregnancy to delivery and postpartum. The maternal health complications responsible for 70% of mortality are: bleeding, infection, eclampsia, and obstructed labor. Specialized healthcare before, during, and after childbirth can improve and save the lives of pregnant women and newborns [26].

The dynamics of migration can disrupt continuous care and compromise access to prenatal care, skilled birth attendants (SBA), and emergency obstetric care (EmOC) [21]. Camps, shelters, and urban settlements require urgent solutions to address the maternal and neonatal healthcare needs of Venezuelan migrants and refugees. This section discusses the use of maternal health care by Venezuelan migrants and host community individuals, and is grouped into four health services: i) prenatal care, ii) hospital or birth center care for childbirth, iii) SMM during and after pregnancy, and iv) gestational and congenital syphilis.

Figure 4.4. Distribution of use of maternal health services for 2019.

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. CIE X: Z340 - Z369; Ø800 - O849; O00-O075; O92 O85-; O980-O94X; O987; O981y A500 - A509

Guidelines for local health services

- Increase primary care coverage for migrants, so that they can have access to early diagnosis.
- Guarantee medical advice for pregnant women, both, Venezuelan migrants and refugees, and Colombians.
- Provide adequate information on prenatal care, nutrition. and risk factors for the gestational stage.
- Ensure access to antenatal care and balanced prenatal supplements to reduce the risk of stillbirth in women with nutritional deficiency.
- Ensure that pregnant women have access to maternal and fetal evaluation health services.
- Strengthen female community participation groups as part of the support system for the needs of pregnant women.
- Reduce inequalities and increase opportunities for the migrant population, so they can have access to a better quality of life that allows for healthy habits.
- Through the Public Health Surveillance System, improve reporting and monitoring from the health service providers and the community regarding pregnancy complications.

Prenatal care

Prenatal care saves lives because it provides more opportunities to detect and treat possible pregnancy complications. The standard prenatal care timeline recommends a minimum of eight visits to reduce perinatal mortality and improve the women's experience. However, only 64% of women worldwide receive four or more antenatal care visits during their pregnancy [27].

Use of prenatal services in Colombia, 2019 and variation 2018-2019

Migrant population

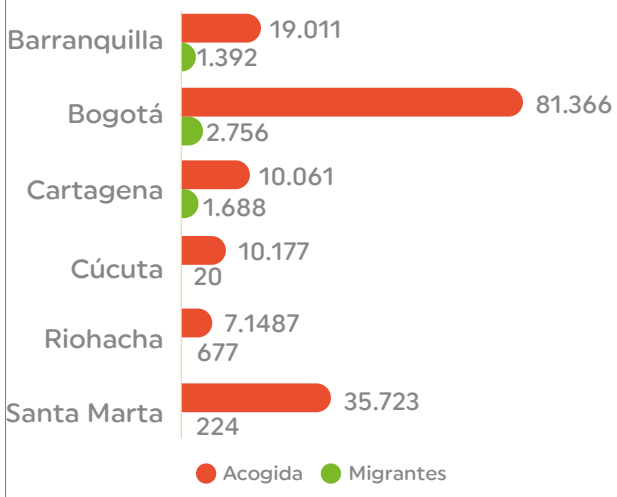
27,446 people
80.3% from 2018

Host community

488,324 people
-15.1% from 2018

- The use of prenatal care by migrants and refugees increased by 80% between 2018 and 2019.
- In 2019, Atlántico, Bolívar, and Norte de Santander reported the largest number of Venezuelan migrants and refugees who sought prenatal care.
- In Norte de Santander, most prenatal appointments took place in municipalities other than Cucuta. In 2019, while Cúcuta had 58 prenatal visits, the department saw a total of 1,660.
- Santa Marta had the greatest increase in the number of prenatal visits (from 6 in 2018 to 224 in 2019), followed by Riohacha (from 181 in 2018 to 677 in 2019).

Figure 4.5. Number of migrant and host community women who used antenatal care in 2019



Source. ISPSIS data cube. Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

The vulnerability of pregnant migrants along with the barriers they face to access maternal and newborn health services, increase the urgency to guarantee proper antenatal care. The determinants include: human mobility, immigration status, inadequate health coverage, absence of healthcare guidelines established at a local level to address the humanitarian crisis, limited information on prenatal visits; xenophobia in health service, and limited health care [7].

Colombia – Venezuela context

In 2018, according to DANE, 63% of pregnant women had less than eight antenatal visits, and 31.6% had between eight and twelve visits. It is important to note that 3.8% of pregnant women did not attend any prenatal appointments [28]. In the same year, according to the MHSP, 8,209 pregnant Venezuelans migrated to Colombia, requiring access to prenatal and specialist care; however, 6,304 had no prenatal care [18].

Use of prenatal health services

In 2019, 515,770 women countrywide had prenatal appointments. In the prioritized departments, 27,446 Venezuelan migrants and refugees, and 76,085 women from the host community used prenatal health services. Moreover, between 2018 and 2019, the use of these health services by Venezuelan migrants and refugees increased by 80%.

According to data by department, Atlántico, Bolívar, and Norte de Santander reported the most migrants and refugees who had prenatal appointments. In the case of Norte de Santander, more women accessed these services in municipalities other than Cucuta; highlighting the need for humanitarian assistance in other border towns. Comparably, Atlántico and Bolivar reported the most prenatal visits for host community women. Regarding the cities, Bogotá, Barranquilla, and Cartagena documented the highest numbers of women in both population groups who sought prenatal care. In addition, between 2018 and 2019 Santa Marta reported the greatest increase in the number of women attended for prenatal care (from 6 to 224), followed by Riohacha (from 181 to 677).

Delivery Care

Even though childbirth is a critical moment in the life of the mother and the newborn, it should be a positive experience. Giving birth in a healthy and safe environment from a clinical and psychological perspective, having practical and emotional support, and meeting the personal and sociocultural beliefs and expectations of women define a positive birth experience [29]. Without these standards, the risk of complications, morbidity, and mortality in childbirth increase.

Use of delivery care services in Colombia, 2019 and variation 2018-2019

Migrant population

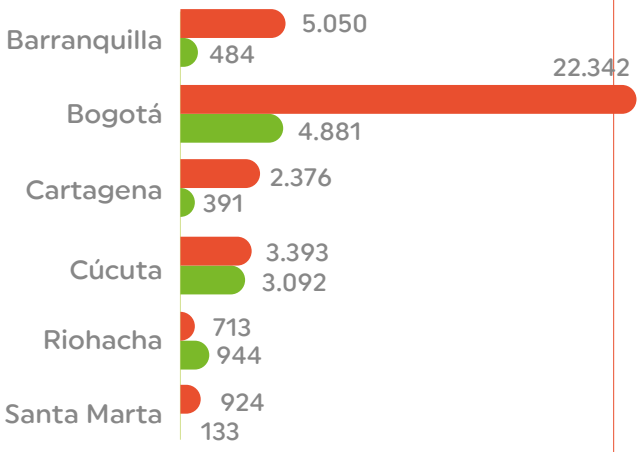
20,076 people
73.1% from 2018

Host community

121071 people
-39.3% from 2018

- In 2019, 141,147 women used childbirth services countrywide: 20,076 Venezuelan migrants and refugees, and 121,071 women from the host community.
- In 2019, Norte de Santander and La Guajira reported the highest numbers of delivery care for Venezuelan migrants and refugees.
- Between 2018 and 2019, the departments of La Guajira and Norte de Santander had the highest percentage increases in the number of childbirth services (58.2% and 40.0%, respectively).
- Between 2018 and 2019, the municipalities of Bogotá and Santa Marta had the highest percentage increases in the number of childbirth services (118% and 41.5%, respectively).
- In 2019, Bogotá had the most births attended by health personnel in the migrant community (4,881), followed by Cucuta (3,082), and Riohacha (944).

Figure 4.6. Number of migrant and host community women who sought delivery care in 2019.



Source. RIPS data cube – Migrant population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Delays in health care, unworthy treatment, discrimination, ignorance, and absence of national guidelines constitute common barriers that migrants face when seeking delivery care at hospitals and birth centers. This puts their lives, quality of life, and their babies at risk [7]. Although Venezuelan migrants have access to childbirth care, several situations compromise the quality of the experience [28].

Colombia – Venezuela context

In Colombia, 98.3% of births in 2018 took place in health institutions and 1.4% in domestic households. In addition, 54.6% of deliveries were natural and 44.4% spontaneous caesareans [28]. Between 2009 and 2018, delivery care used by Venezuelan migrants and refugees increased by 2,253%, from 164 to 3,859 births [9].

Use of childbirth services

In 2019, 141,147 women countrywide used childbirth services, of which 20,076 were Venezuelan migrants and refugees and 121,071 women from the host community. Even though delivery care for women from the host community is considerably higher, the number of Venezuelan migrants and refugees who sought such services increased significantly between 2018 and 2019. More specifically, the use of prenatal care by Venezuelan migrants and refugees increased by 36.8%, from 8,479 in 2018 to 11,597 in 2019. Accordingly, four out of the five prioritized departments saw an increasing trend, with the exception of Atlántico, which registered less use of such services.

By departments, Norte de Santander and La Guajira reported the highest numbers of Venezuelan migrants and refugees who accessed childbirth services; highlighting a wide difference compared to the rest of the departments studied. For the host community, Atlántico and La Guajira documented the greatest numbers of host community women who sought such care. Meanwhile, in 2018 and 2019 Magdalena had the least births attended by health personnel in both population groups.

When comparing the cities, in 2018 and 2019 Bogotá reported the most migrants and refugees who used childbirth services, with a 118% increase between the two years. Cúcuta followed Bogotá in the number of births attended by health personnel in the migrant community, and represented the greatest proportion for its entire department (Norte de Santander). Likewise, in the host community, Bogotá reported the most women who sought delivery care, despite documenting a decrease of 45.9% compared to 2018. Even though La Guajira registered high numbers of migrant and host community women accessing such services, its capital, Riohacha, reported low numbers. Thus, most births in La Guajira took place in other municipalities. No other department reported this trend.

Severe maternal morbidity

SMM refers to a serious complication that occurs during the pregnancy, childbirth, or postnatal period and requires immediate attention to prevent maternal death. From a public health perspective, SMM can be used to assess the performance of health services, given that timely and quality care can prevent a fatal outcome when dealing with severe obstetric complications [21].

Use of services associated with severe maternal morbidity in Colombia, 2019 and variation 2018-2019

Migrant population

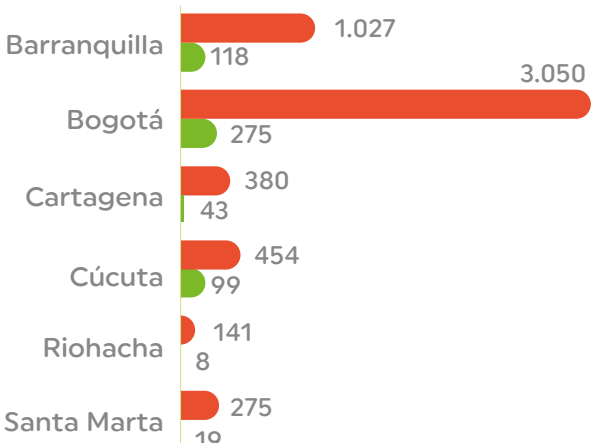
1,323 people
59.9% from 2018

Host community

19,777 people
-7.6% from 2018

- In 2019, 39,353 Venezuelan migrants and refugees used health services associated with SMM.
- Norte de Santander, La Guajira, and Atlántico reported the highest numbers of Venezuelan migrants and refugees attended by health professionals for SMM.
- Bogotá, Cucuta, and Barranquilla, recorded the highest numbers of Venezuelan migrants and refugees attended by health professionals for SMM.
- In 2019, all prioritized cities, except for Barranquilla, documented a higher number of Venezuelan migrants and refugees attended by health professionals for SMM compared to 2018.

Figure 4.7. Number of migrant women treated for SMM, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

The dynamics of migration flows, such as stress, anxiety, displacement, changes in feeding, limited basic sanitation and health services, weather-related challenges, and long journeys have negative effects on the maternal health of migrants and refugees [31]. Pregnant migrants arrive to the country under extreme vulnerability and risk of complications. These complications tend to be related to a specific disease (eclampsia, severe pre-eclampsia, sepsis or severe systemic infection), organ dysfunction (vascular, renal, liver, metabolic, or brain failure), and management (need for intensive care, transfusion, or surgical emergency) [32].

Colombia – Venezuela context

During 2019, Colombia's health system reported 11,786 confirmed cases of SMM, with the majority comprising women over 35 years old. Major health concerns associated with SMM include severe pre-eclampsia, uterine rupture, and respiratory and heart failure [32]. Fortunately, the SMM trends in Colombia have generally declined. Between 2008 and 2011, the maternal mortality ratio ranged between 60.7 and 71.6 deaths per 100,000 live births, and between 2011 and 2017 this ratio dropped by 19.6 [33]. Nonetheless, the number of SMM cases recorded for Venezuelan migrants and refugees in Colombia increased from 49 confirmed cases in 2018 to 183 in 2019; a percentage increase of 273.5% [35]. Meanwhile, the latest information available on SMM rates recorded in Venezuela indicated 110 cases per 100,000 live births in 2016 [3, 4].

Use of health services for severe maternal morbidity

In 2019, 39,353 Venezuelan migrants and refugees used health services associated with SMM. This represents a 114.9% increase in the number of Venezuelan migrants and refugees attended by a healthcare professional for SMM between 2018 and 2019. When looking at the departments, Norte de Santander, La Guajira, and Atlántico reported the highest numbers of visits for SMM by Venezuelan migrants and refugees. At the city level, Bogotá had the highest quantity of Venezuelan migrants and refugees attended by a healthcare professional for SMM, showing a significant increase from 2018. Cucuta and Barranquilla followed Bogotá in the number of migrants and refugees who sought services for SMM; however, Barranquilla was the only city that did not record an increase in these services for 2019.

Syphilis during pregnancy and congenital syphilis

The spirochete bacterium Treponema pallidum causes syphilis, a curable infection that is transmitted through sexual contact or during pregnancy from the mother to the fetus. During the primary stage, the chancre (sore that appears where bacteria enters the body) increases the risk of transmission and acquisition of HIV. Syphilis during pregnancy can have serious consequences, such as premature birth, stillbirth and neonatal death. Furthermore, congenital syphilis (transmitted from the pregnant mother to the fetus) can cause low weight, neonatal infection, severe anemia, enlarged liver and spleen, and nervous system and neurological disorders such as deafness, blindness, skin rashes, delayed growth, bone deformities, and meningitis. Health impacts on a baby are preventable if the infection is detected and treated before the second half of the second trimester [36].

Use of services in Colombia for congenital syphilis, 2019 and variation 2018-2019

Migrant population
138 people
46.8% from 2018

Host community
998 people
12.1% from 2018

Migrant population
367 people
249.5% from 2018

Host community
1,037 people
20.7% from 2018

Figure 4.8. Number of migrant and host community women treated for syphilis during pregnancy. 2019

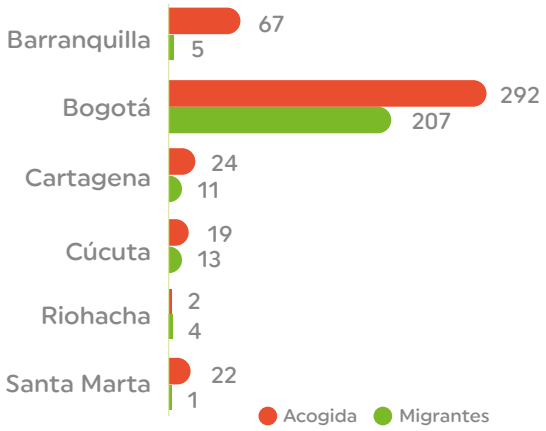
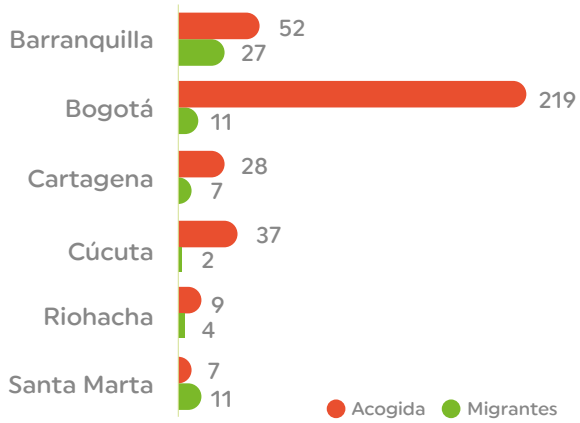


Figure 4.9. Number of migrant and host community children treated for congenital syphilis. 2019



- In 2019, 1,404 women used health services associated with syphilis during pregnancy countrywide: 1,037 from the host community and 367 from the migrant population. There was a 249% increase from 2018 to 2019 in the use of these health services by the migrant and refugee population.
- Bolivar and Norte de Santander reported the highest numbers of migrant women attended by health professionals for syphilis during pregnancy. For the cities, Bogotá documented the most women who received medical attention for syphilis during pregnancy in both population groups.
- In 2019, 1,136 people countrywide sought health services associated with congenital syphilis; 998 from the host community and 138 people from the migrant and refugee population. There was a 46% increase from 2018 to 2019 in the use of these health services by the migrant and refugee population.
- By department, Magdalena and Atlántico reported the highest numbers in cases of congenital syphilis in the migrant and refugee population. By municipality, Barranquilla, Santa Marta, and Bogotá treated the highest numbers of congenital syphilis cases in the same population group. In the host community, Bogotá, Barranquilla, and Cúcuta recorded the highest numbers of cases.

Migration as a determinant

In the context of migration, given the difficulties to access health services, particularly prenatal care, takes on greater significance mitigate cases of gestational and congenital syphilis [37]. Barriers in access to information on prevention, access to screening and diagnostic tests, management and treatment of syphilis during pregnancy increase the risk. In 2019 only 31.8% of pregnant migrant and refugee Venezuela agreed to tests to diagnose this disease [38].

Colombia – Venezuela context

In 2019, 3,090 cases of syphilis during pregnancy were reported in Colombia. Of these, 8.9% were Afro-Colombian women and 2.6% indigenous women. Furthermore, 90.6% of the cases of syphilis in pregnancy were diagnosed during pregnancy, 5.5% at childbirth and 2.5% in the puerperium. Regarding congenital syphilis, 992 cases were reported nationwide; an increase of 35.0% from 2018 [39]. In 2018, 88 Venezuelan migrants were diagnosed with syphilis in pregnancy. In the first half of 2019, this number increased to 411. Similarly, 36 cases of congenital syphilis in migrant children were reported in 2018, and 108 in the first half of 2019 [39].

Use of health services for syphilis during pregnancy

In 2019, 1,404 women used health services associated with syphilis in pregnancy nationwide; 367 Venezuelan migrants and 1,037 women from the host community. The use of these health services increased by 249% in the migrant and refugee population, and by 20.7% in the host community.

When analyzing the departments, in 2019 Bolívar and Norte de Santander reported the highest numbers of migrant women treated for syphilis during pregnancy, whereas Magdalena and the Atlántico recorded the lowest. For the host community, Atlántico reported the most women treated for these services.

As for the cities, in 2019 Bogotá documented the most women treated for syphilis in pregnancy in both population groups. In addition, between 2018 and 2019, Barranquilla reported the highest increase in the number of migrants treated for syphilis in pregnancy, and Cartagena of women in the host community. Conspicuously, when excluding Bogotá, Cúcuta accounted for nearly 50% of the total cases of migrant and refugee women with syphilis during pregnancy.

Use of health services for congenital syphilis

In 2019, Colombia reported that 1,136 children under 6 used health services associated with congenital syphilis; 138 migrants and 998 children from the host community. Between 2018 and 2019, the use of health services for congenital syphilis increased by 46.8% in the migrant population, and by 15.7% in the host community.

Based on the departments, Magdalena and Norte de Santander reported the highest numbers in migrant children under 6 years of age treated for congenital syphilis in 2019. Whereas, in the host community, Atlántico, Bolívar, and La Guajira recorded the highest numbers of children under age 6 treated for congenital syphilis. On a city basis, Barranquilla documented the most migrant children treated for congenital syphilis in both, 2018 and 2019.

CHILD HEALTH

Girls and children under five, especially infants, are particularly vulnerable to malnutrition and infectious diseases; most of which are preventable or treatable. The Global Strategy for Women's, Child, and Adolescent Health (2016 - 2030) focuses on the protection of women, children, and adolescents living in fragile humanitarian settings. It seeks to ensure the effective enjoyment of the highest attainable standard of health, even in the most difficult circumstances [40].

Migrant children experience specific vulnerable situations that affect and violate their rights. For instance, they face barriers in access to balanced diets and nutrition, drinking water, hygiene, and habitable conditions, among others. Due to insufficient health services during transit, these situations expose them to infectious diseases that in most cases are treated inadequately. In addition, during border mobilization, children are more exposed to phenomena that can hinder their development such as forced recruitment, violence, sexual exploitation, trafficking, discrimination, abandonment, neglect, and limited emotional attention from their caregivers [41].

The risk experiencing children in their early years, particularly when they are abandoned, they travel separately and in groups of their own increasing age the chances of worsening their health and suffer early deaths that could be avoided if we consider their needs and most urgent diseases and adequate and differential care is guaranteed by the health system within the humanitarian response. This section discusses the use of child health services among the migrant population in Venezuela and host community Colombian from three health outcomes that represent the biggest challenges for the care of children's health in the context of migration: i) Acute Diarrhea, ii) Acute Respiratory Infection and iii) Childhood Cancer.

In order to avoid the risks that children face in their early years and that are associated with the humanitarian crisis, it is essential to meet their needs, identify the most urgent diseases, and guarantee adequate and differential health care. Furthermore, when the children are abandoned, and when they travel separately or in groups of their own age, the chances of worsening health conditions and suffering early death increase. This section discusses the use of child health services in Colombia by the Venezuelan migrant population and the host community. The section focuses on the three health conditions that represent the biggest challenges for children's health care in the context of migration: i) acute diarrhea, ii) acute respiratory infection, and iii) childhood cancer.

Figure 4.10. **Distribution of child heal**

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were A00-A09, Z110; Z221; Z270;J00- J22; Z251; C710; C820 - C859; C910 and D330 - D332.

Guidelines for local health services

- Provide information in shelters and border points that enables families with children to recognize health care centers where they can access services.
- Continue to promote immunization programs for the population that needs it.
- Increase primary care coverage for children, adolescents, and pregnant women as part of disease prevention and early diagnosis.
- Engage children through a biopsychosocial perspective sensitive to their needs and circumstances, as well as to those of their parents and caregivers.
- Ensure access to safe drinking water and basic sanitation.

Acute diarrhea

Acute Diarrhea (AD) tends to be a symptom of an infection in the digestive tract caused by bacteria, parasites, fungi, or viruses. The infection spreads through contaminated food or water, or from one person to another due to poor hygiene practices. It is characterized by an increase in the number of liquid stools that cause acute loss of fluid and electrolytes resulting in dehydration. It is considered to be the eighth leading cause of death in all ages worldwide, and the second for children under five, killing around 525,000 children yearly [42].

Use of services in Colombia for acute diarrhea in children aged 0 to 5 years in 2019 and variation 2018-2019

Migrant population

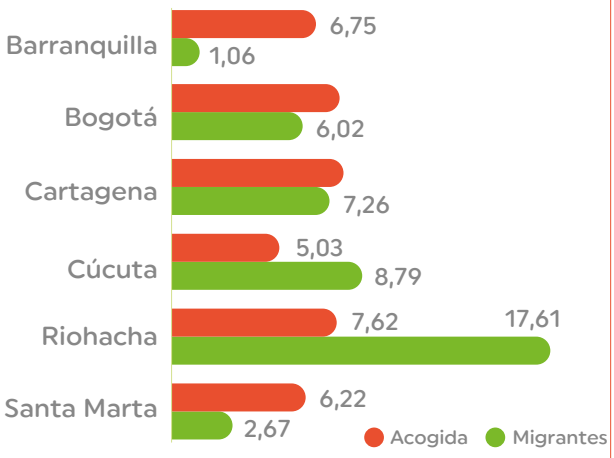
2,318 people
-2.9% from 2018

Host community

212,702 people
-34.9% from 2018

- In 2019, 39,353 Venezuelan migrants and refugees used health services associated with SMM.
- Norte de Santander, La Guajira, and Atlántico reported the highest numbers of Venezuelan migrants and refugees attended by health professionals for SMM.
- Bogotá, Cucuta, and Barranquilla, recorded the highest numbers of Venezuelan migrants and refugees attended by health professionals for SMM.
- In 2019, all prioritized cities, except for Barranquilla, documented a higher number of Venezuelan migrants and refugees attended by health professionals for SMM compared to 2018.

Figure 4.11. Percentage of migrant and host community children between 0 and 5 years old treated for AD in 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

During migration, basic sanitation, hygiene, and access to drinking water are not guaranteed which increases the risk of spread of outbreaks [43]. In Colombia, the National Institute of Health monitors the morbidity and mortality associated with acute diarrhea in children under 5 years old, due to its high prevalence. It is considered to be the second leading cause of death in this age group, especially if the children are malnourished or immunosuppressed [44].

Colombia – Venezuela context

In 2019, 426,425 AD cases were reported in children under age 5. Also, the incidence of AD in this group was 88.5 cases per 1,000 population [42]. On the other hand, the latest information available in Venezuela was published in the Epidemiological Bulletin of the Popular Power Health Ministry in 2016, which reported 34,174 cases of AD among children under 5 years old [45]. Moreover, PAHO reported in its last record of 2016 a total of 2,013 deaths related to AD in this population, representing 3.7% of the deaths in the country [46].

Use of health services for acute diarrhea

In 2019, 2,318 health services for AD were provided to migrant children and refugees from Venezuela under 5 years old, and 212,702 to children of the same age group in the host community. In relation to 2018, a decrease was evident in the provision of services to treat AD in both population groups. In the Venezuelan migrant and refugee population there was a decrease of 2.9% corresponding to 70 fewer children, while the host community reported 34.9% less cases, corresponding to 114,023 fewer children.

According to the departments, La Guajira (762) and Norte de Santander (600) reported the highest numbers of Venezuelan migrants and refugees under 5 years old treated for AD in 2019. On the other hand, the most children under age 5 treated for AD in the host community were in Atlántico (11,310) followed by Bolivar (10,595). Between 2018 and 2019, despite a decreasing trend countrywide, all prioritized departments identified an increase in the percentage of Venezuelan migrant and refugee children under age 5 treated for AD. Bolivar documented the largest increase, from 32 cases in 2018 to 171 in 2019.

Based on the cities, in 2019 Bogotá (780), Riohacha (361), and Cucuta (323) reported the highest numbers of Venezuelan migrant and refugee children under age 5 treated for AD. Relative to 2018, the number of migrant and refugee children from Venezuela treated in Bogotá increased by 239.0 % (582 more cases), and in Cartagena by 392.9% (110 more cases). Meanwhile, this number fell in Cucuta by 6.1% (21 less cases). On the other hand, Bogotá recorded the most cases of AD in children under age 5 from the host community (48,895), followed by Barranquilla (6,998), and Cartagena (5,598).

Table 4.1 reports the five most common causes of AD for which children under age 5 in the Venezuelan migrant and refugee population and the host community sought medical attention in Colombia in 2019. It is important to highlight that in the Venezuelan migrant and refugee population, 175 of the consultations were due to intestinal protozoal infection from drinking water contaminated with feces, and 157of the cases were due localized salmonella infections as a result of drinking contaminated water, or contaminated or decomposing food.

Furthermore, in 2019 Colombia reported that 1,468 Venezuelan migrants and refugees between ages 6 and 10 sought health services related to AD nationwide. This represents an increase of 79.6% from the previous year, or 572 additional cases. On the other hand, 65,371 children from the host community in the same age group used these health services.

When analyzing the departments, Norte de Santander (245) and La Guajira (243) documented the highest numbers of children aged 6 to 10 treated for AD in the Venezuelan migrant and refugee population in 2019. Meanwhile, in the host community, Atlántico reported the most cases of children in the same age group with AD (3,179), followed by Bolivar (2,543). In general, from 2018 to 2019 the number of cases in the host community decreased in the departments analyzed. The largest decrease was found in La Guajira (3,925 fewer cases in 2019), whereas the smallest decrease corresponded to Bolivar (899 less cases).

According to the cities, in 2019 Bogotá (257), Cucuta (140), and Riohacha (125) had the highest numbers of Venezuelan migrant and refugee children aged 6 to 10 treated for AD. However, Cartagena recorded the largest increase from 2018

with 52 additional cases in 2019, corresponding to an increase of 800%. Based on gender, in 2019 more boys used health services for AD than girls in both population groups. More specifically, in the Venezuelan migrant and refugee population 777 boys were treated compared to 691 girls; and 33,568 boys compared to 31,803 girls in the host community.

Table 4.2 presents the five most common causes of AD for which children aged 6 to 10 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019.

Table 4.1. Five leading causes of AD for which children under age 5 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019 (n: number of people served)

n	Migrant population	Place	Host community	n
408	Other intestinal infections	**1**	Diarrhea and gastroenteritis	**145412**
278	Other viral enteritis	**2**	Gastroenteritis and colitis	**33,743**
274	Intestinal viral infection unspecified	**3**	Viral intestinal infection, unspecified	**19,154**
175	Other protozoal intestinal diseases by drinking contaminated water with feces	**4**	Other viral enteritis	**17,758**
157	Salmonella infections due to consumption of contaminated water or food rotting	**5**	Other gastroenteritis and colitis of infectious origin	**16,980**

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Table 4.2. Five leading causes of AD for which children aged 6 to 10 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019 (n: number of people served).

n	Migrant population	Place	Host community	n
888	Diarrhea and gastroenteritis of presumed infectious origin	**1**	Diarrhea and gastroenteritis of presumed infectious origin	**38465**
155	Other specified intestinal infections	**2**	Gastroenteritis and colitis of unspecified origin	**7720**
88	Viral intestinal infection, unspecified	**3**	Other viral enteritis	**5698**
73	Gastroenteritis and colitis of unspecified origin	**4**	Viral intestinal infection, unspecified	**5713**
62	Other specified intestinal protozoal diseases	**5**	Other gastroenteritis and colitis of infectious origin	**3766**

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Acute Respiratory Infection

Acute Respiratory Infection (ARI) encompasses a group of infections in the respiratory tract caused by bacteria or viruses that usually remain in humans for an incubation period of 15 days in the lower and upper respiratory tracts. Children under 5 years old are amongst the group of people most affected by ARI; one of the main causes of infant mortality [47].

Use of services in Colombia for acute respiratory infection in children aged 0 to 5 in 2019 and variation 2018-2019

Migrant population

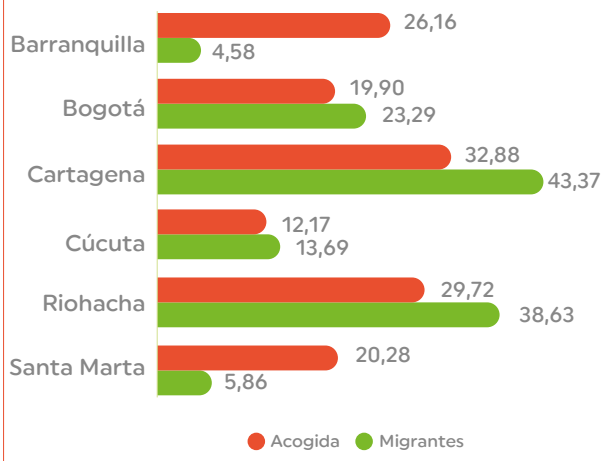
14,097 people
82% from 2018

Host community

648,746 people
-26.8% from 2018

- In 2019, 14,097 Venezuelan migrants and refugees under 5 years old sought ARI-related health care, compared to 648,746 children from the host community.
- Norte de Santander and La Guajira had the highest numbers of migrant and refuge children under 5 years old from Venezuela treated for ARI.
- Bogotá, Cartagena, and Riohacha had the highest numbers of children under 5 years old from Venezuela who used health services related to ARI.
- Boys under age 5 frequented health services related to ARI at a higher level than girls, both in the Venezuelan migrant and refugee population and the host community.

Figure 4.12. Percentage of children aged 0 to 5 treated for ARI in the migrant and host communities, 2019



Source. RIPS data cube – Migrant Population. Social Protection Information System(ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migration increases overcrowded spaces, settlements in outlying areas with uninhabitable living conditions, and the number of people in places with high concentration flows (e.g. transport terminals). In addition, it limits access to adequate hygiene, sanitation, and potable water for hand washing. All of these conditions increase the risk of ARI. Also, sudden temperature changes, and weakened immune systems as a result of dehydration, nutritional deficiencies, and an incomplete immunization history, further increase the likelihood of developing an ARI.

Colombia – Venezuela context

In Colombia, ARI is the fifth leading cause of death in the general population and the third in children under 5 years old [47]. Since 2012, special strategies have been implemented consisting of surveillance for unusual severe ARI and ARI-related deaths in this age group. In addition, constant monitoring is performed of morbidity figures in inpatient and outpatient emergencies for this condition. In 2019, there were 6,113,619 outpatient and emergency visits due to ARI. Furthermore, 660 deaths were reported, of which 70% were children under 5 years old [48]. On the other hand, the latest report on Venezuela is from 2016, which reported 95,722 ARI cases [4;5]. However, updated information on Venezuela is limited and highlights the need to disaggregate data in order to identify ARI health dynamics.

Use of health services for acute respiratory infection

In 2019, 14,097 Venezuelan migrant children under 5 years old received health care related to ARI in Colombia; an increase of 82% compared to 2018 (i.e. 6,353 additional cases). On the other hand, in the host community 648,746 children were treated for ARI; a reduction of 26.8% compared to 2018.

According to the departments, in 2019 Norte de Santander (1,099) and La Guajira (1,415) recorded the highest numbers of Venezuelan migrant and refugee children under 5 years old treated for ARI. In the same population group Bolívar documented the highest percentage increase in ARI cases (376%), from 192 children in 2018 to 914 in 2019. In the host community, the largest numbers of children under age 5 treated for ARI corresponded to Atlántico (4,413) and Bolivar (42,868).

At a city level, Bogotá (3,019), Cartagena (824), and Riohacha (792) documented the highest numbers of Venezuelan migrant and refugee children under 5 years old who used health services related to ARI. Similarly, Bogotá reported the most cases in the host community (126,007), followed by Barranquilla (28,117), and Cartagena (27,515). Table 4.3 summarizes the five most common causes of ARI for which children under age 5 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019.

In 2019, 4,303 Venezuelan migrant and refugee

Table 4.3. Five leading causes of ARI for which children under 5 years old in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019. (n: number of people served)

n	Migrant population	Place	Host community	n
6,107	common cold or acute nasopharyngitis	**1**	Acute nasopharyngitis or common cold	**382938**
2,018	acute infection unspecified	**2**	acute tonsillitis	**75977**
1,720	acute bronchiolitis	**3**	acute bronchiolitis	**73324**
1,450	acute infection of the upper airways	**4**	INFECTION acute upper respiratory	**63992**
1,094	acute tonsillitis	**5**	Acute infection unspecified lower airways	**50427**

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were J00- J22; Z25.

children aged 6 to 10 sought medical attention for ARI nationwide; an increase of 73.2% compared to 2018. Meanwhile, 179,889 children from the host community in the same age group were treated for ARI; a reduction of 37.6%.

When looking at the departments, La Guajira (472) and Norte de Santander (309) reported the highest numbers of Venezuelan migrant and refugee children aged 6 to 10 treated for ARI. Differently, Bolivar (14,041) and Atlántico (13,016) documented the highest numbers of cases in the host community.

According to the cities, Bogotá documented the most Venezuelan migrant and refugee children aged 6 to 10 treated for ARI (932), followed by Riohacha (292). Likewise, Bogotá reported the most cases in the host community (31,226), followed by Cartagena (8,292). From 2018 to 2019, the number of children treated for ARI in the host community decreased in all six cities, with the highest decrease recorded in Riohacha (48.9%). No significant differences were found by gender for 2019. Table 4.4 reports the five most common causes of ARI for which children aged 6 to 10 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019.

Childhood cancer

Childhood cancer includes all the cancers that develop in children and adolescents under 19 years old. It is rare and represents only between 1% and 3% of cancer diagnoses globally, and between 0.5% and 4.6% of childhood morbidity [49]. Until 2008, childhood cancer in people under 19 years old was recognized as a public health problem in Colombia due to its increased mortality, which was attributed primarily to acute pediatric leukemia [50].

Table 4.4. Five leading causes of ARI for which children aged 6 to 10 in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019 (n: number of people served).

n	Migrant population	Place	Host community	n
1888	Common cold or acute nasopharyngitis	**1**	Acute nasopharyngitis or common cold	**102306**
571	Acute bronchitis	**2**	acute tonsillitis	**32508**
501	Acute infection unspecified lower airway	**3**	acute infection of the upper airways	**14057**
326	acute tonsillitis	**4**	acute pharyngitis	**12834**
313	Infection acute upper airway	**5**	Acute bronchitis	**8940**

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Consultation on - in September 2019.

Use of services in Colombia for childhood cancer in children aged 0 to 5, 2019 and variation 2018-2019

Migrant population

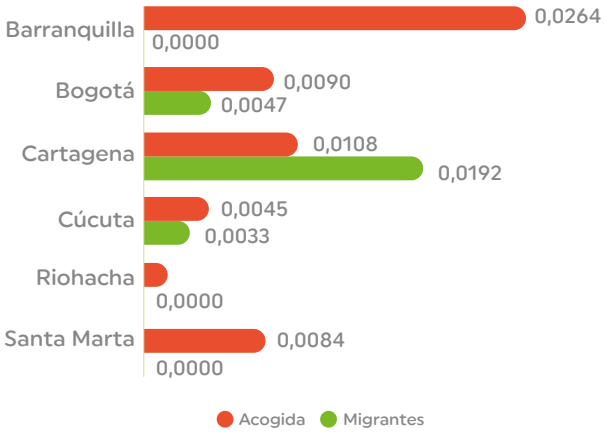
28 people
86.7% from 2018

Host community

1,072 people
17.8% from 2018

- In 2019, 1,100 children and adolescents under the age 19 used health services associated with cancer in Colombia.
- Between 2018 and 2019, the use of health services for childhood cancer increased by 17.8% in the host community, and by 86.7% in the migrant and refugee population from Venezuela.
- Bolivar and Norte de Santander were the only departments that reported medical attention related to cancer in migrant children and adolescents.
- In 2018 and 2019, Bogotá, Cucuta, and Cartagena documented only cases of boys treated for cancer in the migrant and refugee population, none of girls.
- Cartagena had the highest percentage of migrant and refugee children from Venezuela under 19 years old treated for cancer.

Figure 4.13. Percentage of children under age 19 treated for cancer in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migrant children and adolescents with cancer are likely to suffer from adaptive disorders, anxiety, or depression. The double impact of having cancer and confronting a new reality and culture, exacerbate these conditions. In this sense, children and adolescent migrants have a threefold vulnerability: being underage, migrants, and suffering from some form of cancer [51]

Colombia – Venezuela context

In 2019, Colombia reported 1,406 cases of childhood cancer, of which only 49 corresponded to Venezuelan migrants and refugees. Acute lymphoblastic leukemia represented 31.3% of cases, nervous system tumors 15.4%, and lymphomas 10.4%. The same report reveals that childhood cancer is more common in boys (54.9%) than in girls. On the other hand, in Venezuela 50 out of 100 children die of cancer due to a lack of treatment, supply shortage, and high costs. Accordingly, in 2018 there was a 45% increase in infant mortality rates [52].

Use of health services

In 2019, Colombia reported 1,100 children and adolescents under age 19 who used health services associated with cancer; 28 Venezuelan migrants and refugees, and 1,072 children from the host community. There was a slight difference between gender in both population groups, since more boys and young men sought medical care for cancer than girls and young women. Between 2018 and 2019, the percentages of people treated for childhood cancer increased in both population groups; by 17.8% in the host community (from 910 to 1,072 cases), and by 86.7% in the Venezuelan migrant and refugee community (from 15 to 28 cases). By gender, even though cases of migrant girls with cancer were documented at national level, the number of boys is slightly higher. This is similar in the host community, which reported a higher percentage of boys treated for childhood cancer than girls. In the same population group, Bogotá (201) and Barranquilla (161) reported the highest numbers of people treated for childhood cancer.

On the other hand, Bolivar (3) and Norte de Santander (1) were the only two departments to report medical attention for migrants under 19 years old with cancer. Meanwhile, Atlántico (161) documented the most cases in the host community. At the city level, Bogotá (5), Cartagena (3), and Cúcuta (1) were the only cities to report childhood cancer care for Venezuelan migrants and refugees under the age 19.

ADOLESCENT HEALTH

Adolescence is the growth and development period that occurs after childhood and before adulthood; corresponding to ages 10 to 19. Since 2015, the UN included teenagers for the first time in the global spotlight, and recognized the important consequences of sanitary problems that affect the health of this population [40]. Although research on the social determinants of health has emphasized the importance of including lifelong analysis; in general, studies have focused on childhood and adulthood, leaving aside adolescence and the social determinants that influence their health [53]. In particular, the migrant adolescent population faces a series of disadvantages that impact their health and wellbeing during a sensitive period of transition.

Guidelines for local health services

- Ensure access to comprehensive sexuality education for adolescents, including pregnancy prevention.
- Promote campaigns for contraceptive use, with a differential approach for the teenage migrant population.
- Promote the use and identification of clean water sources, access to restrooms and air quality in shelters, points of passage at the border, and settlements taking into account the conditions of the context.
- Provide assistance in shelters and border points with information that enables families to recognize health care centers where they can access services.
- Guarantee the use of health services and access to information regarding prevention and management of ARI and AD. These must recognize care specific to situations of mobilization, accommodation in hostels, settlements, and places with large flows of people, and to unfavorable changes in weather.
- Promote immunization plans in the population that needs it.
- Encourage the importance of recording the gender of patients at institutions that provide health services, since undefined sex or sexless cases limit the possibilities to recreate action plans for healthcare.

Health services used by adolescents in Colombia, 2019 and variation 2018-2019

Migrant population

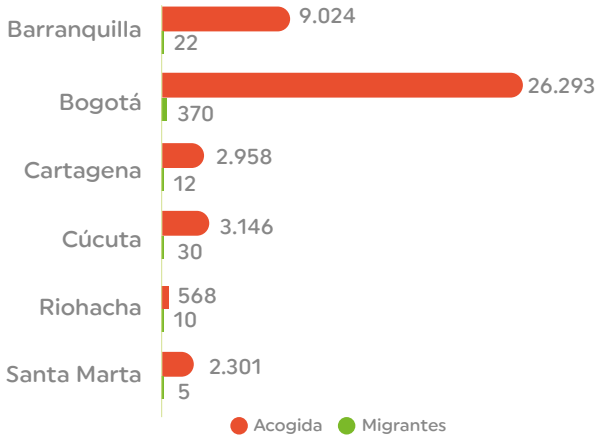
61084 adolescents
99.5% from 2018

Host community

3831909 adolescents
-13.0% from 2018

- In 2019, 4 million adolescents used health services in the country, of which 61,084 were migrants and refugees from Venezuela.
- Adolescent women from both, the migrant and refugee population and the host community, sought more health services than men.
- Bogotá reported the most adolescents from both population groups attended by a health professional.
- Riohacha reported the highest percentage in care for migrant and refugee adolescents.

Figure 4.14. Percentage of adolescents aged 10 to 19 who received health care in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS).

Migration as a determinant

During migration, teenagers experience high rates of depression and symptoms of posttraumatic stress disorder. Adolescents are more vulnerable to sexual exploitation. In addition, they suffer from abandonment and neglect from part of the parents who either do not migrate with them or who are preoccupied with the health of the children that remain behind. The migration process along with the working conditions of migrant adolescents pose different risks to their physical and mental well-being [54]. Migrant adolescents are particularly exposed to various types of violence [55], and mental illness [56], while they also have specific needs in sexual and reproductive health [7].

Use of health services by adolescents

In 2019, Colombia reported 3,892,993 adolescents who used health services; 61,084 from the Venezuelan migrant and refugee population, and 3,831,909 from the host community. Significant differences exist between genders, as adolescent females from both population groups sought more health services than adolescent men. Migrant and refugee adolescent women (45,159) sought three times more medical attention than men (15,925). In addition, the use of health services by Venezuelan migrant and refugee adolescents increased from 30,626 in 2018 to 61,084 in 2019; a 99.5% increase.

According to the departments, in 2019 Norte de Santander (7,664), La Guajira (7,684), and Atlántico (3,776) reported the highest numbers of migrant and refugee adolescents from Venezuela who accessed health services. On the other hand, in the host community, Atlántico (240,892) reported the most adolescents attended by a health professional, followed by Bolívar (237,209), and Magdalena (156,692). At a city level, Bogotá (9,245) documented the most migrant and refugee adolescents who sought health care. Similarly, in host community, Bogotá recorded the most adolescents who received some form of medical attention (666,891), followed by Barranquilla (147,427), and Cartagena (151,347).

Tables 4.5 and 4.6 report the five most common causes for which adolescent females and males, respectively, in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019. It is evident that migrant and refugee adolescent women share similarities with those from the host community in the five most common reasons to seek health care. These related to their sexual and reproductive health, mental health, and the presence of AD and ARI. Moreover, in both groups, labor was among the top three motives for care, which relates to the occurrence of teenage pregnancy.

At the same time, important differences in the leading causes of adolescent care exist between the two population groups. Foremost, the top ten causes for which Venezuelan migrant and refugee adolescents used health services involved injuries related to violence and hazardous work. Second, the presence of consultations related to rare ARIs in the same population group indicated possible impacts of migration on their epidemiological profile. Lastly, the presence of oral cavity disease in the same population group is conspicuous and related to the lack of access to dental care.

Table 4.5. Five most common causes for which adolescent females in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019.

migrant population	Place	Host community
Symptoms and signs involving the digestive system and abdomen.	1	Birth.
Acute infections of the upper respiratory tract.	2	Symptoms and signs involving the digestive system and abdomen.
Maternal care related to the fetus and the amniotic cavity and possible problems of delivery.	3	Maternal care related to the fetus and the amniotic cavity and possible problems of delivery.
Prenatal care	4	General symptoms and signs.
Care and reproductive sexual health	5	Other diseases of the urinary system.

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Date of query up to September 2019. Notes: in the office all types of diagnosis were included.

Table 4.6. Five most common causes for which adolescent males in the Venezuelan migrant and refugee population and the host community sought medical attention in 2019.

migrant population	Place	Host community
Symptoms and signs involving the digestive system and abdomen.	1	General symptoms and signs.
Acute infections of the upper respiratory tract.	2	Symptoms and signs involving the digestive system and abdomen.
Head trauma.	3	Diseases of the appendix.
Traumatism of the forearm and elbow.	4	arthropod-borne viral fevers and viral hemorrhagic fevers.
Trauma wrist and hand.	5	mental disorders and behavior due to the use of psychoactive substances.

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

COMMUNICABLE DISEASES

Communicable or transmissible diseases are those spread from one human being to another, or from an animal to a human. Specific disease-causing agents or their toxic products infect a susceptible host resulting in illness. Transmissible diseases that contribute critically to the morbidity and mortality in Latin America and the Caribbean region include: HIV / AIDS, sexually transmitted infections (STIs), viral hepatitis, tuberculosis, malaria and other vector-borne diseases, neglected diseases, tropical and zoonotic diseases, and vaccine-preventable diseases [57].

Migrants are at increased risk of developing a communicable diseases because of higher exposure to infections, lack of access to health care, disruption of care, and poor living conditions during migration and displacement. Nonetheless, the proportion of STI and vector-borne cases registered in the migrant population in a host country varies depending on the prevalence of this disease in the host community. For instance, a significant proportion of migrants who are HIV-positive may have been infected after arriving at a place or during transit from one place to another. Despite widespread belief to the contrary, the risk of migrants introducing diseases to their host community is minor [58]. This section discusses the use of health services in Colombia to address three types of communicable diseases in the Venezuelan migrant and refugee population and the host community: i) HIV / AIDS, ii) viral hepatitis (emphasizing types A, B, and C), and iii) Malaria.

Figure 4.15. Distribution of health services for communicable diseases in 2019.

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were: B20; B24; Z114; Z206; Z21X .; B15 - B19; Z205; Z225; Z246; B500 - B54X and Z116 - Z119.

Guidelines for local health services

- Promote the use of barrier contraceptive methods even when using other birth control methods.
- Prioritize prevention campaigns and access to diagnosis in the most vulnerable communities and the migrant population.
- Provide guidance regarding local services and register positive cases through the public health surveillance system.
- Provide clear and quality information for different forms of communicable disease prevention in both population groups (brochures, TV, radio, monitoring IPS and EPS).

HIV / AIDS

Human immunodeficiency virus (HIV), which progresses to acquired immune deficiency syndrome (AIDS), is one of the most monitored STIs in the world. This is due to the effects it can have on the quality of life of people and the economic burden associated with an increased need of healthcare resources to treat it. HIV can be transmitted through sex, blood transfusions, contaminated needles handled by intravenous drug users, or from mother to child during pregnancy, childbirth, and breastfeeding [59].

Use of health services for HIV / AIDS in Colombia, 2019 and variation 2018-2019

Migrant population

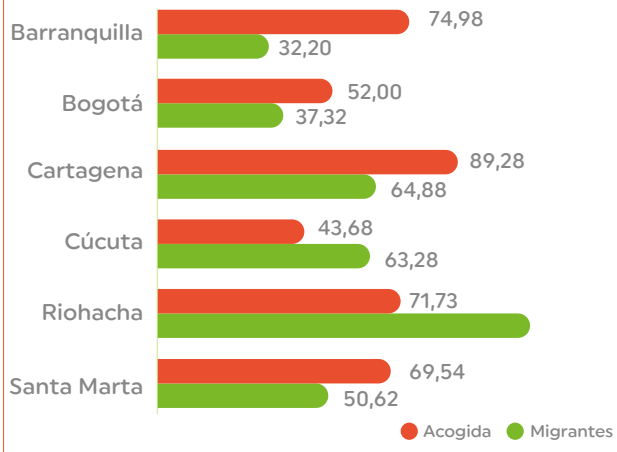
1,128 people
88.6% from 2018

Host community

92,483 people
29.0% from 2018

- In 2019, Colombia reported that 85,635 people used health services for the management and care of HIV / AIDS: 1,040 from the migrant and refugee population and 84,595 from the host community.
- Between 2018 and 2019, the use of health services to manage HIV / AIDS increased by 120% in migrant and refugee women, and by 20% in women from the host community. Men in both population groups sought more healthcare related to HIV / AIDS compared to women.
- Bogotá reported the most people treated for HIV / AIDS in both population groups.

Figure 4.16. Number of people treated for HIV / AIDS in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migration, may increase the risk factors for HIV / AIDS transmission due to displacement dynamics and vulnerabilities during transit and migration routes. These dynamics subject migrant women and girls to a greater disadvantage, especially those traveling without support networks and in irregular or circular migration forms. During migration these women and girls can be exposed to sexual exploitation, human trafficking for commercial purposes, and survival sex, which all increase the chances and risks of contracting infections such as HIV [60].

Colombia – Venezuela context

In Colombia, the prevalence of HIV / AIDS for 2019 was 0.19 per 100 inhabitants, corresponding to 75,000 people infected with the virus [61]. Over 90% of the cases were able to access antiretroviral therapy (ART); however, between 60% to 65% of cases demonstrated adherence problems. On the other hand, in Venezuela an estimated 120,000 people were infected with HIV / AIDS in 2019. In addition, the humanitarian crisis limited access to ART and diagnostic testing, with health facilities reporting a 100% shortage in supplies and treatment. In early 2019, about 8,000 people with HIV migrated from Venezuela to other countries in Latin America in search for access to treatment and care. Nevertheless, to date there are no data to account for the distribution of these migrants in Latin American countries [62, 63]. Similarly, there is no available information and systematic evidence to determine a relationship between increased migration flows and increased HIV / AIDS cases. In 2019, Colombia reported 14,010 cases of HIV / AIDS, of which 81.6% were men and 18.4% women. Compared to the reports for the first half of 2019, the number of foreigners with HIV in Colombia increased, since 573 cases were reported. Moreover, the Venezuelan migrant population accounted for over 94% of these cases [64].

Use of health services for HIV / AIDS

In 2019, 85,635 people over the age 18 were treated for HIV / AIDS in Colombia; of which 1,040 were Venezuelan migrants and refugees, and 84,595 people from the host community. Between 2018 and 2019, the number of Venezuelan migrants and refugees who received HIV / AIDS care increased by 79.6% (from 579 to 1,040); whereas, in the host community there was an increase of 19.8% (from 70,588 to 84,595).

By gender, men in both population groups used more health services related to HIV / AIDS than women in 2019. In the case of Venezuelan migrants and refugees, twice the number of men (711) than women (329) accessed such services. In the case of the host community, the number of men treated for HIV / AIDS (64,924) was three times higher than that of women (19,671).

According to the departments, Norte de Santander (35), La Guajira (29), and Atlántico (21) reported the highest numbers of migrants and refugees from Venezuela treated for HIV / AIDS in 2019. In addition, between 2018 and 2019, Bolivar documented the largest increase in the use of health services related to HIV / AIDS in both population groups; the cases increased by 400.0% in the Venezuelan migrant and refugee community (from 2 people to 10), and by 77.7% in the host community (from 1,567 to 2,785). By city, Bogotá (370), Cucuta (30), and Barranquilla (18) reported the highest numbers of migrants and refugees from Venezuelan treated for HIV / AIDS, while Cartagena (9) and Santa Marta (5) recorded the lowest numbers. Similarly, Bogotá (3,668) reported the most people from the host community who received medical care for HIV/ AIDS, followed by Barranquilla (2,665).

Viral hepatitis

Viral hepatitis is an inflammation of the liver caused by one of the five types of hepatitis (A, B, C, D, or E). The viruses are transmitted via different routes: hepatitis A and E through contaminated food and water; hepatitis B through infected blood, saliva, and secretions; and hepatitis C, mainly through infected blood and unprotected sex. Hepatitis D only occurs in individuals infected with hepatitis B. All these viruses cause acute hepatitis, which is characterized by fatigue, loss of appetite, fever, and jaundice. Most people recover completely, but a small percentage can die or become chronically ill suffering from cirrhosis or liver cancer [65]. Hepatitis can be prevented by providing access to safe food and water for types A and E, and vaccines for types A, B, and E. Hepatitis B and C can be prevented by screening blood donations, sterilizing materials for injection, and guaranteeing infection control [65].

Use of health services for HIV / AIDS in Colombia, 2019 and variation 2018-2019

Migrant population

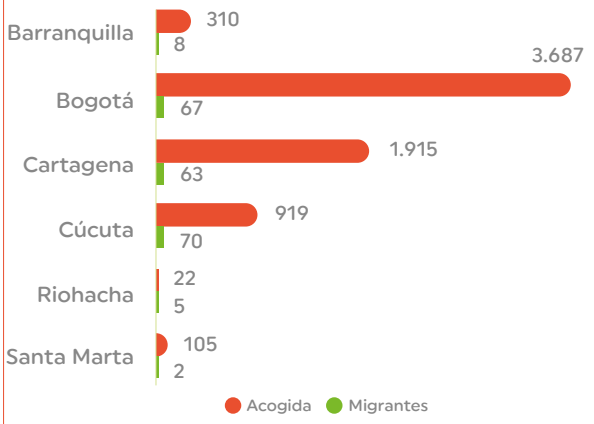
914 people
151.8% from 2018

- In 2019, Colombia reported 20,268 people over the age 18 who used health services associated with hepatitis A, B, and C: 914 from the Venezuelan migrant community and 19,354 from the host community.
- Norte de Santander and Bolivar reported the highest numbers of people in both population groups who sought care related to viral hepatitis.
- Bogotá, Cartagena, and Cucuta reported the highest numbers of people in both population groups who received medical care related to viral hepatitis.
- Between 2018 and 2019, the number of people from the host community treated for viral hepatitis increased in Bogotá.

Host community

19,354 people
-53.9% from 2018

Figure 4.17. Number of people treated for hepatitis (A, B, and C) in the migrant and host communities in 2019.



Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

During transit and in migration routes, migrants are vulnerable to viral hepatitis for several reasons. These include, limited access to public services (potable water, aqueducts, and sewage), the high probability of consuming unhygienic and unsafe foods, human-trafficking for commercial purposes, sex work, and the lack of information about risk factors and symptoms of these diseases. However, prevention measures and awareness are lacking in both, the migrant and host communities.

Colombia – Venezuela context

In Colombia, 3,107 cases of hepatitis A and 2,113 cases of hepatitis B and C were reported in 2019. Furthermore, over 60% of the cases nationwide corresponded to infections in men, and over 77% of the cases were confirmed through laboratory tests facilitating access to antiviral treatment through the public health surveillance system [66, 67]. Since 2016, the country delivers Hepatitis C medication under supervision (1,500 treatments), and in 2019 the possible elimination of hepatitis B in children under ten years old was evaluated. On the other hand, Venezuela reported that up until 2018 over 25,000 people had been infected with some type of viral hepatitis, with less than 1% agreeing to antiviral treatment [68].

Use of health services for viral hepatitis

In 2019, 20,268 people in Colombia over 18 years of age used health services associated with Hepatitis A, B, and C; 914 migrants and refugees, and 19,354 people from the host community. Between 2018 and 2019, the use of health services for viral hepatitis by Venezuelan migrants and refugees increased by 51.8% nationwide (from 363 to 551). It is important to note that the data were not disaggregated by gender.

According to the departments, Norte de Santander (397) reported the most Venezuelan migrants and refugees treated for one of these hepatitis. Meanwhile, in the host community Bolivar (2,241) documented the most cases followed by Norte de Santander (1,777). By city, Cúcuta (70), Bogotá (68), and Cartagena (63) reported the highest numbers of migrants and refugees treated for viral hepatitis. Meanwhile, Bogotá (3,687) reported the most cases in the host community, followed by Cartagena (1,915). Nonetheless, Bogotá reported a 79.4% decrease in the number of people treated for viral hepatitis in the host community, declining from 17,895 in 2018 to 3,687 in 2019.

Malaria

Malaria is an infectious disease caused by Plasmodium parasites that are transmitted by the bite of infective female Anopheles mosquitoes. It is characterized by acute episodes of fever that can be life threatening. Although malaria is preventable and treatable, it continues to have negative effects on the populations that are in endemic areas; particularly in vulnerable populations that lack access to health care, testing, and basic elements to prevent infection, such as insecticides or mosquito nets [69].

Use of services for Malaria in Colombia, 2019 and variation 2018-2019
migrant population Host community

Migrant population

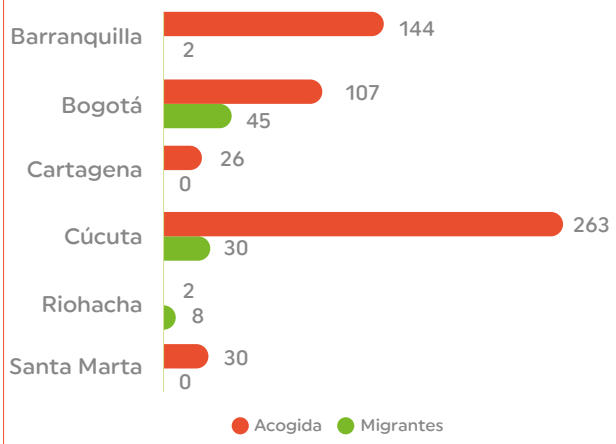
745 people
58.5% from 2018

Host community

5,169 people
-7.8% from 2018

- In 2019, 5,914 people in Colombia used health services associated with malaria; 745 migrants and 5,169 people from the host community.
- By department, Norte de Santander reported the most Venezuelan migrants and refugees treated for malaria, whereas Magdalena reported the least.
- By city, Bogotá reported the most Venezuelan migrants and refugees treated for malaria in 2019.
- In the host community, Cúcuta, Barranquilla, and Bogotá documented the highest numbers of people treated for malaria.

Figure 4.18. Number of people treated for malaria in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

The Venezuelan migrant population has a high risk of contracting malaria due to their vulnerable conditions, and because they can contract malaria in both, Venezuela and Colombia, once they have initiated their migration route. In addition, both countries have the highest number of malaria cases in Latin America [69].

Colombia – Venezuela context

Because of its geographical location, and climatic and epidemiological conditions, malaria remains an event of public health interest in Colombia [70]. In 2019, Colombia reported 70,421 cases of malaria, of which 69,249 were uncomplicated malaria and 1,172 complicated malaria. Furthermore, 57.5% (36,029) of the cases were men, and 47.2% (29,557) were in rural areas. Throughout the country there was an 29.2% increase in malaria cases compared to 2018. Even though Venezuela was the first country to reduce malaria cases in the region, almost sixty years later, it is the country with the highest transmission rates in America [71]. In 2018, nearly 16 million people were at risk of contracting malaria in endemic areas of Venezuela. As a result of high migration flows from Venezuela, countries in Latin America initiated surveillance and control systems to mitigate new malaria cases in the migrant population and host communities [71].

In 2019, Colombia reported 2,108 cases of malaria in the migrant population; 2,007 cases were uncomplicated and 101 complicated. Moreover, 96% of these cases corresponded to Venezuelan migrants. According to the MHSP, for the first half of 2019 malaria was the most notified public health event in the Venezuelan migrant population, accounting for 22.8% of public health interest events in this population [9].

Use of health services for malaria

In 2019, 5,914 people used health services associated with malaria in Colombia, of which 745 were migrants and refugees, and 5,169 people from host community. The use of health services for malaria in the migrant and refugee population increased by 58% compared to 2018 (from 470 people to 745). It is important to note that data were not disaggregated by gender.

According to the departments, Norte de Santander (100) documented the most migrants and refugees treated for malaria in 2019. In the other departments studied, the number of people treated for malaria did not exceed 10 cases. In the host community, Norte de Santander (566) reported the most people treated for malaria, followed by Bolivar (313). By city, Bogotá (45) and Cucuta (30) documented the highest malaria cases in migrants and refugees in 2019. On the other hand, Cúcuta (263), Barranquilla (144), and Bogotá (107) recorded the highest numbers of people in the host community who received medical care for malaria.

NON-COMMUNICABLE DISEASES

Noncommunicable diseases are often long-lasting, and their origin is multicausal as they may result from a combination of genetic, physiological, environmental, and behavioral factors. These diseases are most common between 30 and 69 years of age, in both, men and women. Among the main types of noncommunicable diseases are cardiovascular and chronic respiratory diseases, cancer, and diabetes [72].

At their time of arrival, migrants seem to be less affected than host populations by many non-communicable. However, if they live in poverty, their prolonged stay in the host country increases the risk of suffering cardiovascular disease, cerebrovascular accidents, or cancer. As migrants are likely to change their lifestyle, do less physical activity, and consume less healthy foods, they are also more exposed to risk factors for chronic diseases [58]. This section discusses the use of health services in Colombia for five non-communicable diseases in the migrant population from Venezuela and the host community: i) circulatory system diseases, ii) diabetes, iii) cervical cancer, iv) breast cancer, and v) prostate cancer.

Figure 4.19. Distribution of use of health services associated with non-communicable diseases in 2019.

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were: Diagnosis Chapter I00 - I99; Z034 - Z035; Z135;E00-E07; E10 - E14; E15 - E16; E20 - E35; E70 - E90; Z13; C53.0 - C55; D06.0 -D06.9; C500 - C509; D057; D059; D486; D24X; Z123; Z853; C61X, D075, D291, D400 and Z125.

Guidelines for local health services

- Guarantee early diagnosis and treatment supported by public policies in the health sector, and sufficient coverage by the entities providing health services.
- Integrate the health sector with food producers and manufacturers to help prevent diseases, such as cardiovascular ones.
- Ensure access to primary care and other types of care for migrants and refugees.
- Promote programs that help migrant population follow a healthy diet, prevent the use of psychoactive substances, reduce the body mass index, and increase exercise.
- Provide medical attention that is responsible, people-centered, and recognizes the circumstances and needs of each patient.
- Build cost effective policies for chronic disease care based on new evidence regarding the needs of migrants and refugees.
- Provide advice to community groups in order to strengthen them, as part of the health response to the needs of migrant and refugee populations.

Circulatory system disease

Diseases of the circulatory system are one of the biggest public health concerns at a global, regional, and local scale, since they are the leading cause of death worldwide [73], in the Americas [74] and in Colombia [75]. Diseases of the circulatory system affect a heterogeneous group of vital organs including the heart, brain, kidney, arteries, and veins. As a result, these diseases can lead to many different conditions. It is worth noting that most of the diseases of the circulatory system are preventable with good habits, diet, and physical activity[73].

Use of services for circulatory system disease in Colombia, 2019 and variation 2018-2019

Migrant population

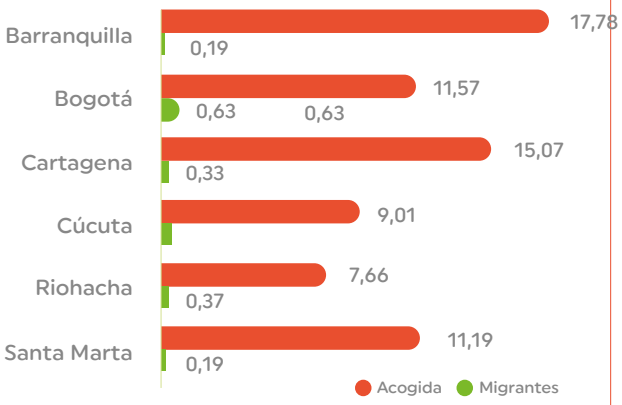
6,312 people
93.4% from 2018

- In 2019, Colombia reported that 3,5 million people sought medical attention for the circulatory system: 6,312 Venezuelan migrants and refugees.
- Women in both groups, the Venezuelan migrant and refugee population and the host community, used health services associated with diseases of the circulatory system more frequently than men in their respective groups.
- Bogotá and Cucuta had the highest numbers of Venezuelan migrants and refugees treated for diseases of the circulatory system.

Host community

3,383,916 people
-9.5% from 2018

Figure 4.20. Percentage of people over the age 18 treated for diseases of the circulatory system in migrant and host communities, 2019.



Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

People that are forced to migrate are more likely to develop diseases of the circulatory system, such as cardiovascular and cerebrovascular diseases, due to changes in lifestyle habits. In the migrant population, unbalanced diets, poor working conditions, and an increase in episodes of anxiety and depression, among others, may increase the risk of developing a disease of the circulatory system [73].

Colombia – Venezuela context

In Colombia, diseases of the circulatory system have been the leading cause of death for decades; ischemic heart disease and cerebrovascular accident are among the top causes of death. Ischemic heart disease is predominant in men; whereas diseases related to hypertension and the cerebrovascular system, such as heart failure, are prevalent in women [73, 76]. In the case of Venezuela, according to the Venezuelan Society of Internal Medicine (2019), approximately 30% of deaths were due to heart problems, and the primary risk factor was high blood pressure, which affected 7 million Venezuelans (34.1% of the population). Also, the most common cardiovascular disease was ischemic heart disease or myocardial infarction, followed by heart failure [77].

Use of health services for circulatory system disease

In 2019, Colombia reported that 3,5 milion people used health services associated with diseases of the circulatory system; 6,312 migrants and refugees from Venezuela and 3,393.000 million people from the host community. Nationwide, the number of migrants and refugees who sought medical attention for diseases of the circulatory system increased by 93.4%; from 3,263 in 2018 to 6,312 in 2019. Based on gender, more women than men used health services related to diseases of the circulatory system. In the case of Venezuelan migrants and refugees, twice as many women (4,257) than men (2,055) sought these services. In the case of the host community, the number of women treated for diseases of the circulatory system (2,102,676) was 1.5 times greater, than that of men (1,281,240).

According to the departments, Norte de Santander (492) and La Guajira (474) reported the largest numbers of Venezuelan migrants and refugees treated for diseases of the circulatory system in 2019. However, Bolivar reported the largest increase, rising from 4 people treated in 2018 to 173 in 2019. On the other hand, the departments of Atlántico (199,788) and Bolivar (153,587) documented the highest numbers of people treated in the host community. On a city level, Bogotá (1,772) registered the most Venezuelan migrants and refugees who used health services related to diseases of the circulatory system, followed by Cucuta (319). Similarly, in the host community, Bogotá (627,743) reported the most cases, followed by Barranquilla (157,940).

Diabetes

Diabetes is a chronic disease that occurs when the pancreas does not produce enough insulin, or the body does not use the insulin it produces efficiently. Diabetes eventually damages other organs and systems, especially nerves and blood vessels [78].

Use of diabetes services in Colombia, 2019 and variation 2018-2019

Migrant population

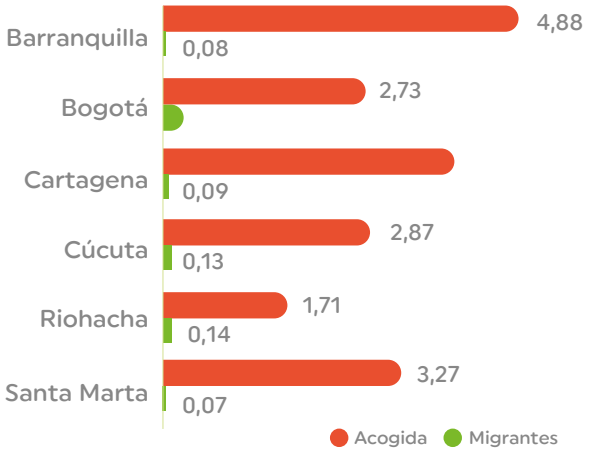
2,482 people
68.5% from 2018

Host community

846,736 people
-1.6% from 2018

- In 2019, 849,218 people were treated for diabetes in Colombia: 2,482 Venezuelan migrants and refugees and 846,736 people from the host community.
- Between 2018 and 2019, the use of health services for diabetes by migrants and refugees increased by 68.5%.
- More women than men sought medical attention for diabetes in both, the Venezuelan migrant and refugee population and the host community.
- Bogotá and Cucuta reported the highest numbers of Venezuelan migrants and refugees who used health services for diabetes.

Figure 4.21. Percentage of people over the age 18 treated for diabetes in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Overall, the incidence and prevalence of diabetes among migrants, and mortality associated with this disease are higher in women than men [78]. Migration creates a relationship between health deterioration during transit from one place to another and the length of residence in the receiving country. When people migrate they are more likely to change their lifestyle, be less physically active, and consume less healthy foods, which in turn exposes them to risk factors related to chronic illness once they have settled in their host community [58]. Eventually, these factors impact the health of the migrant population increasing the chances to develop disorders and diseases like diabetes, which require special treatment and care. Moreover, guaranteeing access to medications and insulin, among other necessary supplies to manage diabetes increases healthcare costs [79].

Colombia – Venezuela context

In Colombia, over the last five years the prevalence of diabetes increased from 1.3 to 2.2 cases per 100 people, with an average age of 59 years old for new diagnoses [59]. In 2018, 1,099,471 people were diagnosed with diabetes; 41.8% men and 58.9% women. On the other hand, it is estimated that 13.1% of the population over 20 years old in Venezuela has diabetes, equivalent to 2.5 million people. Thus, the prevalence of this disease in the country increased from 7.7% in 2010 to 13.1% in 2017, while the percentage of people at risk increased from 22% to 39.8% [80] .

Use of health services for diabetes

In 2019, Colombia reported that 849,218 people used health services associated with diabetes; 2,482 Venezuelan migrants and refugees and 846,736 people from the host community. Nationwide, the use of health services related to diabetes increased by 68.5% in the Venezuelan migrant and refugee population, increasing from 1,473 people in 2018 to 2,482 people in 2019. By gender, more women than men sought medical attention for diabetes in both population groups. In the case of Venezuelan migrants and refugees, over twice as many women (1,679) than men (803) sought these services in 2019. In the case of the host community, the number of women treated for diabetes in 2019 (500,936) was 1.4 times greater than that of men (345,800).

When analyzing the departments, Norte de Santander (163) and La Guajira (148) reported the highest numbers of Venezuelan migrants and refugees treated for diabetes in 2019. In the host community, the largest numbers of people treated were in Atlántico (53,095) and Bolivar (36,604). At a city level, Bogotá (840) documented the most Venezuelan migrants and refugees who used health services for diabetes, followed by Cucuta (197). Similarly, Bogotá (148,373) reported the most cases in the host community, followed by Barranquilla (43,332).

Cervical cancer

Usually cervical cancer is associated with the presence of Human Papillomavirus (HPV), which can be a necessary cause, although insufficient for this cancer to develop [81]. Cervical cancer is the fourth most common cancer in women and the fourth with most deaths worldwide [82].

Use of services for cervical cancer in Colombia, 2019 and variation 2018-2019

Migrant population

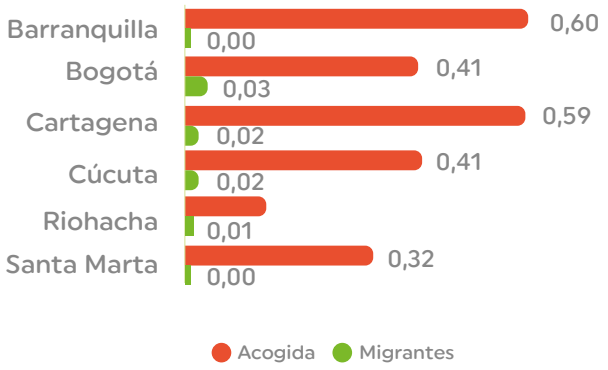
122 people
112.9% from 2018

Host community

29,038 people
40.8% from 2018

- In 2019, 29,378 women used health services for cervical cancer: 132 migrants and refugees and 29,246 women from the host community.
- Compared to 2018, there was an overall increase in the number of women treated for cervical cancer in 2019.
- Bogotá, Cartagena, and Cúcuta reported the highest numbers of women treated for cervical cancer in both, the migrant and refugee population and the host community.

Figure 4.22. Percentage of people treated for cervical cancer in the migrant and the host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Cancer in migrant women is more likely to be diagnosed at an advanced stage, which may lead to considerably worse health outcomes compared to those of women in the host community [83]. HPV is spread through intercourse. It can be assumed that migrant women are at a high risk of contracting HPV, given the difficulties they face in access to services and products related to sexual and reproductive health. In addition, migrant women usually face complications in access to gynecological services and testing to identify this cancer in a timely manner.

Colombia – Venezuela context

Between 2000 and 2010, Colombia achieved a steady decline in rates of cervical cancer incidence and mortality, and increased the proportion of promptly detected in situ cases [84]. However, cervical cancer remains the second cause of death from cancer in women, with a rate of 17.2 deaths per 100,000, and a prevalence of 49.6 cases per 100,000 women [85]. In 2019, 4,199 cases of cervical cancer were reported, equivalent to 126 cases per week. This represents an increase of 83.9% in the number of cases compared to 2018. It is estimated that 34.7% and 33 % of women had a timely diagnosis via biopsy and received treatment, respectively [81]. In the case of Venezuela, the prevalence shows 101.5 cases per 100. 000 women [85] and the mortality rate was 9.97 per 100,000 women in 2017 [86]. Regarding the Venezuelan migrant and refugee population in Colombia, 11 cases were documented in 2017 (1.2% of national value), followed by 30 cases in 2018 (1.8% of national value), and 41 cases in 2019 (1.21% of national value) [87].

Use of health services for cervical cancer

In 2019, Colombia reported that 29,378 women used health services associated with cervical cancer; 132 migrants and refugees, and 29,246 women from the host community. Moreover, the number of migrant and refugee women treated for cervical cancer nationwide increased by 112.9%; from 65 women in 2018 to 132 in 2019. Similarly, the cases in the host community increased by 12.8% nationwide, from 25,933 in 2018 to 29,246 in 2019.

By department, Norte de Santander (23) and Bolivar (10) reported the highest numbers of Venezuelan migrant and refugee women who used health services for reasons associated with cervical cancer in 2019. In the host community, Atlántico (1,199) and Bolivar (9,438) documented the largest numbers of women treated for cervical cancer. For the cities, Bogotá recorded the most Venezuelan migrant and refugee women treated for cervical cancer (26), followed by Cucuta, (22), and Cartagena (10). On the hand, Cartagena reported the most cases of cervical cancer in women from the host community (9,249), followed by Bogotá (4,707).

Breast cancer

Breast cancer is the abnormal and disorderly proliferation of malignant mammary cells leading to the uncontrolled growth of a tumor within the breast, and may have the ability to invade other organs [88]. Breast cancer is the second most common cancer worldwide and the most frequent in women, given that one in eight women may develop this disease throughout her life. In addition, its incidence is increasing, especially in middle- and high-income countries, and particularly in women living in urban areas [89].

Use of services for breast cancer in Colombia, 2019 and variation 2018-2019
migrant population Host community

Migrant population

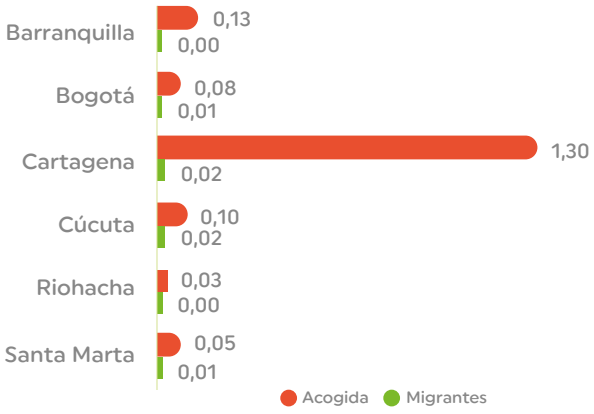
185 people
65.1% from 2018

Host community

85,868 people
2.75% from 2018

- In 2019, 289,881 people used health services associated with breast cancer: 515 migrants and refugees, and 289,366 people from the host community.
- Between 2018 and 2019, the number of cases increased by 114.6% in the migrant and refugee population, rising from 240 to 515.
- In 2019, 508 women and 7 men in the Venezuelan migrant and refugee population sought medical attention for breast cancer.
- In 2019, 286,452 women and 2,914 men from the host community sought medical attention for breast cancer.

Figure 4.23. Percentage of people treated for breast cancer in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were: 500-509; D057; D059; D486; D24X; Z123 and Z853.

Migration as a determinant

Recognizing that early detection improves prognosis and survival in patients, migrants and refugees from Venezuela, especially undocumented migrant women, may be at risk of developing cancer and detecting it late. This is mainly because they are not targeted by awareness campaigns and thus miss out on diagnostic services and treatment.

Colombia – Venezuela context

In Colombia, breast cancer is the leading cause of illness and death from cancer in women, whereas in men it occurs to a lesser extent [88]. For women, nearly 12% of deaths countrywide can be attributed to breast cancer [90]. In 2018, the incidence rate calculated with respect to 2016 was 4.5 per 100,000 people over 18 years old [91]. In Venezuela, 124,248 people were diagnosed with breast cancer between 2013 and 2018, with a higher incidence in women. Furthermore, the highest mortality rate from breast cancer was found in women between 55 and 64 years of age, and increased incidence in women 45 to 54 years of age [86]. Regarding the Venezuelan migrant population in Colombia, there was an increase in cases of breast cancer between 2017 and 2019. Nonetheless, it is important to highlight that the Colombian territories where Venezuelan migrant women with breast cancer are arriving in search of healthcare have documented inequities in survival. These have been associated with health insurance coverage and the socioeconomic position of women [92, 93].

Use of health services for breast cancer

In 2019, Colombia reported that 289,881 persons used health services associated with breast cancer; 515 migrants and refugees from Venezuela, and 289,366 people from the host community. Health care for breast cancer is considerably higher in the host community compared to in the migrant community; nonetheless, the number of services for breast cancer provided to Venezuelan migrants and refugees increased by 114.6%, rising from 240 in 2018 to 515 in 2019. Although, a higher percentage of women used health services for breast cancer in 2019, cases in men were also reported. In the Venezuelan migrant and refugee community, two men from Bogotá and one man from Riohacha sought these services. In the case of the host community, all prioritized cities documented cases of men who used these services; Bogotá documented the most (503), followed by Barranquilla (146), and Cartagena (74).

Based on the departments, Bolívar (101) reported the most Venezuelan migrants and refugees treated for breast cancer in 2019. In the host community, Bolívar (16,687) and Atlántico (13,865) reported the largest numbers of people treated for breast cancer. By city, Bogotá and Cucuta registered the highest numbers of female Venezuelan migrants treated for breast cancer. In the host community, Bogotá documented the most women treated for breast cancer (44,976), followed by Cartagena (15,125), and Barranquilla (12,462).

Prostate cancer

Prostate cancer is the most common type of cancer in men and the second leading cause of death in males in Latin America [94]. Usually, this type of cancer occurs in older men (after age 65) [95]; indicating a relationship between age and the risk of prostate cancer (i.e., the older the age, the higher the risk). Other factors that influence the onset of prostate cancer include high consumption of red meats and dairy, physical inactivity, obesity, alcohol consumption, and exposure to chemical contaminants [96].

Use of services for prostate cancer in Colombia, 2019 and variation 2018-2019

Migrant population

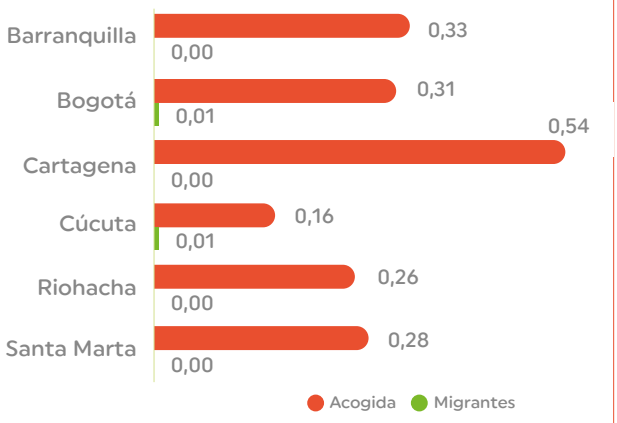
58 men
114.8% from 2018

Host community

76,085 men
-14.6% from 2018

- In 2019, 76,143 men used health services associated with prostate cancer: 58 Venezuelan migrants and refugees, and 76,085 men from the host community.
- Between 2018 and 2019, the use of health services for prostate cancer increased by 114.8% in the Venezuelan migrant and refugee population, rising from 27 men to 55.
- Regarding the prioritized cities, Bogotá reported the most men treated for prostate cancer overall, with 19 Venezuelan migrants and refugees, and 17,056 from the host community.

Figure 4.24. Percentage of people treated for prostate cancer in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Venezuelan male migrants may be exposed to developing prostate cancer due to unhealthy lifestyles. Moreover, elderly undocumented migrants have no access to early screening or diagnostic tests that would otherwise allow for timely treatment of the cancer.

Colombia – Venezuela context

In Colombia, prostate cancer is the most common cancer in men, and second in mortality [81]. By 2018, the prevalence of prostate cancer in Colombia was recorded at 127.0 cases per 100,000 inhabitants, and according to the WHO, 12,712 new cases were diagnosed in the country. However, in Colombia there are still inequities in access to health services to detect this cancer and reduce its mortality rate [95]. Likewise, in Venezuela, prostate cancer is also the most common cancer in men, with a prevalence of 49.22 cases per 100,000 men. This represented an increase of 5 new cases per 100,000 men in 2017 [86].

Use of health services for prostate cancer

In 2019, Colombia reported that 76,143 men used health services related to prostate cancer; 58 Venezuelan migrants and refugees, and 76,085 men from the host community. Health services for this cancer were considerably higher in the host community than in the Venezuelan migrant and refugee population. Nonetheless, there was an increase of 114.8% in the number of migrant and refugee men from Venezuela treated for prostate cancer, rising from 27 cases in 2018 to 58 in 2019.

According to the departments, Norte de Santander (4) documented the most Venezuelan migrant and refugee men treated for prostate cancer. In the host community, Bolivar (4,235), Atlántico (3,216), and Magdalena (1,156) reported the highest numbers of men treated. By city, Bogotá reported the most Venezuelan migrant and refugee men treated for prostate cancer (19), followed by Cúcuta (4). Similarly, in the host community, Bogotá recorded the most men treated for prostate cancer (17,052), followed by Cartagena (3,854), then Barranquilla (2,919), and Santa Marta (1,036).

VIOLENCE AGAINST WOMEN

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". According to the WHO, approximately one in three (35%) females worldwide undergo some form of violence in their lifetime, oftentimes by an intimate partner. Almost 30% of women who have been in relationships report that their partner subjected them to some form of violence, and 38% of murders of women were committed by their male partner [97]. The men most likely to commit violent acts are those with low levels of education, who during their childhood were maltreated, and exposed to domestic violence, harmful use of alcohol, and gender inequality. At the same time, women with low levels of education, who have been exposed to partner violence against their mothers, abused during their childhood, and lived in environments were violence, male privilege and female subordination are accepted, are at a higher risk of experiencing intimate partner violence [97].

Displacement situations due to migration can exacerbate violence inflicted against women by an intimate partner and non-partner sexual violence, as well as trigger new forms of violence against women. Violence can adversely affect the physical, mental, sexual, and reproductive health of women and, in some situations, it may even increase the risk of contracting HIV or other communicable diseases [97]. This section discusses the use of health services for three forms of violence against women in the Venezuelan migrant population and the host community: i) sexual violence, ii) psychological violence, and iii) physical violence.

Figure 4.25. Distribution of health services used for violence against women in 2019

Source. RIPS data cube - Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were: T742; Y05 - Y059; : T41; T48 - T49; X850 - Y049; Y070 - Y099; Y10 - Y34; Y35 - Y36; T743; Z601 - Z613 and Z617 - Z659.

Guidelines for local health services

- Recognize the vulnerability and the risk of abuse of migrant and refugee girls and women from Venezuela in order to provide services that meet their needs.
- Strengthen health care services relevant to sexual violence, especially in cities like Bogotá and Cartagena, as well as in the departments bordering Venezuela.
- Disseminate information, including in the male population of the migrant, refugee, and host communities, that helps understand and recognize violence against women.
- Promote gender equality and women's rights, and most importantly disseminate the rights that migrant and refugee women have as migrants in host countries.

Sexual violence

Sexual violence includes any action that forces a person to have some contact - either physical or verbal - of a sexual nature, or participate in interactions of this type by using force, intimidation, coercion, blackmail, bribery, manipulation, threat, or any other mechanism against personal will. It is considered sexual harm or suffering when the perpetrator forces the victim to perform any of these acts with third parties [98].

Use of services related to sexual violence in Colombia, 2019 and variation 2018-2019

Migrant population

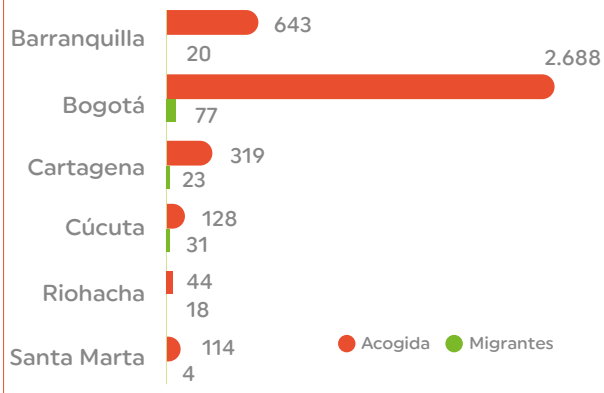
573 women
92.3% from 2018

- In 2019, 18,346 women in Colombia were attended by health professionals for cases of sexual violence: 573 Venezuelan migrants and refugees, and 17,773 women from the host community.
- The number of sexual violence cases in women increased in both, the Venezuelan migrant and refugee population and the host community.
- La Guajira (52) and Norte de Santander (41), reported the highest numbers of female migrants and refugees who were provided with services for sexual violence.

Host community

17,773 women
3.5% from 2018

Figure 4.26. Number of women aged 18 and older who were provided with health services related to sexual violence in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Social Protection Information System (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migrant girls and women suffer increased sexual violence, because they can be subject to trafficking for commercial purposes, forced sex work, and labor abuse and abuse of power that manifest in sexual assaults, among others. This is exacerbated by the lack of access to health services, care, and justice to restore their rights in cases of sexual violence [99].

Context Colombia - Venezuela

In Colombia, 22.5% of gender-based violence cases reported in 2019 pertained to sexual violence, with women being the main victims in over 70% of the cases [100]. In 2018, the majority of women who accessed legal medical examinations for an alleged sexual offense were between 5 and 24 years old, accounting for 87.45% of total cases. This highlights how vulnerable girls and young women are to suffer some form of sexual abuse [101]. In addition, 237 cases of sexual violence against members of the LGBT community were documented in 2018, of which 22.36% were bisexual women and 34.14% lesbian [101]. In Venezuela, the Scientific, Penal, and Criminal Investigation Service Corps recorded 1,180 cases of sexual abuse in 2019. Of these cases, 63% received medical attention and justice [102].

Use of health services related to sexual violence

In Colombia, 18,346 women were attended by health professionals for cases of sexual violence in 2019; 573 Venezuelan migrants and refugees and 17,773 women from the host community. Nationally, the number of cases concerning Venezuelan migrants and refugees increased by 92.3%, from 298 in 2018 to 573 in 2019. On the other hand, the cases in the host community increased by 3.5% in the same period, from 17,172 women to 17,773.

By department, La Guajira (52), Norte de Santander (41), and Atlántico (41) reported the largest numbers of migrant and refugee women who were provided with services for sexual violence in 2019. On the other hand, Atlántico (869) and Bolivar (514) documented the highest numbers of cases in the host community. In addition, all departments except for La Guajira reported an increase in the number of cases in the host community compared to 2018. La Guajira had a 62.1% decrease, declining from 396 cases in 2018 to 150 in 2019; whereas, Norte de Santander had the largest percent increase (22.2%), rising from 261 to 319 cases, and Atlántico the smallest (15.9%).

By city, in 2019 Bogotá reported the most women who were provided with medical attention in both, the Venezuelan migrant and refugee community (77) and the host community (2,688). Compared to 2018, Cartagena recorded the highest increase in cases concerning Venezuelan migrants and refugees, with an additional 20 cases in 2019. In the host community, Barranquilla (643) and Cartagena (319) also reported high numbers of cases in 2019. In addition, all the cities studied except for Cúcuta, documented an increase in the number of cases in the host community compared to 2018. Bogotá recorded the smallest percent increase, 2.8% (rising from 2,614 to 2,688 cases), whereas Riohacha had the highest, 51.7% (rising from 29 to 44 cases).

Physical violence

Physical violence against women has been understood as that which causes risk to or a decrease in the integrity of a woman's body. Therefore, this type of violence includes beatings, shoving, slapping, suffocation attempts, harm from the use of blunt weapons, acid attacks, deprivation of basic needs through physical damage, or any other act that may give rise to pain, discomfort, or personal injury [103].

Use of services related to physical violence in Colombia, 2019 and variation 2018-2019

Migrant population

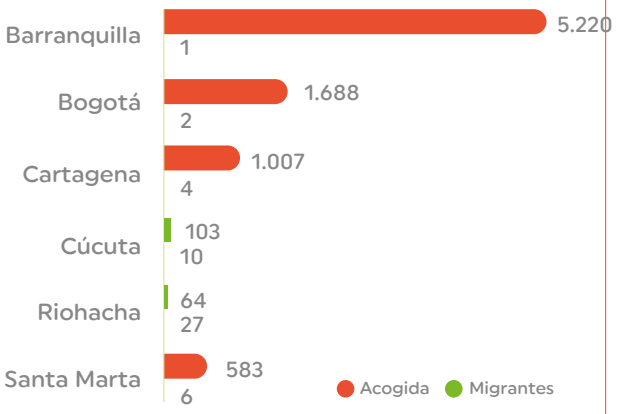
214 women
60.9% from 2018

Host community

28,889 women
175.6% from 2018

- In 2019, about 29,000 women in Colombia were provided with health care for some type of physical violence. Most cases corresponded to Colombian women (28,889), with a few cases of migrant and refugee women (214).
- In both population groups there was an increase in the numbers of cases between 2018 and 2019. There was an increase of 175.6% in the host community (from 10,483 to 28,889 cases), and of 60.9% in the migrant and refugee population (from 133 to 214 cases).
- La Guajira (41 in 2018 and 51 in 2019) and Norte de Santander (17 in 2018 and 16 in 2019) reported the highest numbers of female migrants and refugees who were attended by health professionals for physical violence.

Figure 4.27. Number of women aged 18 and older who were provided with health services related to physical violence in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Information System of Social Protection (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migrant and refugee women and girls are more likely to face cases of physical violence due to the vulnerable conditions in which they live during their migration process, in addition to the working and housing conditions they may have in host countries. Moreover, cases of physical violence within households increase due to economic problems and power relations that make migrant women and girls more vulnerable [99].

Colombia - Venezuela context

In Colombia, 52.0% of gender and domestic violence cases in 2019 pertained to physical violence. Of these cases, 77.3% involved physical violence against women, and in 72.8% the aggressor was a family member of the victim. In Venezuela, due to food shortages and strict management of the few available resources, situations of intimate partner violence or child abuse, manifested in physical violence, have increased in recent years [103].

During 2018, 16 feminicides of Venezuelan women were reported and one was attempted, representing 1.9% of feminicides committed in Colombia that year. The majority of feminicides and physical violence cases against Venezuelan migrant and refugee women were registered in the two border departments, Norte de Santander and La Guajira. Furthermore, in most cases the aggressor was either the partner or a relative who migrated with the victim, and in some cases the aggressor was Colombian. Nonetheless, it is estimated that in many cases the victim did not report the crime [99].

Use of health services related to physical violence

In Colombia, 29,103 women were provided with health care for physical violence in 2019. Of these cases, 28,889 were against host community women and 214 against migrant and refugee women from Venezuela. For the latter, the number of cases increased by 60.9%, rising from 133 people in 2018 to 214 the following year. Likewise, in the host community there was an increase of 175.6%, rising from 10,483 people in 2018 to 28,889 in 2019.

By departments, La Guajira (51) and Norte de Santander (16) documented the highest numbers of migrants and refugees who were provided with health services related to physical violence; whereas, Atlántico (7,806) and Bolívar (3,274) reported the highest numbers of cases against the host community. Additionally, Bolívar recorded the highest percent increase in the number of cases of migrant and refugee women, rising from 3 in 2018 to 11 in 2019 (a 266.7% increase). For the prioritized cities, Riohacha (27) and Cúcuta (10), recorded the highest numbers of migrant and refugee women who were attended by a health professional for physical violence. On the other hand, Barranquilla (5,220) documented the most cases of women from the host community, followed by Cartagena (1,007).

Psychological violence

Psychological violence consists of actions and omissions designed to degrade or control the behaviors, beliefs, and decisions of other people. These actions can be generated through the abuse of power, manipulation, intimidation, threats, humiliation, or any other act that harms psychological health, self-determination, or free personal development [98].

Use of services related to psychological violence in Colombia, 2019 and variation 2018-2019

Migrant population

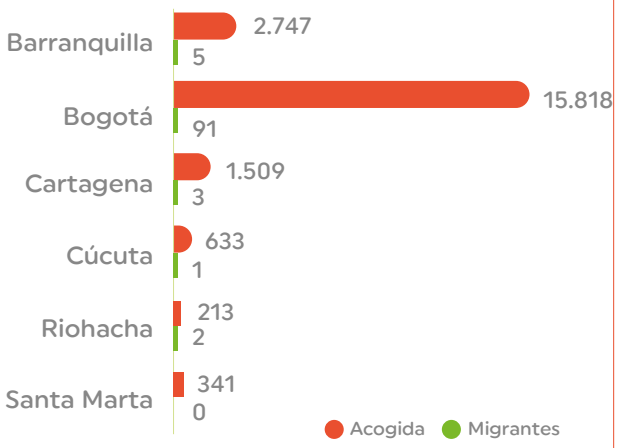
546 women
80.8% from 2018

Host community

59,042 women
-9.6% from 2018

- In 2019, over 59,000 women nationwide were provided with health care for cases of psychological violence: 59,042 were women from the host community, and 546 were migrants and refugees from Venezuela.
- Prioritized departments reported approximately 7,000 cases of psychological violence against women, while the cities - excluding Bogotá – recorded over 5,000 cases.
- In 2018 and 2019, the number or migrant and refugee women who used services related to physiological violence across all prioritized departments did not exceed 10 cases.
- Bogotá documented the most women who received medical attention for psychological violence from both, the Venezuelan migrant and refugee population (105 in 2018 and 91 in 2019), and the host community (17,697 in 2018 and 15,818 in 2019).

Figure 4.28. Number of women aged 18 and older who were provided with health services related to psychological violence in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Information System of Social Protection (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

In migration contexts, the risk of facing psychological violence increases as a result of xenophobia, discrimination, family separation, adaptation problems, and economic, food and housing difficulties, among others. Mainly, women can face extreme situations of depression and anxiety due to the adverse circumstances encountered in the migration routes. These are related to sleep disturbances, labor exploitation, and concerns for their children and relatives with whom they have migrated, as well as for those who still live in Venezuela [104].

Colombia - Venezuela context

In Colombia, cases of psychological violence in 2019 accounted for 7.8% of gender and intra-family violence cases. As in the cases of sexual and physical violence, the majority of psychological violence victims were women [100]. A total of 64% of women between 13 and 49 years of age experienced psychological violence from their partner, ex-partner, or a family member. Of this figure, 23.9% were victims to intimidation, 39.0% to derogation, and 57.9% to controlling behavior [105]. In Venezuela, there is a significant gap in information regarding cases of psychological violence against women. However, in 2004 the Center for Women's Studies based at the Universidad Central de Venezuela stated that psychological violence represented 42.75% of gender violence cases against women, making this kind of violence the most common.

Due to the difficulty of accessing psychological treatment and counseling services for psychological violence in Colombia, the exact number of Venezuelan migrant and refugee women who have been subject to this type of violence is unknown. What is more, stereotypes, discrimination, and ignorance further prevent victims of psychological violence from seeking professional help and reporting the abuse [104].

Use of health services related to psychological violence

In Colombia, over 59,588 women were provided with health services for psychological violence in 2019. Of these, 59,042 were Colombian and 546 migrants and refugees from Venezuela. Between 2018 and 2019, there was an increase of 80.8% (from 302 to 546) in cases of migrant and refugee women who sought health care related to psychological violence.

In the prioritized departments, the number of migrant and refugee women who were provided with health services for psychological violence did not exceed 10 cases in 2018 and 2019. The departments with the highest numbers of cases for this population were Bolívar (10) and Atlántico (8), while Magdalena reported no cases in the two years analyzed. According to the data, Bolívar had the largest increase (from 0 cases in 2018 to 10 cases in 2019), followed by La Guajira (from 1 in 2018 to 4 in 2019).

In the host population, the departments with the highest numbers of women who were provided with health services for psychological violence in 2019 were Atlántico (3,438) and Bolívar (1,789). In the prioritized cities, Bogotá reported the most women who used services for this type of violence in both, the Venezuelan migrant and refugee population (105 in 2018 and 91 in 2019) and in the host population (17,697 in 2018 and 15,818 in 2019).

MENTAL HEALTH

Mental health is defined as the mental and psychological well-being of an individual. It has been recognized that not only individual characteristics but also cultural, social, and political factors – including forced migration – impact mental health and mental disorders [106]. Depression and anxiety tend to affect migrants and refugees more often than host community members. However, the variation in the group of migrants in question and in the methods used to assess the prevalence of mental disorders make it difficult to draw definitive conclusions [58]. Unmet basic needs, family separation, and acts of discrimination expose a large proportion of Venezuelan migrants to developing mental illnesses such as depression, anxiety, sleep disturbances, sadness, anger, and the feeling of losing control of their lives [107].

Even though Colombia established a mental health policy in 1998 that has been continually updated, as indicated in the Comprehensive Health Care Policy (Country) and the results of the 2015 National Mental Health Survey (NMHS), the growing phenomenon of migration creates new challenges that must be taken into account [108]. Venezuelan people arrive with multiple unmet mental health needs related to this phenomenon, and because of the insufficient implementation of the mental health policy developed in Venezuela in 1991 and of the National Plan for Mental Health in 2010 [109].

This section analyzes the use of mental health services in the Venezuelan migrant population and the Colombian host community based on three conditions: i) suicide attempts, ii) depression, and iii) anxiety.

Figure 4.29. Distribution of three mental health services, 2019.

Source. RIPS data cube - Migrant Population. Information System of Social Protection (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia. Notes: ICD-10 codes used to filter the query in the cube were X60 - X84; F320 - F339 and F400 - F419.

Migration as a determinant

- Strengthen inter-agency support between the sectors of health, education, work, and social assistance focused on mental health strategies with a differential approach to the most vulnerable populations.
- Prioritize the migrant population within the strategies to prevent suicide, and supervise depression and anxiety.
- Increase psychosocial care programs in the most vulnerable populations nationwide.
- Establish programs that provide information regarding places of care and risk factors for mental health.
- Develop strategies to strengthen surveillance and evidence in relation to mental health.
- Include migrants and refugees in the following surveys: demographic, health, and mental health; to increase the evidence about their current situations and needs.
- Generate programs for prevention and treatment of mental disorders, and to protect the human rights of those suffering from any mental or psychological disorder

Suicide attempts

Suicidal behavior includes both, suicide and suicide attempts. It should be noted that rather than being considered a disease, suicidal behavior is an undesired outcome, resulting from different factors and determinants. Hence, suicide is a preventable event of special interest to public health [108].

Use of services related to suicide attempts in Colombia, 2019 and variation 2018-2019

Migrant population

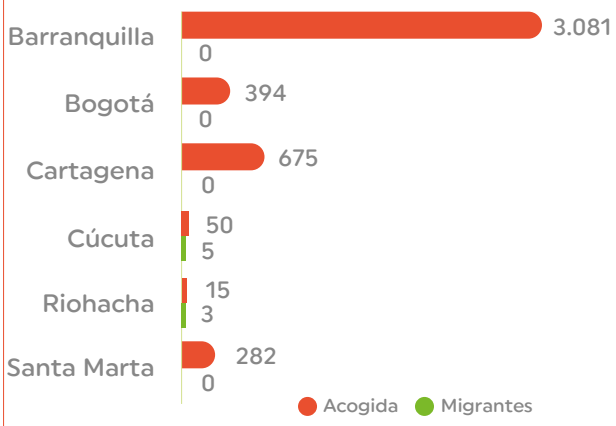
43 people
19,4% from 2018

Host community

15,110 people
282.5% from 2018

- In 2019, 8,665 people used health services associated with self-inflicted injuries nationwide: 8,627 from the host community, and 38 Venezuelan migrants and refugees.
- Norte de Santander (7) reported the most Venezuelan migrants and refugees who were attended by a health professional for self-inflicted injuries.
- Between 2018 and 2019, Atlántico, Magdalena, and Bolivar had a considerable increase in the number of cases in the host community (777.4%, 770.1%, and 524.4%, respectively).

Figure 4.30. Number of people aged 18 and older who received medical attention for attempted suicide in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Information System of Social Protection (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

Migration as a determinant

Migration can increase suicide rates and suicide attempts, because it creates situations of stress and mental suffering. Travel preparation, travel, family separation, seeking asylum, and relocation are some of the different circumstances that can lead to suicidal thoughts, suicide attempts, or suicide itself [110, 111].

Colombia – Venezuela context

In Colombia, 20,180 cases of suicide were reported in 2019, representing a national incidence of 40.1 cases per 100,000 inhabitants. This is 0.7 cases per 100,000 inhabitants more than the previous year (39.4 cases per 100,000 inhabitants) [112]. According to the 2015 NMHS, being over the age of fifteen, male, single, separated, divorced, or living in rural areas or in a free union increases the probability of suicide. On the other hand, the World Bank reported a suicide mortality rate of 3.6 in Venezuela for 2016. According to the Venezuelan Violence Observatory, for 2019 this number had been increasing. Nevertheless, there is little clarity on the data because the last annual directory of cause of death was published in 2014. In that report, suicides ranked fifth in the causes of death in the Venezuelan population [113].

In Colombia, the Venezuelan migrant population is the fourth group with the highest number of suicide attempts after psychiatric center patients, the population deprived of liberty, and pregnant women. In these four groups, a total of 13,754 cases of suicide attempt were reported in 2019. Out of these, 112 cases (0.8%) were Venezuelan migrants; placing this population in the fourth most vulnerable group [112].

Use of health services related to suicide attempts

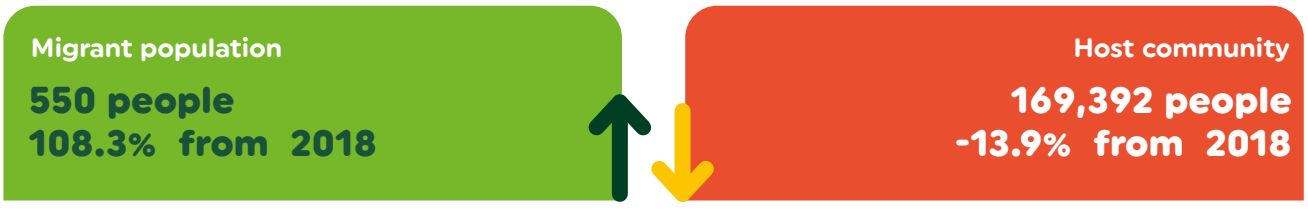
In Colombia, 8,665 people used health services related to self-inflicted injuries; 8,627 people from the host community and 38 migrants and refugees from Venezuela. In the host community, there was an increase of 94,6% in suicide attempts, rising from 4,434 in 2018 to 8,627 in 2019. To a lesser extent, the attempts in the Venezuelan migrant and refugee community increased by 5.6%, from 36 people to 38.

The department that reported the most Venezuelan migrants and refugees treated for self-inflicted injuries in 2019 was Norte de Santander (7). In the host community, Atlántico (1,632), Bolívar (1,024), and Magdalena (670) documented the highest numbers of women treated and the highest percentage increases compared to 2018. By city, Cúcuta (5) registered the most cases of Venezuelan migrants and refugees in 2019, while Barranquilla, Cartagena, Santa Marta, and Bogotá reported none. On the other hand, in the host community, Barranquilla had an increase of 857%, rising from 113 people treated for self-inflicted injuries in 2018 to 1,082 in 2019.

Depression and anxiety

Depression and anxiety are frequent mental disorders that affect the quality of life of people and their relationships with their surroundings. Depression is a mental disorder characterized by the presence of sadness, loss of interest or pleasure, feelings of guilt, or low self-esteem. On the other hand, anxiety is characterized by intense restlessness and a high degree of insecurity [114].

Use of health services for depression in Colombia, 2019 and variation 2018-2019



Use of health services for anxiety in Colombia, 2019 and variation 2018-2019

Migrant population

857 people
224.6% from 2018

Host community

218,373 people
-13.5% from 2018

Figure 4.31. Number of people 18 years and older treated for depression in the migrant and host communities, 2019.

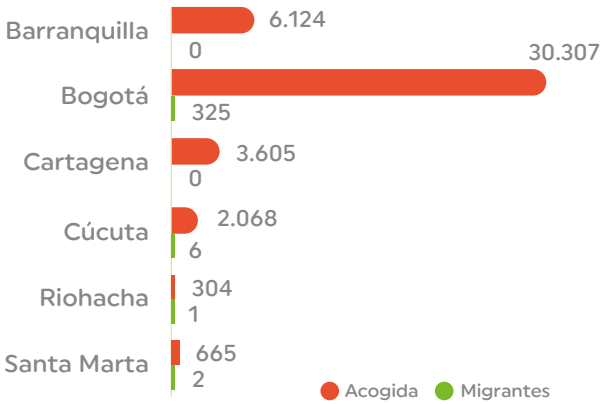
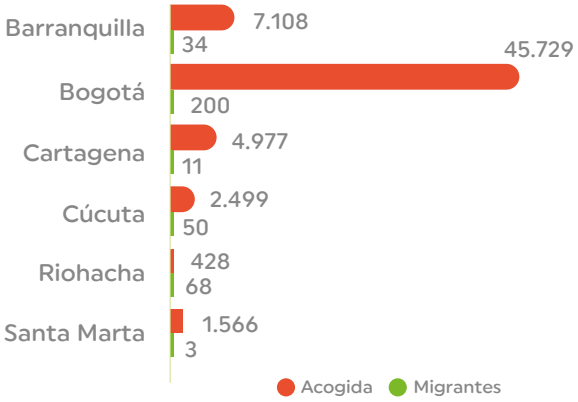


Figure 4.32. Number of people 18 years and older treated for anxiety in the migrant and host communities, 2019.



Source. RIPS data cube – Migrant Population. Information System of Social Protection (ISPSIS). Ministry of Health and Social Protection (MHSP) of Colombia.

- In 2019, 169,942 people used health services associated with depression: 550 Venezuelan migrants and refugees, and 169,392 people from the host community.
- In 2019, 219,230 people used health services associated with anxiety: 857 Venezuelan migrants and refugees and 218,373 people from the host community.
- By department, Norte de Santander (9) reported the most Venezuelan migrants and refugees treated for depression.
- Similarly, Norte de Santander (83) reported the most Venezuelan migrants and refugees treated for anxiety, followed by La Guajira (80).
- At the city level for the period of the study, Bogotá reported the most Venezuelan migrants and refugees treated for both, depression (128 in 2018 and 325 in 2019) and anxiety (128 in 2018 and 200 in 2019).

Migration as a determinant

Migrants are more vulnerable to mental health deterioration due to family separation, difficulties in meeting their expectations, and multiple barriers they face to meet basic needs and adapt to new contexts. Both, anxiety and depression, are multi-causal illnesses that can intensify in a refugee and migration crisis, as a result of the dramatic circumstances that many people undergo [111].

Colombia – Venezuela context

In Colombia, the 2015 NMHS results included new contributions to the recognition of mental health. The survey indicated that 9.6% of people between 18 and 49 years of age who responded the global SRQ questionnaire (5,058 people; 16% of the population), showed positive results for depression. Furthermore, depression was more prevalent in women (10.8%) than in men (7.9%). The SRQ was positive for 11.2% of people aged 45 and older; again, with higher prevalence in women (13.1%) than in men (8.3%). In the case of anxiety, one or more symptoms were present in at least 52.9% of people between 19 and 44 years of age. Similar to the results on depression, more women (59.3%) showed anxiety symptoms than men (46.4%). In the group of people aged 45 and older, one or more symptoms of anxiety were present in 54.8% of people [108]. The aforementioned shows that after suffering traumatic events during transit and being exposed to multiple factors that worsen mental health, Venezuelan migrants are reaching host populations in which one out of two adults may have a mental health disorder.

It is important to note that unlike other topics addressed in this report, the mental health of Venezuelan migrants and refugees has been poorly documented in Colombia. This analysis may be one of the first to provide evidence on the subject.

Use of services for depression

In Colombia, 169,942 people used health services associated with depression in 2019; 550 Venezuelan migrants and refugees and 169,392 people from the host community. Between 2018 and 2019, the number of Venezuelan migrants and refugees treated for depression increased by 108.3%; rising from 264 to 550 cases. For this analysis, the data were not disaggregated by gender.

By department, Norte de Santander (9) reported the most migrants and refugees treated for depression in 2019. Whereas in the host community, Atlántico (8,233), Bolívar (4,087), and Norte de Santander (2,464) documented the highest numbers of cases. By city, Bogotá (325) reported the most cases of depression in Venezuelan migrants and refugees, followed by Cúcuta (6). Likewise, Bogotá reported the most cases in the host community (30,307), followed by Barranquilla (6,124).

Use of services for anxiety

In Colombia, 219,230 people used health services associated with anxiety in 2019; 857 migrants and refugees from Venezuela and 218,373 people from the host community. This represents an increase of 224.6% in the number of Venezuelan migrants and refugees treated for anxiety, rising from 264 people in 2018 to 593 in 2019. The data were not disaggregated by sex.

By department, Norte de Santander (83) and La Guajira (80) documented the highest number of Venezuelan migrants and refugees treated for anxiety in 2019. Whereas in the host community, Atlántico (8,956) and Bolívar (6,190) reported the greatest numbers of people treated for anxiety. As for the cities, Bogotá recorded the most cases of Venezuelan migrants and refugees treated for anxiety (200). In addition, regarding the same population group, Riohacha and Cúcuta documented important increases in the number of cases. In Riohacha, cases rose from one in 2018 to 68 the following year, and in Cucuta from 6 to 50.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

- *Beyond enabling new healthcare services, we must move forward to ensure the mandatory nature of the right to health for the migrant and refugee population, where and when they need the services, particularly amid the health emergency due to Covid-19. The right to healthcare should not be denied based on the immigration status.* Venezuelan migrants and refugees face problems related to insurance, service provision and limited financial protection mechanisms, which can become critical within the Coronavirus situation. In practice, these problems range from unnecessary procedures to enforce their right to healthcare -even when their immigration status is in order-, to unfair barriers based on a subjective and ambiguous interpretation of emergencies and out-of-pocket expenses to cover photocopies of documents or to use emergency services (values range from $15 to 50 thousand pesos); this can eventually impoverish them for simply using healthcare services.

- *A better definition of the primary healthcare models is required in view of the growing needs of the migrant and refugee population and the host communities, the risks of future epidemiological outbreaks and the Covid-19 threats.* There is insufficient primary prevention, specific protection and a renewed primary care model is needed. This means that health realities and needs, both regional and local, must be addressed with healthcare models at the community, neighborhood and settlement levels. The increased use of healthcare services by the migrant and refugee population concentrated on migrant children under five years old due to diagnoses related to acute respiratory infection, people with circulatory system diseases, with anxiety, adolescents and young people requiring counseling in contraception, and pregnant women lacking prenatal checkups and screening for STIs. These are health needs that may be dealt with at the first level of healthcare and with community-based strategies.

- *Family medicine should be an extended reality in our healthcare system, and it should be part of the humanitarian response. Family medicine* should precisely dynamize the models of primary care in the face of these growing needs of the migrant and refugee population, particularly aimed at protecting the most vulnerable from the risks of Covid-19. To achieve this, we need to respond by increasing the number of medical professionals with training in humanitarian crises, family health and public health, so as to respond more effectively to the health needs and risks that threaten both the migrant and refugee population as well as the population of the host communities where they decide to reside.

- *The humanitarian response will never be perfect; however, unfair barriers of a legal, administrative nature, those resulting from misinformation in those same healthcare services, and the lack of implementation of national guidelines at the local level (particularly in the public network of hospitals and the private healthcare providers) are resulting in violations of the right to healthcare services for the migrant and refugee population and the results achieved to date through the humanitarian response are rendered invisible. This violation may be exacerbated during the Covid-19 response.* Ignorance and lack of action to address migration in practice are creating inequities in the access to the right to healthcare for the migrant population. For instance, failure to implement the national response plan, the National Economic and Social Policy Council (Conpes, for its acronym in Spanish) document on migration, of the inter-agency response and the government guidelines, create difficulties for the enrollment to healthcare services, and emergency care should be part of the training and capacity building for healthcare teams at the local level. The foregoing, coupled with the agile implementation of national measures to mitigate and eliminate the spread of Covid-19, may jeopardize the achievements of the response on the right to healthcare for migrants and refugees, and result in social exclusion and ethical dilemmas regarding who should or should not receive hospital care or intensive care based on their immigration status or nationality.

- *Information and communication technologies and platforms have the potential to play a crucial role in helping the migrant and refugee population when gaining access to quality information on how to navigate the health system, particularly to obtain information on to access healthcare services and strategies available to contain the spread of infectious diseases such as Covid-19.* Mobile health apps, the use of WhatsApp enabled channels, and interventions with telemedicine strategies can help meet the expectations and needs of the migrant and refugee population on how to easily find information on the rights, the provision of essential services, health assurance and mobile brigade opportunities, while offering guidance on public health measures, hand washing, infection control, dispelling myths and behavioral changes to support the Covid19 response in humanitarian contexts.

- *There are no humanitarian solutions to humanitarian problems; what we need is to improve cross-sectoral coordination with international agencies, government sectors, local governments and public and private healthcare service providers to mitigate health effects and health inequalities during migration.* To reduce inequalities in the use of healthcare services, there is a need to consider all health-related determinants and work with all national and international players across clusters. Therefore, policies and responses within the humanitarian emergency are required to act on these determinants that create health inequalities before, during and after migration. This is only possible by maintaining cross-sectoral coordination efforts and stressing the importance of sharing common goals in the healthcare agenda for migrants and refugees.

- *Despite the achievements made on access to contraception methods at the Colombia-Venezuela border, the provision of sexual and reproductive health services should remain as a priority issue during the Covid-19 response in humanitarian contexts.* The continued provision of essential sexual and reproductive health services remains critical during the global response to the pandemic. It is urgent to ensure, now more than ever, that services such as access to contraception methods for young migrants and refugees, the prevention of and care for gender-based violence, particularly sexual violence against women and girls, is strengthened and under certain circumstances interrupted during isolation. The national government, the local healthcare authorities and the players of the sexual and reproductive health cluster should adopt clinical and programmatic guidance, assessments, policy documents and statements to ensure the continued prioritization of sexual and reproductive health and rights throughout the Covid-19 response in humanitarian settings, and provide a gender-based perspective to the response.

- *The stories of pregnant women seeking optimal, supportive and respectful services are common, but they find stigma, violence and poor quality in the provision of maternal and child healthcare services.* Migrant women face challenges as a vulnerable group and suffer from social exclusion when seeking to meet their specific needs. Optimal, supportive and respectful maternal healthcare should be offered to all women and pregnant people, and even more in the most difficult times of migration. However, many of them often do not complete prenatal check-ups, are at risk of extreme maternal morbidity and gestational and congenital syphilis, problems that often result from the inefficient and uncoordinated provision of basic health services and from the first level of care. If public and private healthcare service providers do not clearly know how to prevent, control and manage STIs during pregnancy, certainly they are not aware either of the importance of providing quality and safe maternal care.

- *Migrant and refugee children and adolescents require urgent management, control and prevention of preventable infectious diseases, early pregnancy and injuries from external causes.* Migrant and refugee children and adolescents are highly vulnerable at the physical, psychic and social levels. Specifically, the dramatic conditions in which many children live during migration makes them more prone to acquire different diseases that should be cared for on time and without any kind of barriers. The findings in this report show an increased prevalence of diseases such as acute diarrheal disease and acute respiratory infection in girls and boys under the age of five.

- *Given the risk of falling severely ill with Covid-19, the older adult population is doubly vulnerable: migrant and with chronic noncommunicable conditions related to cardiovascular diseases, diabetes and cancer that can increase the risk of death. First, it is urgent to act in view of the increase of migrant and refugee adults with pre-existing conditions that require continued and high-cost care.* The use of healthcare services identified new needs in specialized

healthcare and ongoing and comprehensive care services that emerge within the migrant and refugee population. It is important to point out that migrants and refugees only have access to emergency services, without access to disease treatment within the humanitarian response. *Second, facilitating the physical distancing and preventive isolation of older adults over the age of 70 during the Covid-1 transmission stage should be a priority* in the settlements, shelters and host communities since, because of their co-morbidities, they are at increased risk of Covid-19 severity and mortality.

- *Primary mental healthcare for migrants and refugees and host communities should be a priority in the public health agenda of the national, territorial and local governments, but unfortunately it remains invisible and no reaction is seen within the humanitarian emergency.* Migrants and refugees are reaching host communities where there is already a high number of people seeking care services for problems associated to anxiety and depression, a deterioration of the mental health in general, and insufficient local responses to suicide prevention and absence in the provision of psychosocial care combined with strong social work. Likewise, pre-existing anxiety and stigma can fuel racism, misinformation and rumors about the spread of Covid-19 among the migrant and refugee population.

- *The increase in Venezuelan migrants and refugees served within the Colombian healthcare system emerges as an urgent need to define individualized packages of healthcare benefit plans.* When dealing with populations with growing expectations for healthcare services, the increase in healthcare services related to chronic diseases of the migrant and refugee neglected population, we need to ask ourselves what cost-effective and evidence-based alternatives should we devise within the benefit plan packages to respond to the needs of irregular migration and informality in the labor market. We need to define mechanisms for collective protection, pooling of individual risks and defining the benefits of healthcare services and technologies which should be guaranteed for migrants and refugees enrolled in the General Social Security Healthcare System.

- *Given the Covid-19 situation and the current absence of a vaccine, the ecology companies of the Information and Communication (ICTs) must have a relevant role within the humanitarian response, since now more than ever part of our daily life and to bring health services closer to migrants and refugees and host communities.* During government-implemented virus mitigation and suppression strategies: preventative isolation of cases with symptoms at home; home quarantine of all household members of people with symptoms; social distancing; closure of schools and schools, and physical distancing from adults over 70 years of age who are at serious risk of illness; innovative ICT solutions are needed to prevent disruptions in essential services through telemedicine; remote and virtual primary health care assistance; as well as more intense digital health and mobile health strategies (text messages, barrier-free connectivity and massive use of What's app) while these public health measures are in place.

- Lastly, *mobilizing resources and increasing funding for the humanitarian response is a critical issue in improving access to healthcare services for migrant and refugees and the most vulnerable host communities.* At the same time, we should identify healthcare needs and where healthcare services are failing to bring their supply closer to those migrants and refugees who are most in need, in order to sort out how to develop capacities at the local level to ensure the sustainability of innovative strategies and solutions within the humanitarian emergency we will implement over time.

Recommendations

For all stakeholders

- *Ensure the right to health as a means to ensure universal healthcare coverage and mitigation of the risk of Covid-19 contagion for the migrant and refugee population and the host communities.* Barriers need to be removed by adjusting legal, administrative and financial arrangements, as well as eliminating unnecessary procedures during healthcare assurance, ensuring the provision of healthcare services and effectively implementing financial protection mechanisms for the most vulnerable migrants and refugees during the whole Covid-19 response in humanitarian settings (e.g., subsidies for those who meet criteria and co-payment exemptions in the difficult circumstances of irregular migration).

- *Renew primary healthcare and return to community-based interventions to respond to the increase in healthcare needs and mitigate the risks of Covid-19 spread to migrant and refugee populations and host communities within the humanitarian response.* The first - and more necessary than ever - step is to promote family medicine, migrant and Colombian healthcare promoters, and to increase the number of healthcare volunteers concerned with the healthcare for all community members, regardless of their nationality, during the Covid-19 pandemic; this is possible if we rethink primary healthcare within the humanitarian response and with the local governments. Second, it is urgent to continue identifying the expectations and needs of the most vulnerable people and include them in the budgets of the healthcare agenda at the local level. Examples from the daily life may include the pregnant woman who has not completed her prenatal checkups; a teenager without access to contraception; children without a complete, age-appropriate vaccination scheme; an older adult with cold symptoms or fever and without preventive measures and care via telemedicine. Those instances where primary healthcare services and collective health interventions may improve people's lives again.

- *Promoting the use of Information and Communication Technologies will contribute toward capacity-building and preparedness for the humanitarian response in times of Covid-19. Telemedicine, mobile healthcare and digital healthcare interventions are innovative, scalable and affordable solutions that may prevent discontinuing the use of healthcare services and help to bring them closer to migrants, refugees and Colombians in the host communities, even in the most difficult contexts.* ICTs should play a relevant role in the humanitarian response; therefore, it is urgent to strengthen digital platforms to bring healthcare services to the communities via different information channels. Telemedicine can solve primary healthcare challenges (contraception services, prevention of gender-based violence); collective healthcare interventions can take place in virtual rooms and Moodle platforms; the development of mobile healthcare applications can be helpful for social distancing purposes; and the use of text messages and WhatsApp are essential for disseminating official information. Without a

doubt, the successful implementation of interventions based on Information and Communication Technologies can increase individual and collective care in support of the humanitarian response during the Covid-19 emergency.

- *The health and rights of migrant and refugee women and girls and of the more vulnerable host communities should be placed at the core of the actions and budgets within the humanitarian emergency and the Covid-19 response, within those same contexts.* This can be achieved when healthcare service providers in the public and private network adopt and implement healthcare services based on the people's needs, identities and circumstances, particularly in times of deep social inequality and social discrimination. Placing the most vulnerable migrants and refugees at the center of the healthcare services means prioritizing pregnant women, children, adolescents without support networks, transgender people, people with disabilities and older adults at increased risk of Coronavirus disease.

- *Increase the emergency response and preparedness capacity of the local governments, the private sector and the players involved in the humanitarian response and the Covid-19 response within that same emergency, through the appropriation and implementation of government guidelines and searching for solutions to prevent violations to the right to health for the migrant and refugee population.* The public network of hospitals and the Benefit Plan Management Companies (Empresas Administradoras de Planes de Beneficios or EAPB, its acronym in Spanish) are key players in raising the awareness and understanding of the mechanisms that the government has available to ensure the health of the migrant and refugee population, as well as to guide the people through the healthcare system. In some cities, healthcare workers and administrative staff from the healthcare services are poorly informed about these guidelines, and as a result, this unfairly limits access to essential healthcare services.

- *Continue to stress on cross-sectoral collaboration. The national government should strengthen shared work and goals with other government sectors, private players and local governments to design, adapt and implement policy frameworks, programs and budgets to respond to the migration and the Covid-19 threats as health determinants.* This includes the design and implementation of medium and short term strategies for irregular and regular migrant and in transit populations, and for the population interested in becoming residents. These strategies should suggest how to incentivize employment opportunities; take advantage of the informality market as an alternative mechanism for healthcare funding; provide access to education and healthcare policies in cities with high demographic dependence. Clearly, the diversity of the migrant and refugee population, their needs and dynamics demand cities and urban contexts to ensure a faster adjustment, particularly some more than others (Riohacha, Cúcuta, Bogotá, Barranquilla); that is why local governments are instrumental in leading this cross-sectoral action on migration.

- *Work on a social contract between local governments, private players and the humanitarian response with social communication professionals, journalism and social media leaders, to amplify joint efforts to stop misinformation, discrimination and xenophobia. Particularly, decrease the fear and anxiety that often fuels myths about migrants as Covid-19 carriers.* Stigma is often one of the reasons why migrant and refugee women do not seek healthcare and use the available services. Likewise, misinformation can often be more contagious and spread much faster than scientific evidence itself. Similarly, xenophobia has established itself in healthcare services and host communities, which are unaware of their potential to address migration in a safe, effective and discrimination-free manner. We must work closely with host communities, local governments and private players to build a social contract and information and communication partnerships to promote quality, positive and stigma-free data and information, dispel myths and eliminate rumors and migrant stereotypes. This is the only way in which we can help to counter racism and facilitate the integration of migrants and refugees into their communities.

- *Increase the number of healthcare workers and healthcare volunteers within the humanitarian response. Moreover, it is important to facilitate the integration of migrant and refugee healthcare workers who are still in the process of validating their university degrees in view of an increased demand for healthcare services due to Covid-19 cases.* Considering the growing needs of the migrant and refugee population and the host communities, and the concerns for an increase in the local transmission of new Coronavirus cases, the involvement of migrant and non-migrant healthcare workers and volunteers to strengthen the healthcare frontline is necessary. Taking this opportunity to formally integrate them into the work of the healthcare sector, remove the barriers for the validation of degrees and facilitate their equitable integration into the healthcare market must be a priority.

- *Define common healthcare goals and objectives among public and private service providers, and increase the participation of private Health Promotion Entities (EPS, its acronym in Spanish) within the humanitarian emergency and the Covid-19 response to increase the current effectiveness of the response* and to identify ways and mechanisms to efficiently catalyze actions. For instance, in primary healthcare and in collective health interventions, in the identification of positive Covid-19 cases, and in the adoption of public health measures such as preventive isolation and physical distancing within the settlements, shelters and host communities.

Regarding prioritized health issues

Sexual and reproductive health

During migration, the sexual and reproductive rights of women, adolescents and youngsters are essential and should not change under any circumstances. However, many adolescents and young migrants and refugees still have a limited understanding of how to prevent an unwanted pregnancy and different sexually transmitted infections. For this reason, the following recommendations are critical during the Covid-19 response in humanitarian contexts.

Contraception

- Renew primary sexual and reproductive healthcare focused on youth and adolescents.
- Deliver quality information on the use and access to contraceptive methods.
- Promote shared contraception (contraceptives for men and access to vasectomy).
- Emergency contraception can help prevent unwanted pregnancies, particularly via supervised home deliveries during preventive isolation and social distancing.

Maternal health

Migrant and refugee women and pregnant women are entitled to equitable, quality and respectful care, and need support to make informed decisions for themselves and their children within the humanitarian emergency. Even in the most difficult contexts of the migration and the Covid-19 pandemic, pregnant women should have access to all available maternal health services and options within the healthcare supply, regardless of their immigration status, income level, ethnicity, religion, educational level and many other circumstances arising from their transit and the epidemiological outbreak itself.

Therefore, the following recommendations are essential:

- Women and individuals with breeding capacity need equitable, respectful and supportive healthcare services that consider the social disadvantages of being migrant and the risks of exposure to infectious diseases such as Covid-19 when using healthcare services.
- Improve the implementation of Clinical Practice Guides (CPG) in maternal health and care to reduce morbidity-mortality.
- Renew Primary Healthcare with clear and consistent guidelines that combine prenatal care, institutionalized delivery care, management and

control of complications, and screening of pregnancy alterations and infectious disease disorders comprehensively, and not atomized or without ongoing care.

- All women and individuals with breeding capacity should be prioritized for the screening of sexually transmitted infections (particularly syphilis, HIV/AIDS, Neisseria gonorrhea) and respiratory infections (Covid-19).

- Provide pregnant women with optimal support and ensure the completion of a minimum of 4 to 8 prenatal checkups.

- Providing quality information is essential: guidance on where and how to access sexual, reproductive and maternal and child healthcare services in the municipality where you have decided to reside or on the supply of services available during transit from one place to another.

- Countering rumors and prejudices stating that migrant and refugee women have a high maternal mortality compared to other population with evidence, and properly using data from official sources of information; in some contexts, this may place women and parents to be at risk of failing to receive quality healthcare.

- Increase the knowledge and capabilities of healthcare and administrative staff in healthcare services on how maternal morbidity and mortality can be reduced amid humanitarian emergencies due to migration and pandemics.

Child and adolescent health

There is a need to expand emergency response and preparedness capacity and place girls, children, adolescents and young people as a doubly vulnerable group because of their age and immigration status. It is important to start by acknowledging that children, adolescents and youth are sensitive moments in the course of life and that there are specific needs that require quality information, support networks and healthcare services adjusted to their circumstances within the humanitarian response. Therefore, the following recommendations are essential:

a) Strengthen the first level of care in the prevention, management and control of acute respiratory infections (primary health care + collective interventions); this means that, during the health emergency for Covid-19, unfair and avoidable barriers that limit access to health services should be removed.
b) Extend specific protection services and early detection of growth and development disruptions in settlements, shelters and border points.
c) Provide information on healthcare services offered for children, adolescents and young people.
d) Continue to increase the coverage of immunization programs.

e) Strengthen the strategies on Comprehensive Education on Sexuality for adolescents and young people.
f) Improve cross-sectoral and inter-agency coordination for early and adolescent pregnancy prevention, and priority care when warranted.
g) Monitor and evaluate available healthcare services for children, adolescents and young people.
h) Act on the determinants of child health during migration: ensure access to safe drinking water and basic sanitation, access to primary and secondary education, and promote opportunities for personal fulfilment during youth; providing access to civil registry and primary healthcare services contributes to break the intergenerational transmission of health inequalities.

Transmissible diseases

It is important to identify facilitating processes to maximize the effectiveness of the programs for the prevention, control and management of Covid-19, malaria, viral hepatitis and HIV/AIDS. Additionally, broadly promote the four early approaches to combating sexually transmitted infections: detection, reporting, isolation and early treatment initiation where and when needed, regardless of nationality within the national territory. Therefore, the following recommendations are essential:

a) Ensure primary healthcare (screening, diagnosis and timely treatment initiation).
b) Screening can provide benefits but also result in damage when done just for the sake of it and not as it should be done. For this reason, screening of the migrant and refugee population should be done within an existing screening program at the local, territorial or national level, which should include certain key elements, beginning with the identification of at-risk populations and treatment initiation, to monitoring and evaluation.
c) Promote the use of barrier contraceptive methods, even when other contraceptive methods are being used.
c) Prioritize campaigns to prevent, manage and control different sexually transmitted infections in migrants and refugees, and in the most vulnerable Colombian population.
e) Improve reference and counter-reference systems and take advantage of the development of the public health surveillance system at the local level.

Chronic noncommunicable diseases

Chronic noncommunicable conditions (diabetes and circulatory system diseases, particularly high blood pressure) are causes that contribute to premature mortality among both Venezuelan migrants and refugees and Colombians in host communities. For this reason, the following recommendations are essential:

a) One of the most effective ways to fight chronic noncommunicable diseases is by increasing funding for affordable, equitable and quality primary healthcare services.
b) Investing more resources in the humanitarian response to detect and treat conditions from an early stage, rather than after progressing to more advanced stages can save lives, improves health outcomes, reduces pressure on healthcare services locally, decreases the use of high-cost healthcare services, and strengthens humanitarian emergency preparedness.
c) Identify the most cost-effective interventions to reach migrants and refugees, based on experiences in bringing chronic healthcare services closer to the most vulnerable Colombians. There are simple ways to treat chronic diseases: some measures include primary healthcare as an important entry point for migrants and refugees to the healthcare response of the humanitarian emergency and the healthcare system. This can improve the capacity and resilience of the healthcare system at the local level to manage the disease burden due to noncommunicable diseases, particularly diabetes, cancer and high blood pressure.
d) Improve the coverage and quality of primary healthcare services such as taking blood pressure readings, clinical laboratories and clinical test readings, information on health risk prevention, and promote healthy lifestyles.
e) Determinants of noncommunicable diseases require structural changes emerging from government actions, international agencies and host communities. Local actions of the healthcare system (public networks of hospitals and private healthcare providers) should work on a community-based approach with the education, social protection, poverty reduction, planning, and transportation sectors, and include the private sector to act on those determinants in an early manner. Today's migrants and refugees will be formal workers in the future who will contribute to the healthcare system and will surely require care.

Regarding cervical and breast cancer care, migrant and refugee women need to be detected and offered early treatment within the humanitarian response to increase the chances of survival. Three-month delays in the initiation of treatment have been associated with advanced stages and low survival. That is why healthcare within the emergency is required to be well equipped for early detection, as an essential mechanism in the fight against cervical and breast cancer. Therefore, the following recommendations are necessary:

a) Ensure primary healthcare (screening, diagnosis and timely treatment initiation).
b) Screening, diagnosis and treatment should be aligned with local and national programs.
c) Develop capabilities on prevention and early detection in the healthcare service providers and emergency teams.
c) Early detection, timely access to treatment and vaccination of precancerous lesions (HPV) can significantly reduce the incidence and mortality among migrant and refugee women and girls.

Violence against women

Everyone is entitled to a life free from violence. Attacks on migrant and refugee women and girls and in host communities, against both Venezuelan and Colombian women, have increased during the humanitarian response. Likewise, during the beginning of the preventive isolation due to the Covid-19 emergency, reports have increased and new forms of violence against women have been identified, such as their aggressors threatening to infect them with Covid-19. Women and girls are constantly under attack due to gender-based issues, chauvinist stereotypes and fears as a result of misinformation about the virus. Increasing local, territorial and national support with initiatives that promote the safety of women and girls without support networks is urgently needed. Thus, the following recommendations are essential:

a) Strengthen the first level of healthcare and equip it to address violence within the emergency; this can help improve the case tracking and reference system.
b) Fight against the stigma on migrant and host women and girls affected by different forms of violence. In particular, the new forms of violence emerging during these Covid-19 times as threats of contagion from the aggressors.
c) Raise awareness among healthcare personnel about the importance of handing out dignity kits, which should contain information on how affected women and girls can find service offerings and psychosocial support available online.
d) Support different strategies that effectively accelerate the use of healthcare services by women and girls affected by different forms of violence within the cities with the highest migration flow.
e) Enhance understanding of the negative effects of violence throughout the lives of women and girls among healthcare workers and healthcare providers; address information needs to overcome knowledge gaps.
f) Implement and strengthen laws to protect women and girls, and expand the same protection, reparation and justice mechanisms to benefit migrant and refugee women.
g) Promote changes and transformations of gender stereotypes, perceptions, norms and roles.
h) Promote safe and protective environments for migrant and host community women and girls within the public and private healthcare services.
i) Improve cross-sectoral coordination to help migrant women to easily access economic support, combined with gender training within the humanitarian response.
j) Increase the number of gender experts within the humanitarian emergency.
k) Adjust primary healthcare services to the needs, identities and circumstances of the women and girls affected by different forms of violence, regardless of their nationality and immigration status.

Mental health

Good mental health is related to mental and psychological well-being. All players should begin to increasingly envision the urgent need to work on improving the mental health of migrants and refugees and of the Colombian population in host communities, simultaneously and collaboratively. In particular, in support of the Covid-19 response within humanitarian contexts, since fear and panic can increase the risk of suffering depression, anxiety and other mental disorders, as well as other traumatic events following the forced migration. Therefore, the following recommendations are essential:

a) Strengthen cross-sectoral collaboration between the healthcare, education, labor and social assistance sectors to provide basic psychosocial support and with a differential approach. The kind of support offered should include psychological first aid, stress management, and help the affected by teaching positive coping methods and offering social support possibilities, virtually and remotely in times of preventive isolation and social distancing.
b) Strengthen suicide prevention strategies, care for depression and anxiety, particularly by means of new clinical protocols and guidelines to provide mental healthcare via telemedicine and mobile healthcare for adults and girls, for children exposed to trauma or the loss of loved ones, family separation and neglect during migratory dynamics.
c) Launch mobile clinics on mental health and psychosocial support in emergency contexts.
d) Include migrant and refugee populations in demographic, health and mental health surveys, to increase the evidence on their current situation and needs.
e) Increase the number of professionals in mental health and psychosocial support, and support training and capacity building in emergency contexts as a result of migration and epidemiological outbreaks.

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