Evaluation of the unmet sexual and reproductive health needs of the

Venezuelan migrant population

in four cities on the Colombia-Venezuela border:
Arauca, Cucuta, Riohacha and Valledupar

Profamilia

IPPF International Planned Parenthood Federation
Región del Hemisferio Occidental

SUMMARY

Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities on the Colombia-Venezuela border

While one out of 30 people in the world is displaced or a refugee, in Colombia one out of 46 people is a Venezuelan migrant. At the end of 2018, 1,032,016 Venezuelans had migrated to Colombia. During 2018, the migrant population in the states along the Venezuelan border increased by almost one million people (418%). Arauca, César, La Guajira and Norte de Santander received and hosted nearly two-thirds of the migrant population that has come to Colombia (Colombia Migration, 2018).

Venezuelan migrants arrive in the country with multiple unmet Sexual and Reproductive Health (SRH) needs. The profile of the Venezuelan migrant in Colombia is of men and women, particularly young adults and adults between 18 and 59 years old. Existing SRH needs have been exacerbated by this regional crisis. Despite the capacity of Colombian institutions, this does not translate into effective and timely access to comprehensive sexual and reproductive health services for these women and men. To guarantee access, resources are needed, as well as the elimination of barriers for the migrant population. In this sense, communication strategies are needed to attack misinformation about SRH in migration contexts. There are large inequalities between irregular and circular migrants compared to regular migrants and those in the process of regularization. Responses and interventions in SRH must be targeted to take into account the migrant population's circumstance and meet their needs.

Minimal Initial Service Packages in Reproductive Health (MISP) should be widely implemented in Colombia, particularly in places of humanitarian crisis. Massive migration flows without adequate preparedness or regulation in the receiving countries create significant challenges and risks, including the extreme violation of Sexual and Reproductive Rights, and an increase in all forms of gender-based violence, in their place of origin, during transit, and at the destination.

1 out of 47
People in Colombia is a Venezuelan migrant

48%
Men (496.413).

44%
Women (454.884).

0.03%
Transgender people (339).

7.97%
Do not registers sex (80.380).

93% of the Venezuelan migrant population is concentrated in 12 departments of the country

33,994 %
Ethnic group members
26.572 Indigenous
6.150 Afro-descendant
1.065 Raizales
207 Roma

15% Adolescents and Children under 18 years old
156.575 Children and adolescents
77.422 Girls
79.101 Boys

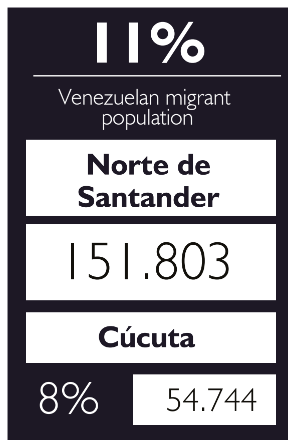
37% Young adults between 18 and 29 years old
378.812 Young Adults
181.350 Women
197.314 Men

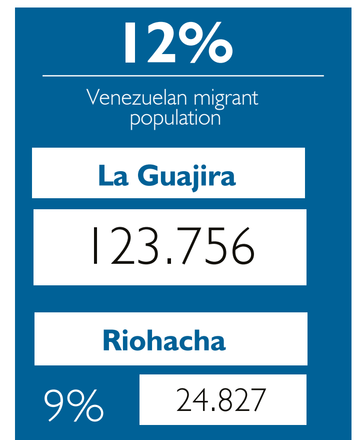
38% Between 30 and 59 years old
391.930 Adults
182.361 Women
209.440 Men

2% People over 60 years
29.311 Older people
13.745 Women
10.558 Men

8% People without data
80.380

As of December 2018, Norte de Santander hosts the largest number of migrants (151,803, who now make up 11% of the state's population. La Guajira hosts 123,756 migrants; the total population has increased by 12%, mainly due to the arrival of irregular, regular and circular migrants from the North of Venezuela during 2018.





Meanwhile, despite the 11% increase in migrants in Arauca (state), in Arauca (city) the increase was 20%. In other words, one in five persons in Arauca is Venezuelan. Cesar hosts 32,471 migrants, a 3% increase compared to the previous year.

This assessment identified ten priority unmet SRH needs in four cities in the Venezuela-Colombia border during 2018. This selection shows the most urgent needs of the Venezuelan migrant population in Arauca, Cúcuta, Riohacha and Valledupar. The purpose of this Top-10 list is to describe the first steps that need to be implemented to fulfill the sexual and reproductive rights of migrants from Venezuela amidst the humanitarian crisis.

Top-10 Unmet Sexual and Reproductive Health Needs of Venezuelan migrants in Arauca, Cúcuta, Riohacha and Valledupar, Colombia, 2018.

TOP 10	CÚCUTA NORTE DE SANTANDER	RIOHACHA LA GUAJIRA	VALLEDUPAR CESAR	ARAUCA ARAUCA	
1	**Access to contraceptive services**			Safe abortion services and post-abortion care	Most urgent needs
2	STI - Sexually Transmitted Infections		Safe abortion services and post-abortion care	Access to contraceptive services	
3	Comprehensive sexuality education	Prevention of teenage pregnancy and youth friendly services	STI - Sexually Transmitted Infections	Effective access to maternal and newborn health care services	
4	**Safe abortion services and post-abortion care**		**Prevention of teenage pregnancy and youth friendly services**		Urgent needs
5	Information and communication on offer and location of SRHS for migrants	**Effective access to maternal and newborn health care services**		Effective and comprehensive care of sexual violence	
6	Effective access to antiretroviral treatment	**Effective and comprehensive care of sexual violence**		Effective access to antiretroviral treatment	
7	**Information on services for survivors of sexual violence**		Effective access to Sexual and Reproductive Health Care for migrants	Information and communication on offer and location of SRHS for migrants	Other important needs
8	**Protection and prevention of sexual exploitation**				
9	Combined response in HIV management and care	**Information and communication on offer and location os SRHS for migrants**		Information on services for survivors of sexual violence	
10	Prevention of teenage pregnancy and youth friendly services	Combined responsive in HIV managment and care	Finding for Sexual, Reproductive, Maternal And Child health	Comprehensive sexuality education	

Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela border: Arauca, Cúcuta, Riohacha, and Valledupar.

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“There was, of course, there was a time when there was family planning [in Venezuela]; it’s called family planning there, and it guaranteed the use of condoms, things and stuff for reproduction, to avoid unwanted pregnancies, (...) but with that issue, the crisis, that no longer exists (...) “.

Venezuelan migrant woman | **Focus Group: 25 to 49 years old** | **Arauca**

PURPOSE

Profamilia, with the support of the International Planned Parenthood Federation–IPPF, during the months of October and November 2018, carried out a rapid assessment of unmet sexual health and reproductive health needs, particularly focused on Gender-Based Violence and HIV among migrants from Venezuelan at the Colombia-Venezuela border. Data were collected in four cities receiving a large proportion of the migrant population: Arauca, Cúcuta, Riohacha and Valledupar.

The purpose of the assessment was to examine the implementation of the Minimal Initial Service Packages – MISP- in Reproductive Health in the humanitarian crisis settings, in Colombia. The report describes the main unmet sexual and reproductive health needs faced by the migrant population, particularly irregular migrant girls and young women.

The report recommends how to best address these unmet sexual and reproductive health needs in each of the four cities, how they are connected to social determinants and the complexity of the migratory phenomenon into Colombia. This report can support fundraising initiatives, create synergies among budgets, improve intersectoral coordination among agencies, government sectors and institutions working on sexual and reproductive health actions and responses at the Colombia-Venezuela border. It provides information on referral and counter-referral systems, and highlights the impact of the different strategies and programs that work to meet the healthcare needs of the migrant population.

In November 2018, the Government of Colombia issued document 3950 of the National Council on Economic and Social Policy (CONPES), which combines the general guidelines to respond to the Venezuelan migration with the national response that prioritizes safe migration and guarantees, among other issues, the sexual and reproductive health of the Venezuelan migrant population in Colombia.

This assessment responds to one of the recommendations made by the World Bank (2018a) in its Report on Venezuelan Migration – the need to carry out studies and health surveys in border areas. Likewise, it is in line with the most recent publication of The University College of London – Lancet Commission on Migration and Health (The Lancet, 2018a), which calls to positively and effectively address the health of migrants; include migrants in health decisions; develop many more multisectoral budgets; confront racism and prejudice with zero tolerance toward xenophobia; promote differentiated approaches to bring health services closer to migrants according to their age, gender and migration situation; and not to forget those who are less acknowledged: undocumented migrants, migrants

with disabilities, trans migrants, ethnic minorities, and those in the most difficult conditions.

At this critical juncture in history, the time has come to seriously consider the impact of migration within the context of humanitarian crises on sexual and reproductive health. The circumstances demand the prioritization of the wellbeing of migrants from Venezuelan and Colombian host communities, particularly of extremely vulnerable girls and women, such as irregular and circular migrants. We have a lot of work ahead of us!

Index of Abbreviations

ADRES: Administrator of the Resources of the General Social Security Health System (Administradora de los Recursos del Sistema General de Seguridad Social en Salud)

ASIS: Health Status Analysis (Análisis de Situación de Salud)

CSpro: The Census and Survey Processing System

DNP: National Planning Department (Departamento Nacional de Planeación)

D&E: Dilation and Evacuation

EPS: Health Promotion Entities (Entidades Promotoras de Salud)

GBV: Gender-based Violence

HIV: Human Immunodeficiency Virus

IAWG: Inter-Agency Working Group on Reproductive Health in Crises

INS: National Health Institute (Instituto Nacional de Salud)

IOM: International Organization for Migration

IPPF: International Planned Parenthood Federation

IPS: Service Provision Institution (Institución Prestadora de Servicios)

IUD: Intrauterine Device

MISP: Minimal Initial Service Packages in Reproductive Health

MPPS: Popular Ministry for Health (Ministerio Popular Para la Salud)

MOH: Ministry of Health and Social Protection (Ministerio de Salud y Protección Social)

NGO: Non-governmental organization.

PBS: Health Benefits Plan (Plan de Beneficios en Salud)

PEP: Special Permanence Permit (Permiso Especial de Permanencia)

Profamilia: Association for the Wellbeing of the Colombian Family (Asociación Probienestar de la Familia Colombiana)

RAMV: Administrative Registry of Venezuelan Migrants (Registro Administrativo de Migrantes Venezolanos)

RIPS: Individual Health Services Provision Registry (Registro Individual de Prestación de Servicios de Salud)

SGSSS: General Social Security Health System (Sistema General de Seguridad Social en Salud)

SISPRO: Social Protection Integrated Information System (Sistema Integrado de Información de la Protección Social-SISPRO)

SPSS: Statistical Package for the Social Sciences

SRH: Sexual and Reproductive Health

SSR: Sexual and Reproductive Rights

STI: Sexually Transmitted Infection

TMF: Cross-border Mobility Card (Tarjeta de Movilidad Fronteriza)

UAESA: Special Administrative Health Unit of Arauca (Unidad Administrativa Especial de Salud de Arauca)

UHC: Universal Health Coverage

UNHCR: United Nations High Commissioner for Refugees

WASH: Water Access, Sanitation and Hygiene

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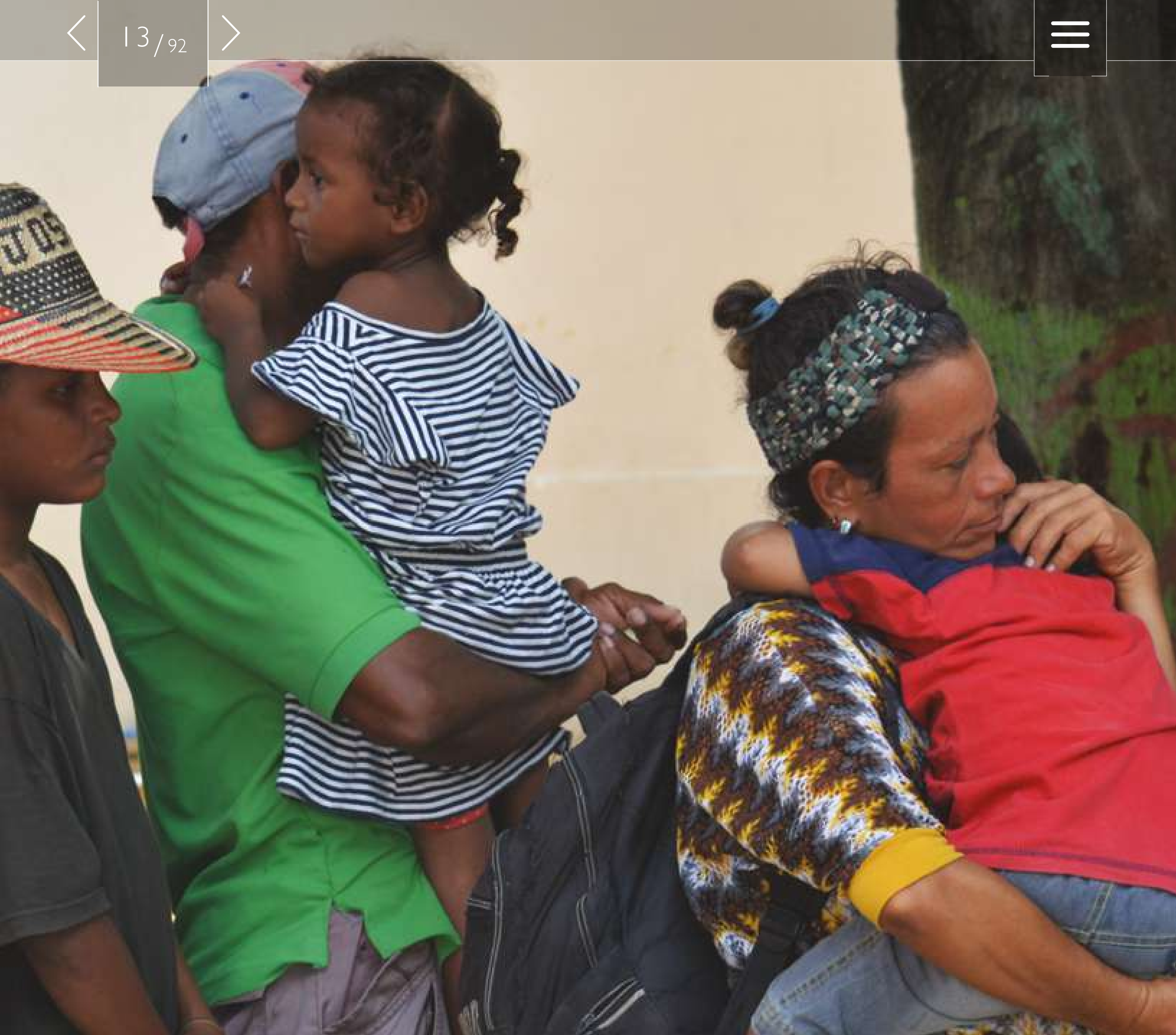

“Right there, those women are from Maracaibo [Venezuela] and they have been even forced into prostitution, and there are husbands who say ‘no, my darling, let’s go and we’ll work there’, and we see that they are forced into prostitution. In fact, I have a friend - by the way, I saw her today -, and her own mom is selling her […]”

Venezuelan migrant woman | **Focus Group: 14 to 17 years old** | **Valledupar**

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Profamilia and the IPPF would like to thank the migrants from Venezuela, children, young and adult men and women who contributed their valuable time and shared their stories, interests and needs during the focus groups, despite the desperate and troubled moments they were experiencing at the time of the assessment in each city.

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INTRODUCTION

Colombian regulations has allowed access to emergency health services for regular inmigrants, but in practices many migrants have been rejected by healthcare providers due to economic reasons, lack of knowledge about the health funding sources at the local level, lack of communication or xenophobia.

Sexual and reproductive rights have been recognized as human and fundamental rights, directly linked to the right to dignity, autonomy, health, freedom and life. When it comes to migrants, these rights are usually forsaken, as their conditions usually leave them in extreme vulnerability to different forms of violence, exploitation and discrimination.

According to the Colombian Government, up to four million Venezuelan migrants could be living in Colombia by 2021, if the situation in the neighboring country worsens. Colombia hosts the second largest Venezuelan population in the world, after Venezuela: nearly one and a half million Venezuelan immigrants already live in Colombia (Colombia Migration, 2018). During the migration processes, many basic needs are not met including housing, food, health, employment and education. These unmet needs create dynamics that directly affect the migrants' sexual and reproductive rights, especially those of women and children. This is reflected in higher numbers and in an increased risk of sexual violence, an absence of contraceptive methods, a higher number of unintended pregnancies, higher unsafe abortion rates and sexually transmitted infections, among others. Furthermore, pregnant women do not have sufficient access to prevention services and in many cases have faced complications registering their children as Colombian citizens.

Migrants often encounter difficulties accessing sexual and reproductive health services. This is caused by conditions such as lack of resources, varying and uncertain work contexts, lack of accessible information and, in many cases, irregular migratory status. Many migrants fear harsh migratory consequences. Colombian regulations only allowed access to emergency services for regular migrants, but in practice, many healthcare providers have refused to provide care to migrants due to economic concerns (they can't pay), miscommunication or xenophobic reasons.

The violation of migrants' sexual and reproductive rights has serious consequences which include preventable maternal and neonatal morbidity and mortality; avoidable consequences of unintended pregnancies, such as unsafe abortion; sexual violence, increased risk of sexually transmitted infections (STIs) and increased transmission of the Human Immunodeficiency Virus (HIV), as well as mental health problems, including depression, anxiety and a feeling of losing control of their lives. However,

Colombian regulations has allowed access to emergency health services for regular inmigrants, but in practices many **migrants have been rejected by healthcare providers due to economic reasons, lack of knowledge** about the health funding sources at the local level, lack of communication or xenophobia.

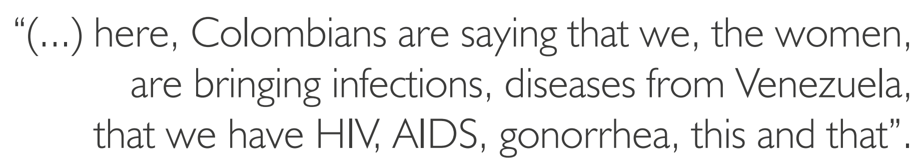
there are ways these rights can be ethically addressed and thus improve personal fulfillment opportunities for many Venezuelan migrant men and women.

The International Planned Parenthood Federation (IPPF) and Profamilia – Colombia, as organizations committed to sustainable development through the guarantee of individuals' sexual and reproductive rights, conducted an evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in the current context of the humanitarian crisis.

The assessment is based on the application of the toolkit developed by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), for the evaluation of the availability of the Minimum Initial Service Packages (MISP) for Reproductive Health in crisis situations. This toolkit combines the use of quantitative and qualitative tools that were applied to: health institutions that provide services to the Venezuelan migrant population, key respondents on sexual and reproductive health, gender-based violence (GBV), and HIV; and focus groups with Venezuelan migrants and Colombian returnees. These tools have already been applied in other humanitarian crises such as Chad (2004), Indonesia (2005), Kenya (2008), Haiti (2011), Jordan (2013) and Nepal (2015). However, it is the first time they have been applied in a Latin American country, which entailed a series of challenges regarding their translation, adaptation and approach in the Colombian context.

The evaluation identified national and international organizations working to satisfy the essential health needs of the Venezuelan migrant population. However, throughout the assessment, the uncoordinated natures of the responses by the different organizations in the territories was apparent in the lack of knowledge, training and implementation of the MISP, and the profound and multiple unmet sexual and reproductive health needs among the migrant population. Girls and women often face great inequities in access and continuum of contraception care, high-quality information, psychosocial support, protection, and attention to all forms of sexual & gender-based violence to which they are exposed when they migrate.

This report describes the unmet sexual and reproductive health needs in the four selected cities, developed throughout six sections. The first section presents the assessment methodology, the second describes the Venezuelan migrant population and the receiving communities. Third, it details the main findings of the evaluation based on the context and analyzes the degree of implementation of the MISP and the comprehensive SRH needs. The fourth section discusses the overall and specific findings in the four cities at the Colombia-Venezuela border. The fifth describes the response of Profamilia within the humanitarian crisis. And finally, the document provides recommendations and key messages to address the unmet sexual and reproductive health needs of the Venezuelan migrant population. It is worth noting that Appendix A describes a brief regulatory framework for migration and the provision of health services in emergencies, in the Colombian context.



"(...) here, Colombians are saying that we, the women, are bringing infections, diseases from Venezuela, that we have HIV, AIDS, gonorrhea, this and that".

Venezuelan migrant woman | **Focus group: 18 to 24 years old** | **Riohacha**

1. Methodology

This assessment used a toolkit developed by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises designed to evaluate the implementation of the MISP. The toolkit combines the use of quantitative and qualitative tools that were applied as follows: i) literature review; ii) interviews with key informants on sexual and reproductive health, gender-based violence and HIV; iii) evaluation of healthcare institutions that provide services to the Venezuelan migrant population; and iv) focus groups with the migrant population. Note: as a reminder this assessment was carried out using tools designed prior to the 2018 version of the MISP, and therefore includes 5 rather than 6 objectives.

All these tools were implemented during fieldwork, and all but one (the literature review tool) was used in each one of the places where fieldwork was conducted. In different ways, they enabled data collection about the scenario at both macro and micro levels. The literature review and the interviews with key informants provided information about the Colombian context and an overview of the crisis settings, as well as the actions developed by different organizations. Meanwhile, the evaluations of healthcare facilities and the focus groups gave information on whether services were being provided, and how those who need them were or were not aware of their availability.

Data collection was carried out in Arauca, Cúcuta, Riohacha and Valledupar between November 6 and 17, 2018. In total the assessment team evaluated 21 health facilities, interviewed 23 key respondents – 10 about sexual and reproductive health, 7 on GBV, and 6 on HIV, and conducted 24 focus groups, including men (12) and women (12) from three age groups (14–17, 18–24, and 25–49 years old). Approximately 300 Colombians and Venezuelans participated in the study.

The application of the IAWG toolkit enabled the collection of information from different sources to build an overall view of sexual and reproductive health needs, services and barriers. One of the strengths of the analysis is that various sources gave similar results; second, its focus on service provision; and finally, the ability to synthesize different information specifically focused on migrants' needs.

On the other hand, the process of translation and adaptation of the toolkit presented several challenges. The IAWG toolkit was conceived with the idea that refugees are usually concentrated in camps or urban settlements. However, Venezuelan migrants can be found throughout Colombia, and healthcare facilities are not necessarily located near their urban settlements. Another limitation involved the process to select the health facilities to evaluate and the subjects to interview. It is worth noting that in some cases, people working at facilities and organizations declined to participate in the assessment, sometimes due to time constraints or because of negative perceptions about assessment processes in general.

The application of the IAWG toolkit enabled the collection **of information from different sources to build an overall** view of sexual and reproductive health needs, services and barriers.

1.1. Description of the tools

Four Profamilia technical professionals carried out the data collection process and were supported by four observers who received one week of training. The data collection process took one month and was driven by a multifocal strategy. Thetools used are described below.

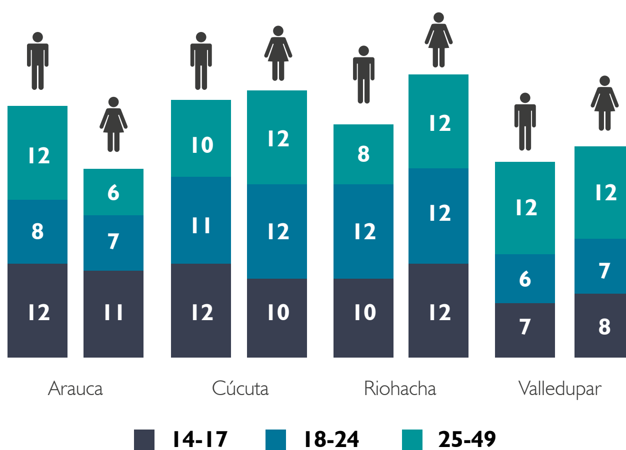
Literature Review

The literature review involved the identification of global, national and local data sources and allowed the identification of information about the migrants' socio-demographic and socio-economic context, as well as the main characteristics of the territories where they are arriving, with a special focus on SRH, GBV and HIV indicators.This review was the main source for the analysis presented in the section entitled "Characterization of the Venezuelan migrant population and the receiving population". Additionally, the literature review provided a comparative perspective of sexual and reproductive needs in both Colombian and Venezuelan settings. Graphs used in this section are based on data reported by governments, non-governmental organizations, researchers and Profamilia.

Focus Groups

Focus groups were conducted by an interviewer and an observer in each city. A total of 24 focus groups, segregated by age (14-17, 18-24, and 25-49 years) and gender (male and female) were conducted, six in each city and two per age group. Graph 1 shows the ages and gender of the research participants.

Graph 1 – Composition by sex and age of focus group participants.



Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

It is worth noting that the tools used with people over 18 years old were the same proposed by the IAWG toolkit, while the tools for adolescents were adjusted, based on a topic list recommend by IAWG and Profamilia. The participant selection process was based on the capacity of Profamilia clinics and their relation to the migrant population in the area.

In Cúcuta, research participants were invited to one of the healthcare facilities for migrants, "Las Margaritas", while in Valledupar the focus group discussions were held at the bus station where some migrants are living and working. In the case of Arauca, participants were selected with the help of local communication and information leaders. Finally, in Riohacha the Departmental Healthcare Office supported with the operation.

Key Respondent Interviews

The IAWG toolkit provides three tools for interviews with key informants in SRH (general), GBV and HIV. The interviewees were selected based on a previous mapping of stakeholders in the territories. The goal was to reach between four and six key informants in each region and at least one for each tool. This was achieved in all cities but one (Valledupar), probably because of the lack and unavailability of institutions addressing the Venezuelan migrants' healthcare needs.

In total, 23 respondents from 14 organizations or governmental offices in the four cities participated in the interviews. According to the type of interviewee, ten dealt on general SRH, six were on GBV and seven on HIV. Table 1 shows the kind of respondents and organizations by city.

Healthcare Facility Assessments

The healthcare facility assessment was guided by the interest to evaluate the institutions that are providing healthcare services for the migrant population. Likewise, some sampling techniques were combined to choose the healthcare facilities to be selected for the assessment, as described below. First, a mapping exercise was conducted to identify the healthcare facilities in the area; this mapping was complemented with information collected in the focus groups, specifically regarding how migrants identified and then gained access to healthcare services. Second, a non-probabilistic sample strategy by networks was applied to find the different types of facilities. It is worth nothing that seeking to identify the gaps, barriers and unmet needs, an attempt was made to select different kinds of facilities. In the findings, the institutions' names were anonymized to guarantee confidentiality during the analysis.

Table 1 – Type of Key Informants and Organizations by City.

	Type of respondent	City	Organization
1	Overall	Arauca	El Bosque – Healthcare point
2	Overall	Arauca	Profamilia
3	Overall	Arauca	UAESA
4	Overall	Cúcuta	Profamilia
5	Overall	Cúcuta	IRC
6	Overall	Riohacha	Profamilia
7	Overall	Riohacha	Red Cross
8	Overall	Riohacha	District Health Office
9	Overall	Valledupar	Municipal Health Office
10	Overall	Valledupar	Departmental Health Office
11	GBV	Arauca	JRS
12	GBV	Arauca	Departmental Victims Bureau
13	GBV	Cúcuta	UNHCR
14	GBV	Cúcuta	IRC
15	GBV	Riohacha	Profamilia
16	GBV	Riohacha	Red Cross
17	GBV	Valledupar	Fundación Casa de la Mujer
18	HIV	Arauca	UAESA
19	HIV	Cúcuta	Fundación Censurados
10	HIV	Cúcuta	AHF
21	HIV	Riohacha	Red Cross
22	HIV	Riohacha	Profamilia
23	HIV	Riohacha	District Health Office

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2019.

In total, 21 healthcare facilities were assessed in the four cities; eight public, eight non-governmental organizations (NGOs), four private, and one mixed (public and private). Table 2 lists the names and types of facilities by city included in the assessment.

Table 2 – Facilities assessed during fieldwork by city.

	City	Name	Type of facility	Type of operating agency
1	Arauca	Patrulla Aérea Civil Colombiana	Mobile Brigade	NGO
2	Arauca	Meridiano 70	Healthcare Center	Public
3	Arauca	Colombian Red Cross	Healthcare point	NGO
4	Arauca	Unicef	Mobile Brigade	NGO
5	Arauca	Hospital San Vicente Arauca	Departmental Hospital	Public
6	Cúcuta	Unidad Básica de Comuneros ESE	Private Clinic (IPS)	Private
7	Cúcuta	Hospital Jorge Cristo	Local Hospital	Public
8	Cúcuta	Centro Regulador de Urgencias y Emergencias (CRUE)	Healthcare point	Public-Private Alliance
9	Cúcuta	IPS Centro de Salud Puerto Santander	Healthcare Center	Public
10	Cúcuta	Unidad Básica Puente Barco Leones	Local Hospital	Public
11	Cúcuta	Colombian Red Cross	Mobile Brigade	NGO
12	Riohacha	Malteser Colombia	Mobile Brigade	NGO
13	Riohacha	Hospital Departamental Nuestra Señora de los Remedios	Departmental Hospital	Public
14	Riohacha	Colombian Red Cross	Healthcare point	NGO
15	Riohacha	Americares	Healthcare point	NGO
16	Riohacha	Profamilia	Private Clinic (IPS)	Private
17	Valledupar	Fundación de Acción Humanitaria Soy tu amigo	Foundation	Private
18	Valledupar	Confacesar	Private Clinic (IPS)	Private
19	Valledupar	Secretaría de Salud Municipal	Municipal Secretariat	Public
20	Valledupar	Hospital Rosario Pumarejo de López	Departmental Hospital	Public
21	Valledupar	Colombian Red Cross	Healthcare point	NGO

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

1.2 Data analysis and triangulation

Data were processed using the Census and Survey Processing System (CSpro); data collected through the interviews and Health Facility Assessments were gathered using the Statistical Package for the Social Sciences Software (SPSS), and focus group codification and analysis used N-Vivo software. Two specific software suites were used for the data analysis and triangulation, aimed at complementing the findings from qualitative and quantitative approaches (N-Vivo and SPSS, respectively).

"Near to where I'm staying there is a woman who is seven months pregnant; she is going back to Venezuela because they don't want to care for her here (...) She is going to give birth there in Venezuela, to be able to present the baby there in Venezuela, because they are both Venezuelans".

Venezuelan migrant woman | **Focus group: 25 to 49 years old** | **Valledupar**

2. Characterization of the Venezuelan migrant population and the receiving areas in Colombia

The characterization of the Venezuelan migrant population and Colombian returnees used the statistical bulletins of the Ministry of Foreign Affairs (2016, 2017), the records of international arrivals and departures collected during the migratory control exercise, research articles and Profamilia data from the Colombia-Venezuela border. It should be noted that there is no systematic and accurate monitoring of the number of migrants entering the country through unauthorized points of entry given the undocumented nature of this type of migration, it is impossible to know the actual magnitude of the phenomenon.

Colombia's current social and economic conditions, and particularly those of the hosting areas pose significant challenges for the provision of adequate housing, education, employment, health, and social protection, as well as growing xenophobia and social cohesion challenges. Moreover, the priority needs of the Venezuelan migrant population are related to the lack of resources for transportation, food, basic hygiene, clothing, shelter and health.

This section is structured as follows: first, a description of the demographic characteristics, second, the socioeconomic characteristics of the Venezuelan migrant population; and the last section describes the sexual and reproductive health status.

2.1. Demographic characteristics

This section presents a description of the demographics of the migrant population by sex and age in Colombia.

Colombia hosts the second largest population of Venezuelans in the world, after Venezuela; nearly one and a half million Venezuelan immigrants live in Colombia (Colombia Migration, 2018). The United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) announced that the number of refugees and migrants from Venezuela worldwide has now reached three million. According to data from the national immigration authorities and other sources, countries in Latin America and the Caribbean have received an estimated 2.4 million refugees and migrants from Venezuela, while other regions account for the rest. Colombia has the highest number of refugees and migrants from Venezuela, totaling over one million (UNHCR, 2018). It is followed by Peru (over half a million), Ecuador (over 220,000), Argentina (over 130,000), Chile (over 100,000), Panamá (around 94,000), and Brazil (approximately 85,000) (UNHCR, 2018; Colombia Migration, 2018).

During 2018, the number of Venezuelan migrants in Colombia increased by 418% (769,726 Venezuelan migrants) compared to 2017 (184,087 Venezuelan migrants). Approximately 1,032,016 people have entered Colombia from Venezuela intending to stay. Disaggregated data enable the identification of four migratory dynamics: return migration, natural migration in transit, regular circular migration, and irregular migration with residential intent (World Bank, 2018). Within this mixed migration flow, 300,000 are Colombian returnees, 2,017 are victims of the Colombian internal armed conflict, and 573,502 are Venezuelans with regular immigration status (meaning they have a visa or a Special Permanence Permit–PEP) (MOH, 2018). Furthermore, 240,416 are in the process of regularizing their status (they registered in the Venezuelan Migrant Administrative Registry – RAMV, and their PEP is in process); 218,098 have irregular migration status, including those that exceeded the length of stay and are now without official documentation, or those who entered through unauthorized paths or trails (Colombia Migration, 2018).

Receiving areas already experienced socioeconomic hardship before the arrival of migrants due to the internal armed conflict, historical underdevelopment and deep social inequalities. Four million Venezuelan migrants will be living in Colombia by 2021 if the situation in the neighboring country worsens (Reuters, 2018). It is worth noting that a total of 1,624,915 cross-border mobility cards (in Spanish, *Tarjeta de Movilidad Fronteriza* – TMF) have been issued, and approximately 919,142 Venezuelans have transited through Colombia to other countries, mainly Ecuador and Peru. On average, 30,000 Venezuelans with a TMF enter Colombia daily to buy medicines, access education or health services, or make purchases in border areas, returning to their homes in Venezuela soon after (Colombia Migration, 2018). Around 93% of the Venezuelan migrant population is concentrated in 12 of the 33 states (departments) of the country.

Men account for 48% of the Venezuelans who have entered Colombia in this migration flow (496,413), 44% are women (454,884), 0.03% are transgender (339), and 7.97% without gender record (80,380) (Ministry of Foreign Affairs, 2018); 33,994 belong to ethnic groups, as follows: 26,572 indigenous, 6,150 Afro-descendants, 1,065 Raizales and 2,017 Romany (*Unidad Nacional para la Gestión del Riesgo de Desastres*, 2018). There was no data available of persons with disabilities.

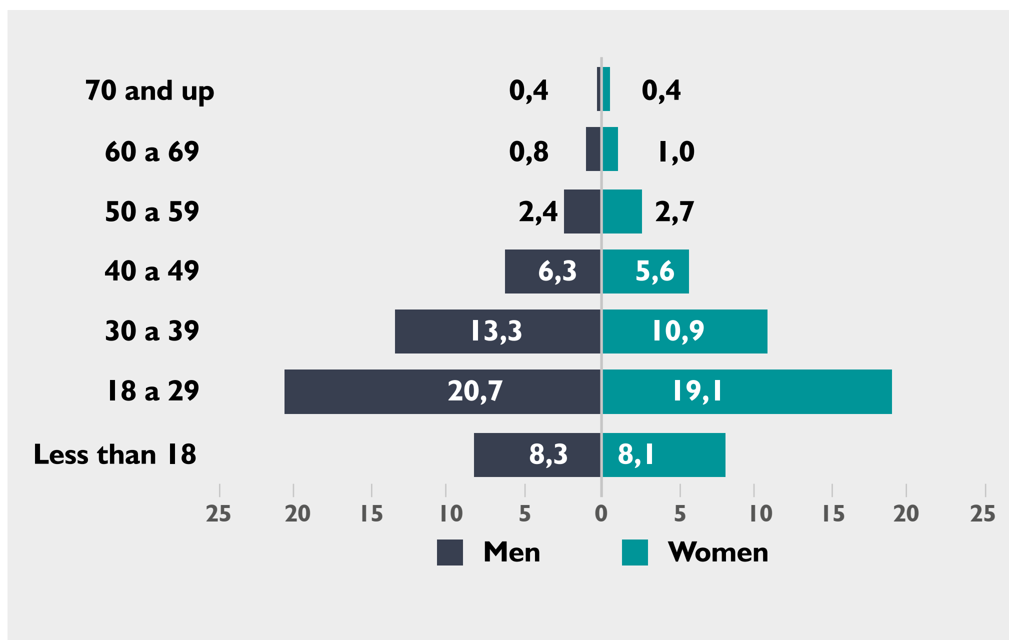
Data disaggregated by sex, age, and geographic location are essential for providing robust evidence for effective and efficient policy responses and programmatic interventions to address the sexual and reproductive health needs of vulnerable groups, and also help ensure that 'no one is left behind', particularly girls and women in the most disadvantaged settings of the humanitarian crisis. The profiles of the Venezuelan migrants in Colombia include men and women, particularly young adults and adults between 18 and 59 years old. Graph 2 shows the demographic distribution of the Venezuelan migration in Colombia by age and sex.

Receiving areas already experienced socioeconomic **hardship before the arrival of migrants due to the internal armed** conflict, historical underdevelopment and deep social inequalities.

A higher percentage of migrants are aged 18 to 29 (37%), followed by 24% aged 30 to 39 and 18% under 18 years old. While transgender people were not represented in the focus groups during the assessment, it is important to point out that there are 339 people registered thus far as transgender among the migrant population (Colombia Migration, 2018).

In Venezuela and Colombia, most of the population speaks Spanish and the Catholic religion prevails; however, in some of the municipalities receiving the largest groups of Venezuelan immigrants, there is a high concentration of indigenous people, and other languages and beliefs prevail. Particularly, these include the Wayuu in La Guajira and the Yukpa in the Perijá highlands in the border between Cesar and Norte de Santander (MOH, 2018). These specific socio-demographic and cultural characteristics of the receiving communities should be considered since the arrival of Venezuelan migrants may be already difficult for these disadvantaged areas and the different backgrounds and beliefs of traditional communities may exacerbate social exclusion, stigmatization for lack of understanding, absence of empathy and solidarity, as well as xenophobia.

Graph 2 – Distribution of Venezuelan migrants by age and sex in Colombia, 2018.

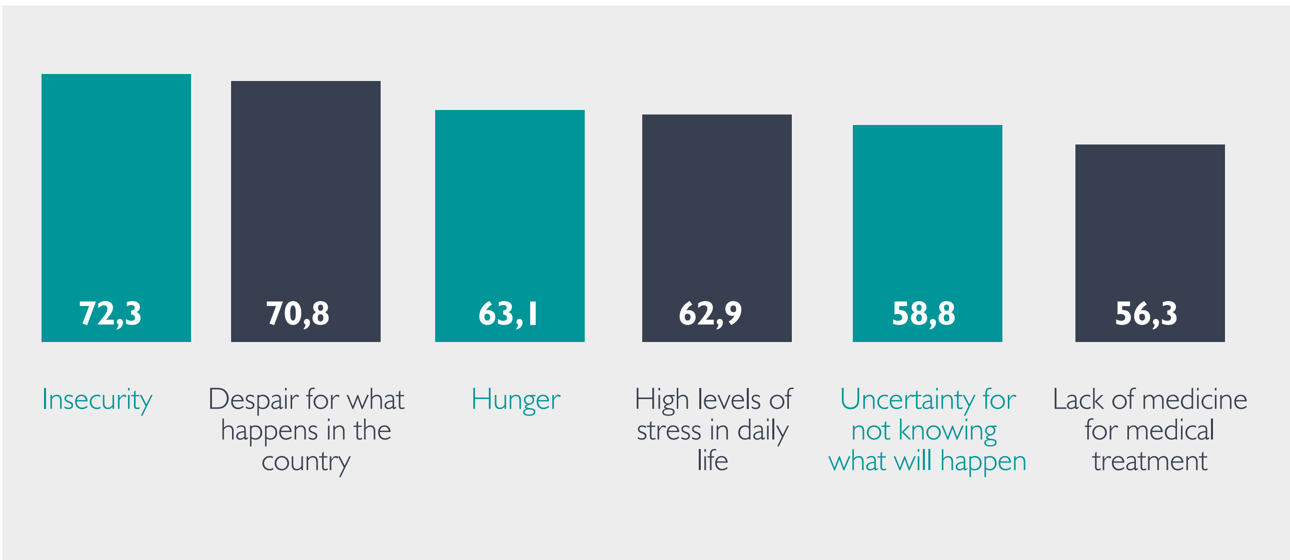


Source: Authors, from data of the Ministry of Foreign Affairs, Republic of Colombia: Everythingyou want to know about Venezuelan migration, 2018.

2.2. Socioeconomic conditions

This section presents an overview of the socioeconomic conditions of the Venezuelan migrant population in Colombia. The most common root causes of the Venezuelan migration include: insecurity (72.3%), despair (70.8%) and hunger (63.1%) (Bermudez et al., 2018).Graph 3 shows the differences between the causes of emigration. The reasons may vary, but they are mainly related to the conditions in their country of origin.

Graph 3 – Causes of the emigration of Venezuelan migrants.



Source: Authors, based on Informe sobre la movilidad humana venezolana. Realidades y perspectivas de quienes emigran, Bermúdez et al. 2018.

The municipalities of Arauca, Cúcuta, Riohacha and Valledupar are state capitals that host massive proportions of the Venezuelan migrant population. Their socio-economic indicators reveal significant challenges: multidimensional poverty rates over 40%, low educational attainment, school lag, low access levels to early childhood education services, high rates of informal employment, and economic dependence. These are some of the most significant barriers faced by these municipalities that prevent them from reducing poverty (National Department of Planning–DNP, 2015).

Additionally, these receiving areas already experienced socioeconomic hardship before the arrival of migrants due to the internal armed conflict, historical underdevelopment and deep social inequalities. For example, La Guajira and Arauca lack universal, affordable and sustainable access to WASH (Water Access,

Sanitation and Hygiene), compared to Cúcuta and Valledupar. In other words, receiving areas have insufficient access to essential services such as drinking water, adequate sanitation, electricity and affordable housing conditions, resulting in high multidimensional levels of poverty, above the national average (World Bank, 2018a). Migrants and receiving communities are exposed to unsanitary conditions and access to deficient drinking water where they live (MOH, 2018), particularly people who arrive on foot, people living in suburban settlements and homeless in the streets; this is especially the case in La Guajira and Arauca, because there is little supply of essential services, which entails the risk of further deterioration of their health status (OMS & OPS, 2018a).

The Venezuelan migrant population is comprised mostly by people of working age who aspire to join the Colombian economy. In turn, most of them are men and women of reproductive age who require and have the right to sexual and reproductive healthcare. Approximately 18% of the Venezuelan migrant population is under 18 years old, which implies a higher demand for education, healthcare and early childhood services. In turn, more than 60% of the Venezuelan migrant population is of working age and aspires to work (World Bank, 2018a). In Colombia, more than 60% of Venezuelan immigrants receive less than the nationally mandated minimum wage and approximately 20% have been victims of labor exploitation (MOH, 2018). This population often earns an income that is insufficient to cover their nutritional requirements, and many are experiencing food insecurity that forces them to reduce the number of meals or the size of the servings they can eat.

Recently, house cleaning services and caregiving began to be an employment alternative for many Venezuelan migrants, particularly girls and women. Unfortunately, in Colombia these job opportunities are part of the informal economy, due to the lack of social security conditions, social exclusion, and in the case of Venezuelans, often dangerous conditions, including exposure to hazardous work environments and physical and sexual abuse. This is the result of inequitable opportunities, the absence of social networks, difficulties to receive care, and lack of access to the primary social protection system on arrival and during their stay. Thus, they may be forced to work longer hours for meager wages, due to their general lack of knowledge about the place of arrival (Arbeláez Jaramillo, 2018).

On the other hand, forced recruitment, either for illicit drug trafficking activities, for joining illegal armed groups or for prostitution in armed conflict areas, contributes to human trafficking in Venezuela and Colombia, both internationally and within the countries (Vargas et al., 2011). In Colombia, human trafficking for sexual exploitation includes forced prostitution of adults and sexual commercial exploitation of children; human trafficking for forced labor includes minors and adults. Among the forms of human trafficking for forced labor purposes include

adult work in factories and restaurants, child labor in agriculture, mining and brickwork, and domestic work. Human trafficking in the form of servitude includes forced begging, servile marriage and debt bondage, with children and adolescent begging being the most common in the country (Vargas et al., 2011). In the past two years, the number of victims of modern slavery increased by 300%, specifically human smuggling and trafficking. Until 2018, records show 198,900 Venezuelan identified victims, 70% of whom are women, and 25% are children 7 to 14 years old (United Kingdom Embassy, Asociación Civil Paz Activa and Observatorio de Delito Organizado, 2018).

2.3. Sexual and reproductive health situation of the migrant population.

Migrants vulnerability, specially of irregular women and children, increases the risk of easley suffer trafficking for sexual exploitation of adults and children.

2.3.1 Gender-Based Violence

During migration, forced migration, and displacement, the risk of sexual violence and GBV increase for everyone, particularly for girls and young women. It is worth noting that there is no recent information available on the forms of violence to which Venezuelan women are exposed in their country. According to the Report on Venezuela from the 26th Round of the Universal Periodic Review, in 2010 about half of ever-married Venezuelan women have suffered violence from their partner at some point in their lives, and sexual violence affects one in fifty women throughout their lives and one in thirty in the past year (PLAFAM and SRI, 2016).

In Colombia, the National Health Institute reported that Venezuelan survivors of gender-based violence seeking healthcare services have increased by 207%, from 71 cases in 2017 to 218 cases in 2018 (MOH, 2018). More cases of GBV are expected, but underreporting because of stigma, fear of deportation or lack of access to health services makes it difficult to determine the true extent of the forms and frequency of gender-based violence to which Venezuelan migrants are exposed (World Bank, 2018a). Graph 4 shows the proportion of women between 15 and 49 years old who have suffered sexual violence from their partner in Colombia 2015 (7.6%) and Venezuela 2010 (the latest situation: 4.7%).

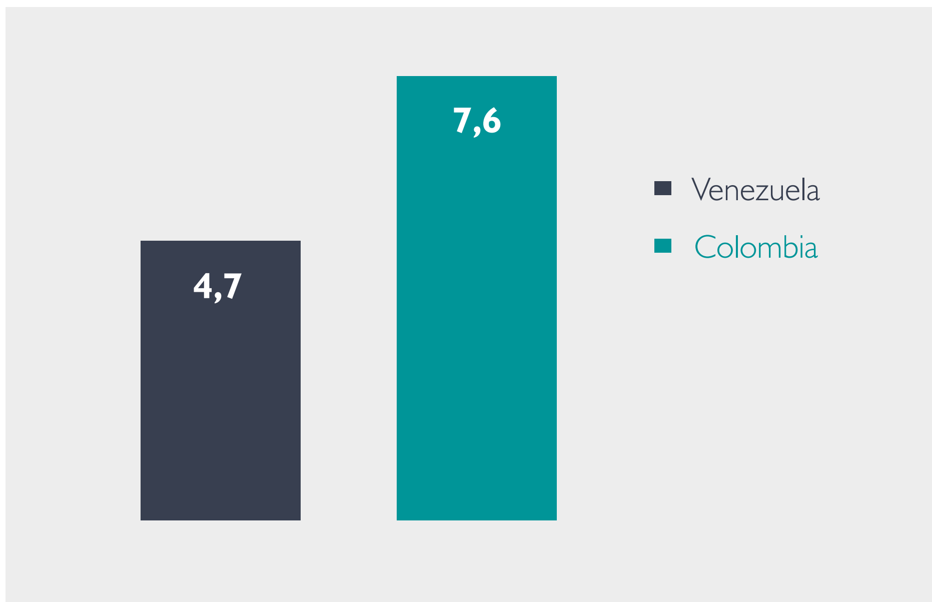
Around 64.1% of Colombian women have suffered psychological violence from their partner or former partner; 31.9% reported that their partner or former partner had exercised physical violence against them; 31.1% were victims of economic violence, and 7.6% were survivors of sexual violence by their partners. Migrants from Venezuela are arriving in a country where GBV is common and

Migrants vulnerability, specially of irregular women **and children, increases the risk of easley suffer** trafficking for sexual exploitation of adults and children.

frequent, and the responses to prevent and eliminate GBV are inadequate and to address the medical, psychosocial, economic, and social impacts on the survivors.

Among the receiving areas, in 2017 there was an increase in the number of Venezuelan citizens who reported access to public health services in the department of Norte de Santander, comparing 2016 and 2015. In the first semester of 2018, the main events reported were GBV and family violence (146 incidents) (OMS & OPS, 2018).

Graph 4 – Proportion of women between 15 and 49 years old who have suffered sexual violence from Intimate Partner Violence in Colombia 2015 and Venezuela 2010.

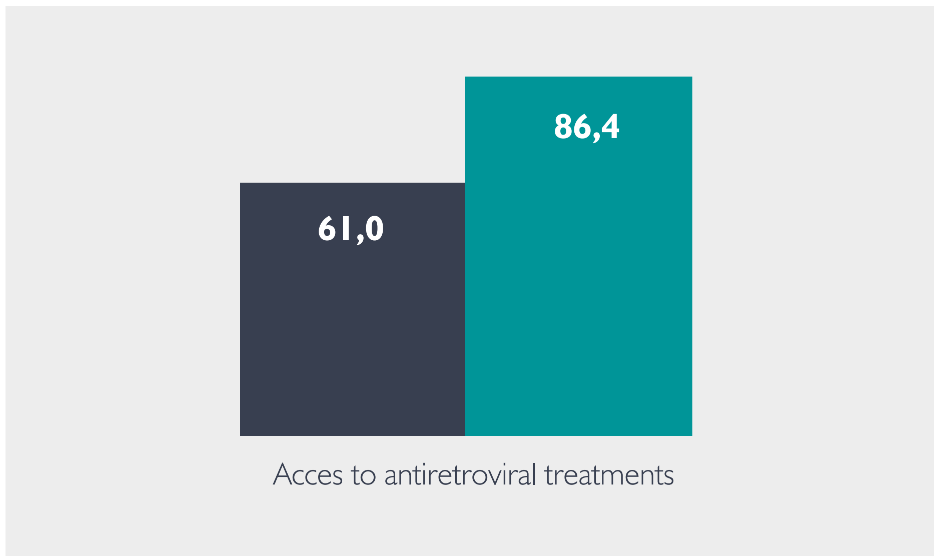


Source: Colombia's DHS 2015 and ENDEVE 2010.

2.3.2 Human Immunodeficiency Virus (HIV)

There is an increase in reported cases of people coming from Venezuela seeking care and access to antiretroviral treatment. In 2016, Venezuela recorded 6,500 new HIV infections and 2,500 AIDS-related deaths. Of the 120,000 people living with HIV in Venezuela in 2016, 61% had access to antiretroviral treatment and, among pregnant women, 48% had access to treatment or prophylaxis to prevent vertical HIV transmission (UNAIDS, 2018). In Colombia, the number of reported cases of Venezuelan immigrants with HIV went from 28 in 2017 to 109 cases in 2018 (World Bank, 2018a). Graph 5 presents this information comparatively.

Graph 5 – New cases and mortality of HIV and access to antiretroviral treatment in Colombia and Venezuela, 2017.



Source: World Bank 2018a: Migración de Venezuela a Colombia and Cuenta de Alto Costo, 2017.

Among Venezuelan immigrants, the number of reported cases of AIDS-related mortality increased from 20 in 2017 to 82 deaths in 2018. In the states of interest, while in Arauca in 2018 there were no mortality cases, there were 3 cases in Cesar for the first time that year; in La Guajira, there was one case in 2017, and rose to 3 cases in 2018; and Norte de Santander has the highest increase in AIDS mortality cases, rising from 7 cases in 2017 to 17 in 2018 (MOH, 2018).

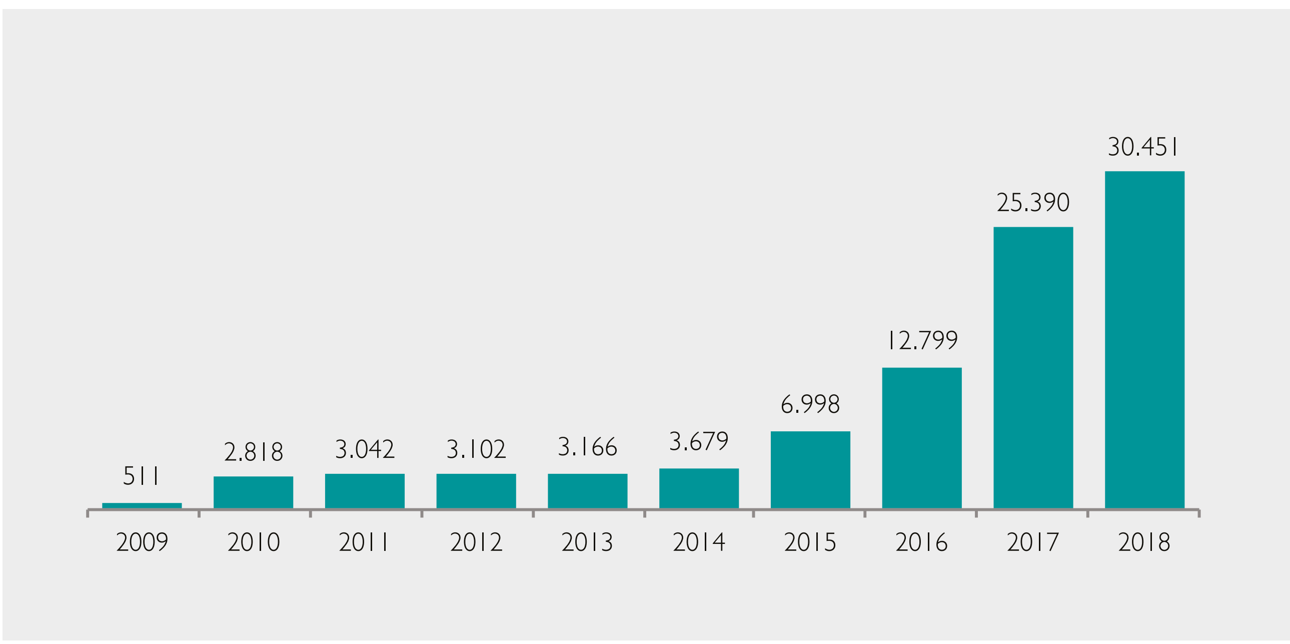
In Colombia, between February 2016 and January 2017, there were 9,399 new cases of HIV and 845 AIDS-related deaths; 26% of the cases were detected in Norte de Santander, 18% in Cesar, 7% in La Guajira and 2% in Arauca. Approximately, 86.5% of the individuals with HIV/AIDS have access to antiretroviral treatment prescription, and 99.96% (40,082) of them have adequate access and are receiving treatment (Cuenta de Alto Costo, 2017). During 2018, 6,980 new cases confirmed by lab tests were reported, a 15.9% increase in the number of notifications compared to the same period in 2017. 135 HIV cases among foreigners were reported, with Venezuela accounting for 89.6% (OMS & OPS, 2018). Furthermore, health authorities of Arauca, Norte de Santander and Riohacha have detected an increase in the number of cases, including an increase in gestational syphilis.

2.3.3 Abortion

The differences between Colombia and Venezuela regarding access to abortion services are mainly determined by its severe legal restrictions in the neighboring country. In Venezuela, abortion is penalized by article 430 of the Penal Code. Both its severe legal restrictions and the lack of updated information make it difficult to understand the magnitude of the situation. According to official records, the percentage of maternal deaths caused by complications from unsafe abortion is 10%, but there is also an evident and important underreporting related to its criminalized nature (PLAFAM and SRI, 2016).

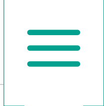
On the other hand, abortion was decriminalized in Colombia in three cases by the sentence C-355 of the Constitutional Court in 2006. According to data registered in the Social Protection Integrated Information System–SISPRO of the MOH, in the last three years more than 10,000 procedures were performed in the country. Graph 6 shows the increase in the number of procedures over the past ten years, from 2009 to 2018. This growth is probably related to stigma reduction, decreases in access barriers and increases in providers.

Graph 6 – Number of abortion procedures in Colombia 2009–2018.



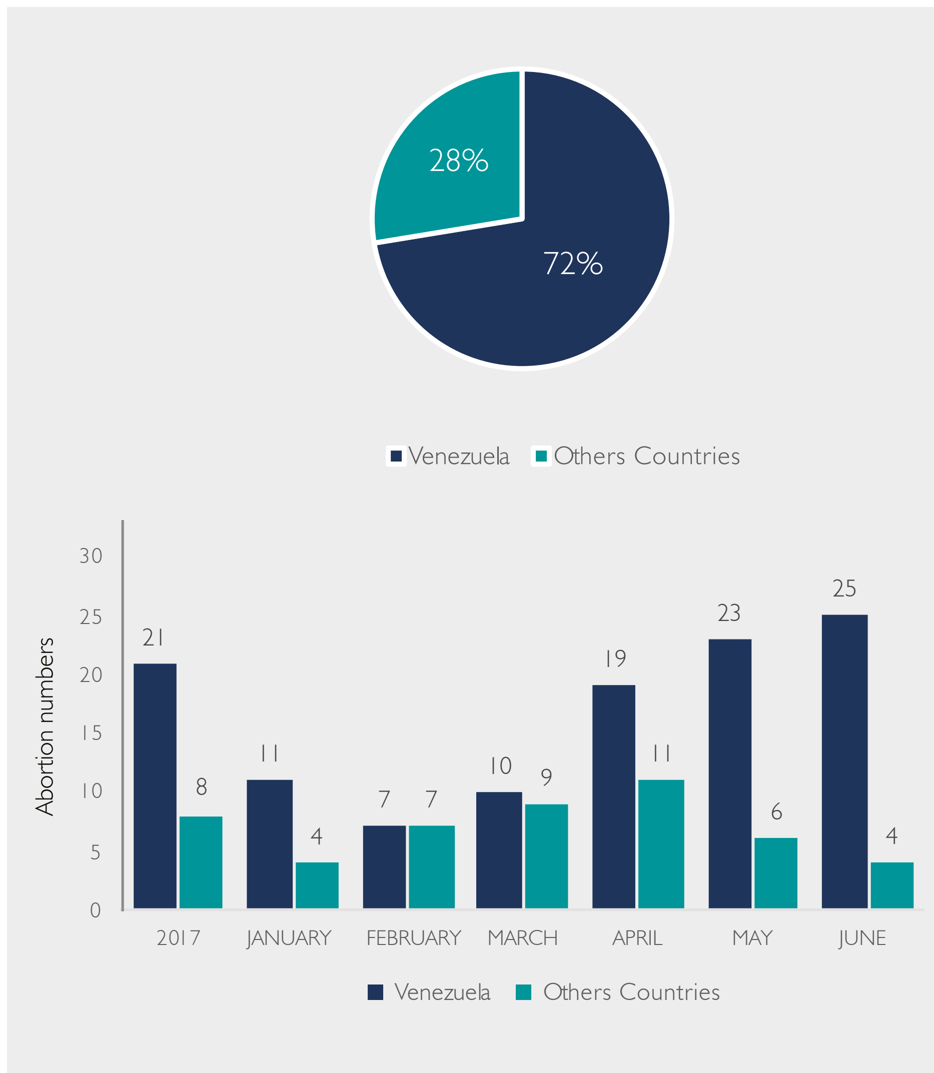
Source: RIPS-SISPRO, MOH, accessed on 19/12/2018.

On the other hand, three out of four abortion procedures for foreigners in Profamilia were provided to Venezuelan women (21 total) during 2017. As of June



2018, 165 abortion services have been provided to non-Colombian women: 116 Venezuelan women (71%) and 49 women from other countries (29%). In other words, procedures increased 500% among Venezuelan women compared to the previous year. Graph 7 describes the percentage of abortion procedures on Venezuelan women and other nationalities in 2017 and 2018.

Graph 7 – Abortion procedures fornon-Colombian women and women at Profamilia Colombia, 2017-2018.

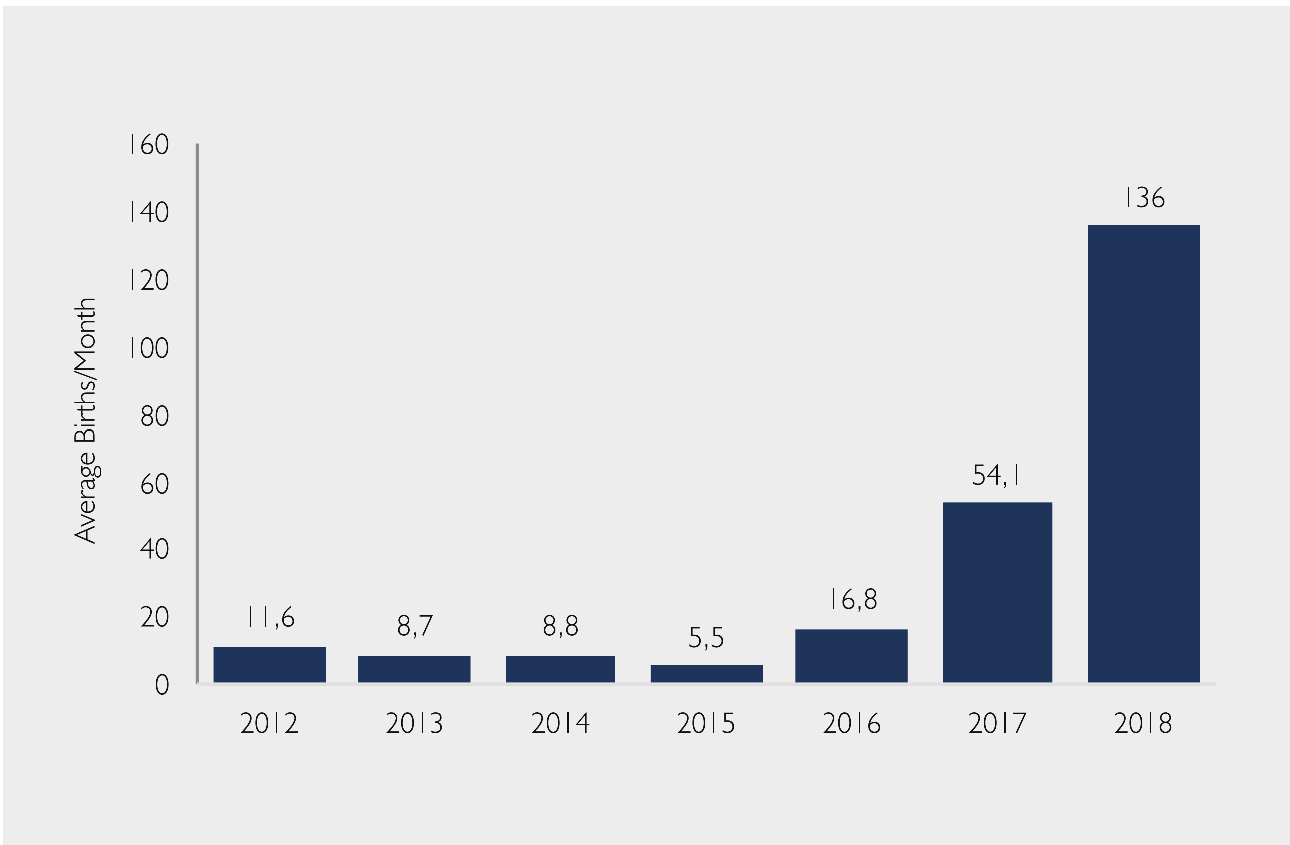


Source: Profamilia Health Services Information Platform, accessed on 12/12/2018.

2.3.4 Maternal and newborn health

In 2016, Venezuela reported 19.2 births per 1,000 inhabitants (gross birthrate), 5.2 deaths per 1,000 inhabitants (gross mortality rate), 12.5 deaths of children under one year old per 1,000 births (infant mortality rate), and 2.35 births per 1,000 women (fertility rate) (Index Mundi, 2018). In 2011, the adolescent fertility rate –women 15 to 19 years old– was 139 births per 1,000 (PLAFAM and SRI, 2016). Graph 8 presents the average number of births per month, by mothers' residence (Venezuela) between 2012 and 2018.

Graph 8 – Average number of births per month in Colombia to Venezuelan women between 2012 and 2018.

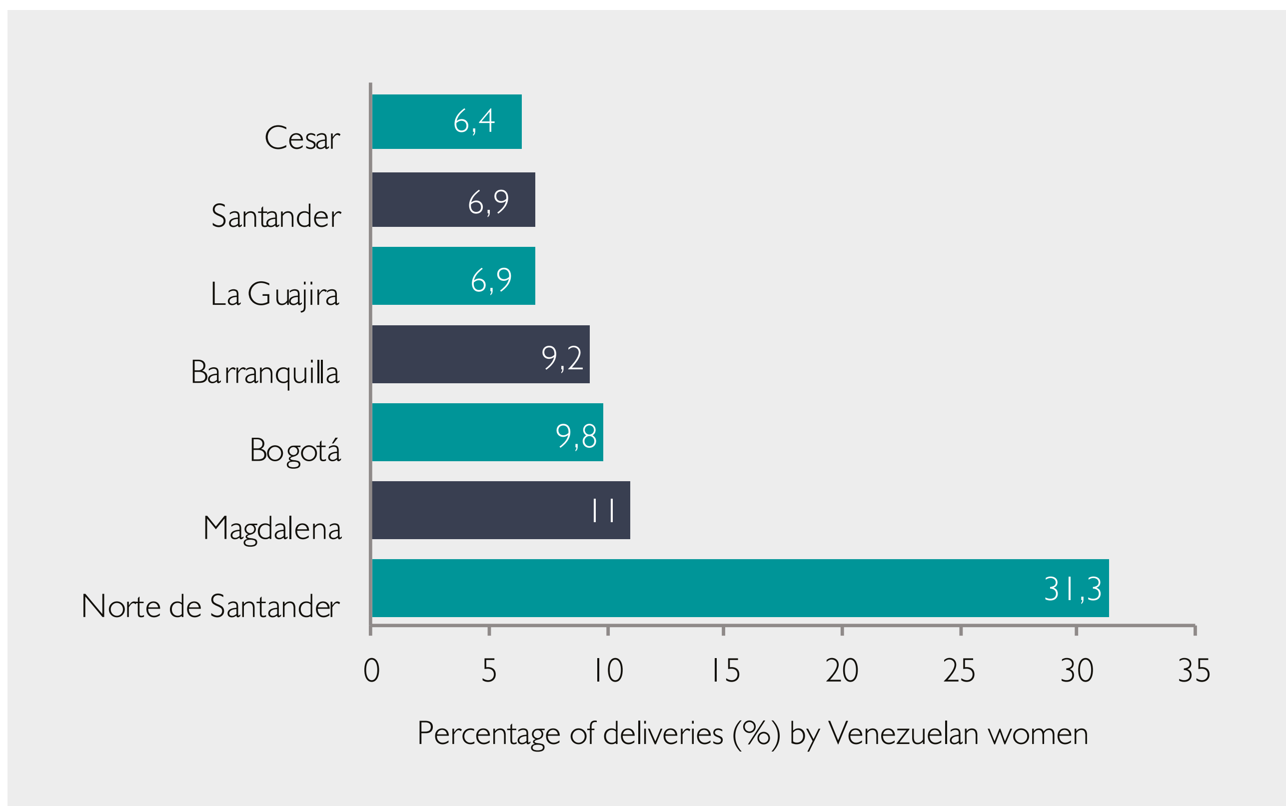


Source: CRVS DANE and data shared by the National Health Institute and PAHO/WHO, 2018.

Most of migrant population are men and women in reproductive age, that need and have the right to sexual and reproductive health services. Approximately the 18% is minor, wich implies a greater demand in access to integral sexual education, contraception services and young friendly services.

In 2018, 8,209 Venezuelan pregnant women have required prenatal care and skilled birth attendance in Colombia, 6,304 of whom have not had any prenatal care (World Bank, 2018b). Based on the Social Protection Integrated Information System- SISPRO of the MOH, during 2017-2018 healthcare providers cared for 1,778 deliveries by Venezuelan mothers. Data disaggregated by state show that Norte de Santander (31.3%), Magdalena (11%), Bogotá (9.8%), Barranquilla (9.2%), La Guajira (6.9%), Santander (6.9%) and Cesar (6.4%) have the highest percentages of deliveries by Venezuelan women, followed by Ecuadorian and Brazilian women (0.3% and 0.2%) respectively (MOH, 2018). Graph 9 shows the departments with the highest percentages of deliveries to Venezuelan women.

Graph 9 – Departments with the highest percentage of deliveries by Venezuelan women in Colombia, 2017-2018.

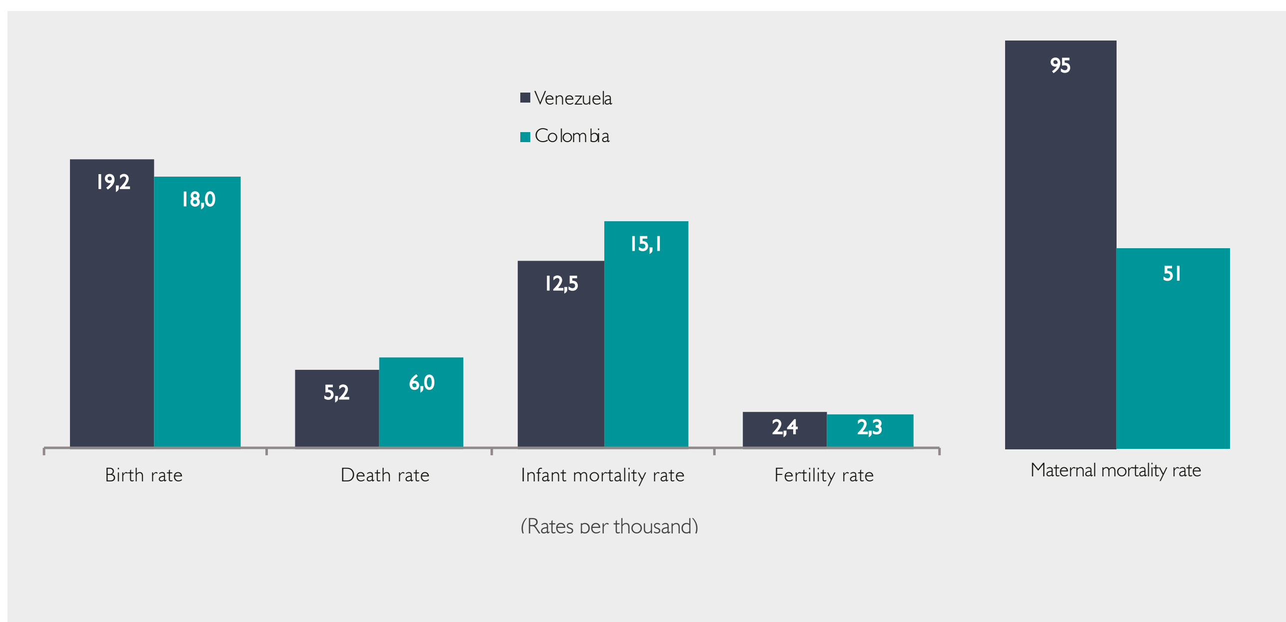


Source: MOH of Colombia, 2018.

In 2015, the maternal mortality rate in Venezuela was 95 deaths per 100,000 newborns (Index Mundi, 2018). However, according to the 25th Epidemiology Bulletin (Boletín Epidemiológico), maternal mortality has increased by 65.7%

(MPPS, 2016). On the other hand, in Colombia the maternal mortality rate was 51 deaths per 100,000 newborns; this rate is higher in the departments and municipalities assessed in this report. Maternal mortality rates were as follows, from highest to lowest: La Guajira (698 deaths per 100,000 newborns); Arauca (204 deaths per 100,000 newborns); Cesar (147 deaths per 100,000 newborns); and Norte de Santander (94 deaths per 100,000 newborns) (ASIS Colombia 2018, MOH, 2018). In Colombia and Venezuela, the most significant gaps in maternal and newborn health are seen in the regions with the highest presence of indigenous communities. Graph 10 shows the indicators for Colombia and Venezuela.

Graph 10 – Infant and maternal mortality indicators for Colombia and Venezuela,2016.



Source: Análisis de Situación de Salud (ASIS) Colombia 2017 and Venezuela Index Mundi, 2018.

2.3.5 Sexual and Reproductive Health

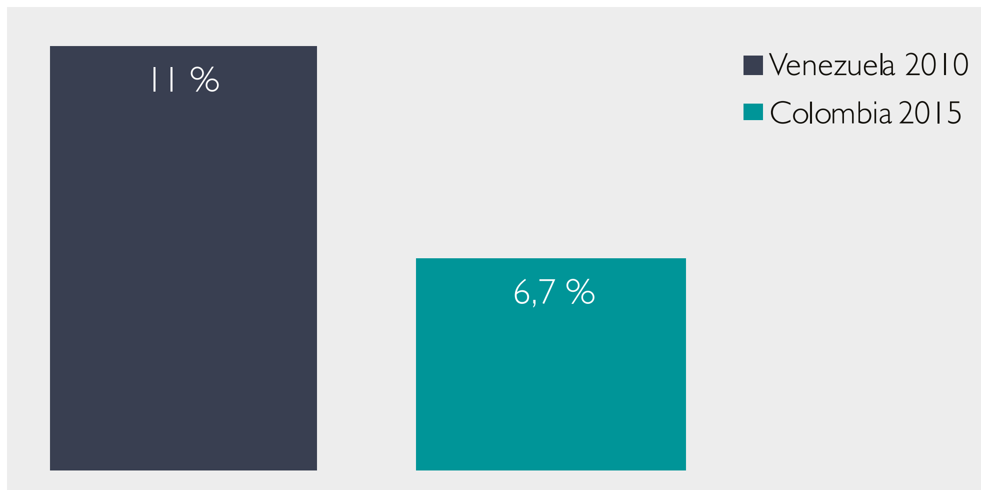
In 2010, the prevalence of contraceptive use in Venezuela was 75% (World Bank, 2018b). Unmet demand for contraceptives was 11% for women 15 to 49 years old and 57% among women 15 to 19 years old. Private market institutions provided 10% of the contraceptives required by the Venezuelan market (PLAFAM and SRI, 2016). The report on Venezuela, according to the 26th Round of the Universal Periodic Review (PLAFAM and SRI, 2016) states that there are no recent official statistical information sources on access to contraceptives; this lack of updated data is also emphasized in the Report "Mujeres al límite" (AVESA, CEPAZ, FREYA, MujeresenLínea, 2017).

Information gaps, differences in maternal mortality rates among regions in Venezuela and the impact of the crisis on healthcare professionals, show difficulties in meeting sexual and reproductive health needs, as well as barriers in contraceptive access and counseling. The crisis has had profound effects on sexual and reproductive health, primarily teen pregnancy and HIV rates, shortages and high prices of supplies such as condoms and contraceptives, failure of the Venezuelan public health system, and unsafe abortions (Albaladejo, 2018).

The rate of unmet needs for contraception for currently married women in Colombia in 2015 was 6.7%. However, it is more inequitable in Norte de Santander (8.1%), Arauca (9.9%), Cesar (10.2%) and La Guajira (13.7%). Among 15 to 19-year-old women, the percentage of unmet needs for contraceptive methods is 19.3%. This influences the rate of early, undesired and unplanned pregnancies in receiving areas such as La Guajira (19%), Cesar (20%), Norte de Santander (21%) and Arauca (35%), which have higher adolescent pregnancy rates than the national level (17%) (MOH &Profamilia, 2017). On the other hand, Graph 11 shows that unmet needs for contraceptive methods in Venezuela almost doubles Colombia's.

The prevalence of contraceptive use in Colombia in 2015 was 81%; in La Guajira, it was 66%, Arauca 75%, Cesar 76% and in Norte de Santander it reached 81%. Regarding preferences in the use of modern contraceptive methods, among long-term contraceptives, female sterilization is the most used method by women (35%), followed by IUD (9%), subdermal implants (5%) and male sterilization (4%); and among short-term methods, injection is the most used method (14%), followed by pills (7%) and condoms (6%) (MOH & Profamilia, 2017).

Graph 11 – Unmet needs for contraceptive methods in Colombia (2015) and Venezuela (2010).



Source: Colombia's DHS 2015 and ENDEVE 2010

"(...) a female neighbor went with her and they gave her 12 condoms; later, her daughter passed by, asked for some and they said 'they're all gone, if you need more, come back tomorrow', and then an other nurse who was there said: 'she's very ungrateful, she comes from Venezuela because she doesn't have them and complains'".

Male Venezuelan migrant | **Focus Group: 25 to 49 years old** | **Cúcuta**

3. Findings

Findings are organized according to the information collected using the IAWG tools. Therefore, each section provides specific information about:

i) What do Venezuelan migrants think about sexual and reproductive health?
ii) Coordination between sexual and reproductive activities and organizations and degree of implementation of the Minimum Initial Services Packages (MISP)
iii) Availability of SRH in the healthcare facilities to meet migrants' needs.

3.1 What do Venezuelan migrants think about sexual and reproductive health?

At the general level, there is a lack of knowledge and difficulties in the appropriation of the MIPS goals, particularly of those who are in charge of HIV and GBV programs. Therefore, the codification process focused on three main topics:

a) Sexual and reproductive health needs;
b) Barriers to healthcare services access; and
c) Stigma, social exclusion and violence experienced by migrants.

It is worth noting that there are important differences between cities regarding unmet sexual and reproductive health needs; however, a degree of agreement was seen on some topics, such as:

- Lack of a comprehensive sexuality education: Focus groups showed that men and women from different age groups were not familiar with the concepts of sexual and reproductive health, or with their services and rights in general. There was insufficient information about contraceptives, abortion, STIs, HIV, and health services needed for the clinical management of GBV.

- Barriers accessing maternal and newborn healthcare (MNH): In the focus groups, many participants were able to identify the symptoms for which a pregnant woman or a newborn child could require care and identify some of the facilities that provide MNH services. However, they identified and described multiple barriers for women that require prenatal care and skilled birth attendance; these barriers often resulted from discrimination, stigma, and violence during their first contact with health services. Moreover, in the focus groups, participants pointed out high costs, discrimination, misinformation, lack of documents, and healthcare staff as the main barriers affecting effective access to health services.

At the general level, there is a lack of knowledge and **difficulties in the appropriation of the MIPS goals,** particularly of those who are in charge of HIV and GBV programs.

- Cultural perspectives about abortion: As stated above, abortion is severely restricted in Venezuela. Most of the women who participated in the focus groups did not know that abortion is legal in Colombia and that some healthcare facilities provide abortion for migrants. In fact, cultural perceptions about abortion related to stigma, probably deepened by its illegal character in Venezuela. Thus, many participants had a negative perception about abortion and women who abort and mentioned many unsafe abortion practices.

- Youth-friendly services: The lack of a comprehensive sexuality education was mentioned repeatedly by adolescents and young people between 14 and 25 years old. They had no information and guidance about the availability of youth-friendly services; this need exposes youngsters to different risky behaviors and unsafe sexual and reproductive health practices, particularly early pregnancies and STIs. Indeed, interviewers noted that most of the young participants already had more than one child. On the other hand, it seems that in Venezuela they had no access to contraceptives; some of the young men and women said that in their country, to buy condoms or gain access to modern contraceptive methods, a medical prescription is required, or they would sometimes ask someone over 18 to help them.

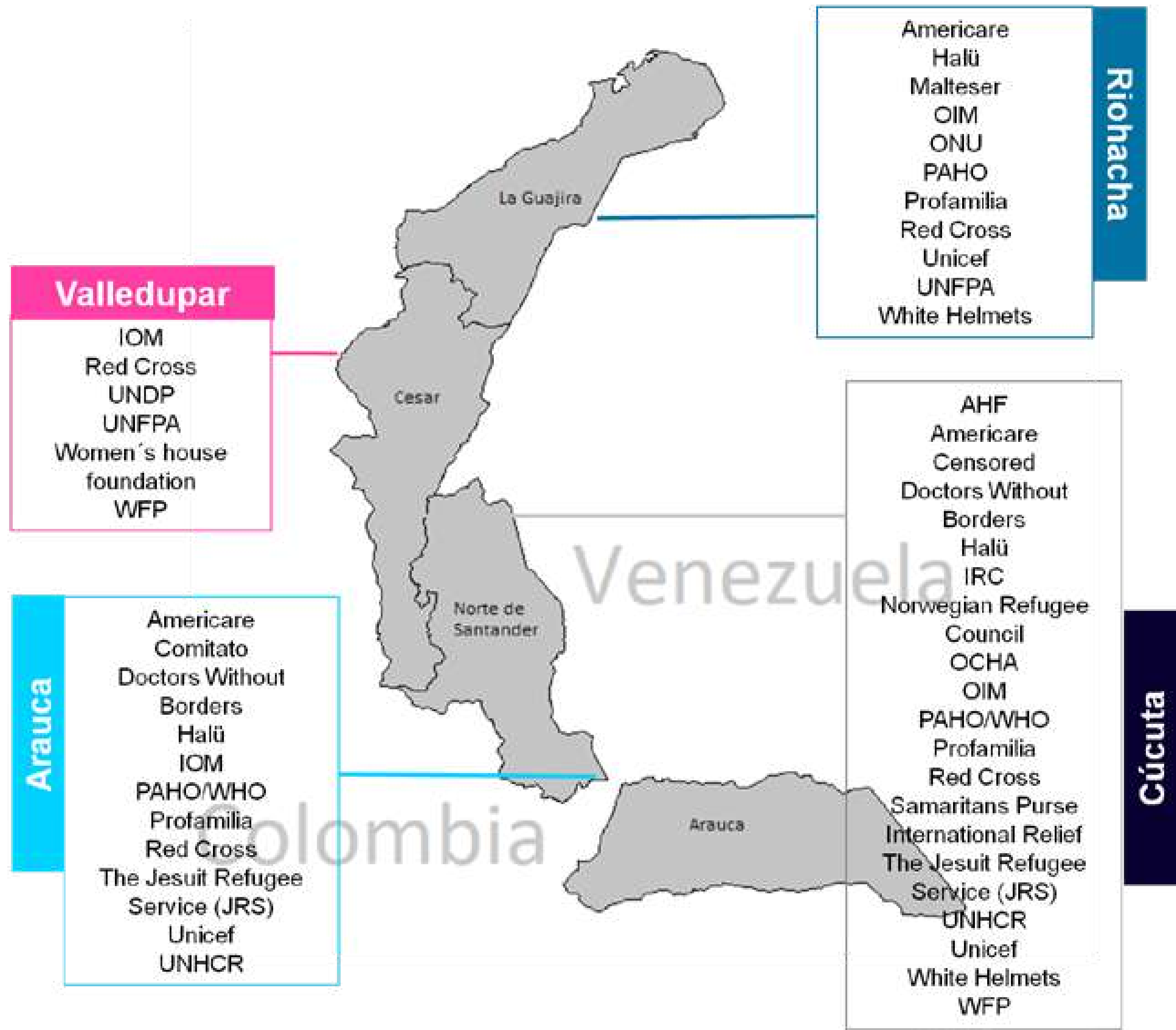
3.2.Coordination between sexual and reproductive actions and organizations, and degree of implementation of the Minimum Initial Services Packages (MISP).

Results presented in this section contain information collected through the interviews. The questionnaires were applied to 23 key respondents from local organizations that provide sexual and reproductive health services (10); local HIV care and treatment organizations (6); and organizations engaged in the prevention of and care for Gender-Based Violence (7). This perspective enabled the identification of:

a) MISP knowledge, appropriateness, and degree of implementation;
b) Inter-institutional and inter-agency coordination addressing migrants' SRH care;
b) Availability and access to SRH services, and barriers and facilitators during the implementation of the MISP; and
d) Reproductive sexual health services needs of the migrant population within humanitarian crisis settings.

Graph 12 shows a map of the organizations that provide sexual and reproductive health services, GBV care, HIV, sexual, reproductive and maternal and newborn healthcare in the Colombia-Venezuela border, 2018.

Graph 12 – Map of organizations that provide care related to gender-based violence, HIV, Sexual, Reproductive and Maternal and Newborn Health in the Colombian-Venezuelan border, 2018.



Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

3.2.1. Overall context

3.2.1.1. Knowledge, pertinence, and degree of MISP implementation in the context of the emergency

- ***Poor knowledge and difficulties in taking ownership of the MISP. In general, the MISP is not known in the assessment locations. Among interviewees, 2/23 have heard of the MISP and only 1/23 received training for its implementation.*** When asked to identify the sexual and reproductive healthcare goals and priorities in an emergency situation, one respondent was able to identify all aspects covered by the MISP.

- ***Lack of knowledge and understanding of the MISP by the organizations responsible for the HIV and GBV prevention and care programs.*** Similarly, health staff responsible of HIV and GBV programs showed little understanding and knowledge of the MISP. Only one of the six evaluated organizations was aware of all the MISP purposes. However, all respondents identified the need to address the free provision of condoms to Venezuelan migrants facing extreme vulnerability. Amazingly, none of the professionals responsible for GBV prevention and care programs identified all the objectives and additional priorities of the MISP.

- ***Interagency coordination in response to SRH, HIV and GBV is not visible.*** In the territories, MOH leadership addressing the humanitarian crisis is not visible, while PAHO/WHO, OIM, Red Cross and the UN are positively recognized. Coordination between the technical teams addressing SRH, GBV and HIV rely on the Departmental Health Offices, and in many cases those coordination efforts are not considered satisfactory. There is an urgent need to improve the common objectives shared between different teams of government sectors and international agencies, for instance disseminating information about local routes of care, generating contingency plans, carrying out joint campaigns to prevent and provide basic health services for GBV victims.

3.2.1.2. Interagency coordination addressing migrants' SRH

The first purpose of the MISP refers to the importance of interagency coordination to address the sexual and reproductive health, HIV and GBV needs during an emergency. As stated before, the degree of interagency coordination is very low, resulting in a major gap for the implementation of the MISP. For instance:

- ***Lack of leadership in the HIV interagency response and coordination during the migration crisis.*** Only 2 of the 23 respondents mentioned international agencies and NGOs responsible for HIV management in migration crises. However, respondents did mention UNAIDs, PAHO/WHO, Aids Healthcare Foundation (AHF), the Jesuit Refugee Service (SJR), UNHCR and the Red Cross.

- ***Governmental lack of leadership addressing HIV prevention and care during the humanitarian crisis.*** Most key respondents did not identify entities at the national level responsible for the coordination of HIV care and prevention in this context. In fact, one stated that this coordination is headed by the MOH and another mentioned the Pan American Health Organization (PAHO/WHO). At the local level, Departmental Health Offices are recognized as responsible for the coordination of regular (monthly, bi-monthly or quarterly) HIV care meetings.

- ***Strengthening the coordinationon SRH and HIV among local technical teams to respond to the emergency is urgently requested.*** Coordination exists at the local level between the technical teams that address SRH and HIV, but in one of the institutions evaluated, SRH and HIV teams do not interact with each other. Furthermore, there is no consensus on the qualification of these efforts and the need to address the emergency through well-coordinated actions between them was highlighted, to build local routes, generate contingency plans and carry out joint campaigns to amplify the impact of the responses.

- ***A more visible national leadership of the MOH and its Comprehensive Healthcare Model for Victims of Sexual Violence in the context of humanitarian crisis is urgently required.*** At the local level, challenges highlighted by the Departmental Health Offices are related to poor coordination to effectively address GBV. It is worth noting that different perceptions were found regarding the effectiveness of these efforts as well as how healthcare providers are not fully meeting protocols and guidelines.

3.2.1.3 Availability and access to SRH and barriers and facilitators during the implementation of the MISP

The demand for health services has increased rapidly in receiving areas, particularly in Cúcuta and Riohacha, the main entry points from Venezuela to Colombia. The MOH reported around 65,000 healthcare services provided to migrants during 2018, which undoubtedly affected the capacity of health services in receiving areas. As a result of this increased demand, availability, quality and access to basic health services are a growing challenge, due to limited health financing, supplies

and healthcare workforce, which in turn negatively impact the achievement of the intermediate universal health coverage (UHC) goals in sexual and reproductive health: equity in resource distribution, efficiency and transparency, and accountability.

Despite this, it is worth highlighting that non-governmental organizations, such as Profamilia, have taken actions to respond to the needs of the migrant population. An example of this is that as of September 2018,Profamilia had provided a total of 6,589 sexual and reproductive health services to Venezuelan immigrants, 165 of which were voluntary pregnancy termination. Services included temporary and permanent contraceptive methods, gynecology consultations, ultrasounds, diagnostic tests, pregnancy tests, voluntary interruptions of pregnancy and sale of condoms and contraceptives, among others. Answers given in these contexts are analyzed below.

3.2.2 Actions and responses to address sexual and reproductive health

Infrastructure and equipment. Overall, the organizations have adequate healthcare facilities: eight of ten have waste disposal personnel, gender-segregated restrooms, and nine of ten have adequate lighting and restrooms with locks.

Protocols that guide the response. The organizations state that the provision of services follows the guidelines and protocols established by the MOH and PAHO/WHO. Colombia has stringent healthcare regulation standards that are monitored regularly.

Preparation and planning to address emergencies. Differences were identified regarding when and how to act in the event of an emergency: ten organizations responded to the emergency within the first 48 hours, four within the first four weeks, one since August 2015, and the other one since April 2018; one organization did not answer. As stated, the differences between the responses are related to the lack of consensus on the emergency start date.

STIs and sexual violence care. Six of ten key respondents reported that clinical and comprehensive care to different forms of sexual violence is offered. The services offered include: seven provide emergency contraception, four provide post-exposure prophylaxis, five offer prophylactic treatment for sexually transmitted infections (STIs), eight provide psychological care and have an established referral system. Despite the availability of services, only five of ten healthcare providers have shared information and have communication strategies to reach communities. It seems they have not inserted themselves in a survivor centered referral mechanism.

Overall, the territories have basic tools for the prevention and management of HIV transmission. Blood transfusions occur at three of the ten organizations and obey the standards set by the General Social Security Health System (SGSSS). Seven institutions facilitate and reinforce adherence to standard precautions, and all offer free condoms. It is urgently necessary for migrants to know their HIV infection status via quick tests and have access to treatment; in practice, there is access to quick tests, but multiple barriers to treatment, due the test are not recommended unless treatment can be offered.

Mother and newborn care. Regarding obstetric care, findings show there are insufficient services available to achieve Goal 4 of the MISP, the prevention of excess morbidity and maternal and neonatal mortality. Four of the ten organizations offer basic obstetric emergency care, and three provide comprehensive emergency obstetric care. It is important to highlight that all of them stated the need to expand newborn care and emergency neonatal care, as well as referral systems for mothers and newborns; one respondent, for example, pointed out that there is no place for the referral complex cases. Additionally, less than half of the organizations have information and communication strategies about the benefits and location of maternal and newborn services. In Colombia, pregnant women and newborn care is part of the universal health coverage, meaning that women in the country, with appropriate documentation, are guaranteed services and care during childbirth and newborn's first year.

Although the MOH recently issued circulars about health insurance for Venezuelan migrants and the elimination of barriers for pregnant women seeking prenatal care, two scenarios were verified: first, the number of pregnant migrants from Venezuela seeking prenatal care has increased; and second, many of them experienced injustice, xenophobia and discrimination by healthcare providers while seeking such care, particularly within the public hospital network, which by law is in charge of providing this care.

Demand for contraceptive methods. Most organizations have satisfied the demand for contraceptives via short-term methods (condoms, pills, and injectables); only half offer long-term contraceptives such as IUDs and subdermal implants. This limited selection offered, in some contexts, limits women ability to exercise their right to choose their preferred contraceptive method.

Institutions interviewed have developed information and communication strategies to inform about the availability and location of sexual and reproductive health services, but in some cases, they believe that awareness is limited. Evidence of this was apparent during interviews and focus groups with migrants, who had very little knowledge about the different contraceptive methods, costs and places of access.

HIV management and treatment. Two institutions provide antiretrovirals for diagnosed users enrolled in the General Social Security Health System (SGSSS), including treatment for the prevention of mother-to-child transmission, while eight offer diagnosis, and access to medicines and management for other sexually transmitted infections (STIs). Therefore, migrants from Venezuela need for effective access to screening, care, and treatment with HIV and other STIs is not satisfied sufficiently.

Participation of the migrant population in response design. Six of the 23 key respondents stated that the affected communities are committed to the sexual and reproductive health programs and noted that they participated in program design, implementation, consultations, and counseling. However, qualitative data show there has been little contact between the implementing organizations and the migrant population and focus group participants stated that this was the first time anyone from an organization had asked them about their SRH needs.

Vulnerable groups and equality-oriented approaches. Six organizations stated they were engaged in SRH interventions for adolescents, mostly via direct counseling or schools. Less frequent approaches to engaging and meeting the needs of youth include youth-friendly SRH services strategies, programs for young community educators, and youth-led education and communication actions. Despite these efforts, it is worth noting that not all institutions provide SRH services for young people without requiring parental authorization, even though Colombian law states that the provision of health services for minors does not require parental accompaniment or consent. However, there are not SRH interventions with special focus on people with disabilities, indigenous people, trans-gender people and victims of sexual violence.

Four of the ten organizations stated that they provide comprehensive care forpeople with disabilities. Most of the work focuses on facilitating access to their facilities, rather than providing comprehensive, integrated healthcare. Very few have translators for people with different communication needs, and none mentioned the use of support and reasonable adjustments for people with cognitive and psychosocial disabilities, despite the fact that in Colombia MOH Resolution 1904 of 2017 compells healthcare providers to implement this kind of strategy.

Health financing and resource mobilization. Six of the ten organizations have allocated their own resources or received financial support from UNFPA, IPPF, UNICEF, IOM or the Canadian Government; however, respondents did not know the amounts of these contributions. In this regard, the scarce participation of donations from organizations aimed at humanitarian healthcare and the limited nature of the funds stands out, since only one of the organizations stated that its funding was sufficient to meet its program's sexual and reproductive health goals. More resources are needed to ensure sufficient and equitable access.

Availability of SRH commodities. Some organizations shared that they have received inter-agency response kits. In general, male and female condom kits and oral contraceptive, injectable and IUD and STI kits were available in more than half of the cases. Four of ten organizations stated that requested some of the kits from an international agency; the low availability or lack of kits for pregnant and maternal care, rape victims, and STI and blood transfusion kits is worth noting.

In general, no problems were identified in the availability of commodities for purchase, but rather the lack of funds to purchase supplies. Organizations pointed out that demand exceeds installed capacity and the availability of supplies. Furthermore, one organization stated that more long-term methods were required. This was evident during the fieldwork in Cúcuta, where there was high demand for subdermal implants by Venezuelan women, who could not get them in Venezuela because of their high costs or limited availability.

3.2.3. Actions and responses to address gender-based violence.

Sexual violence is common in contexts of humanitarian crisis, and in the case of the Venezuelan migrant population it is a phenomenon for which basic care is required. Six of the seven key GBV respondents reported having heard of sexual violence in the context of migration, and the topic was mentioned in focus groups, where it was acknowledged that migrants are especially vulnerable to sexual violence.

In three of the four cities there are organizations delivering gender-based violence programs for the Venezuelan migrant population. In Valledupar, one organization with GBV programs was found, but it does not serve the migrant population. While most of the organizations began their response during the first month of the crisis, they do not have enough resources to meet the program's goals.

Protocols that guide the GBV response. Work on this subject is primarily guided by MOH protocols and the Regional Office of the Pan-American Health Organization/World Health Organization (PAHO/WHO) in Colombia.

Preparation and planning to address the emergency. Among those interviewed, two respondents reported carrying out planning, mobilization of financial resources and supplies procurement before responding to GBV in the Venezuelan migrant population during the emergency. Planning activities include the identification of focal points devoted to GBV, development of informative, educational and communication materials, collection of GBV data indicators, advocacy work and capacity building by the Ministry of Health and Social Protection for the medical care of victims.

Health financing and resource mobilization. Three of the seven organizations received resources for GBV response via quick contributions from donors, UNHCR, internal resources, IPPF, and IRISH AID. Only one of the seven organizations stated that funding was sufficient to meet the GBV program goal, but most did not know how much more funding was required by their agency.

Awareness raising, installed capacity, and referral networks. Most organizations provide service and program information to the migrant population and have information, education and communication (IEC) mechanisms in place. However, the widespread lack of awareness about these programs among the migrant population participating in the focus groups is evident. Although most organizations stated they are creating spaces for staff to be trained in the clinical management of sexual violence and all of them have established GBV referral mechanisms, several organizations stated that these mechanisms were not fully articulated with the health, justice and protection sectors.

Availability of supplies for the prevention of and care for gender-based violence. While most organizations focus their actions on IEC, sufficient installed capacity to provide healthcare in cases of sexual violence is not universal among them. Members of the migrant population who participated in interviews and focus groups were not aware of the need for medical attention after a sexual assault, due gender-based violence is not seen as health emergency in their contexts of origin. No organization has requested post-abortion care kits (Kit 3), most have counseling services, but less than half acknowledge that elements such as injury treatment, emergency contraception, HIV post-exposure prophylaxis and prophylactic treatment for STIs and mental healthcare may be required for GBV care.

3.2.4. Actions and responses for HIV care and management

HIV transmission and limited access to treatment are recurrent problems in humanitarian context. Four of the six organizations that work on the issue stated that, in the context of the migration crisis, they have heard about HIV transmission incidents, new cases appear daily and migrants face difficulties accessing treatment. HIV transmission is a common concern to the health care providers, which they correlate to the lack of antiretroviral and continuum treatments.

Protocols that guide the response. Work on this subject is primarily guided by protocols of the MOH and the PAHO/WHO in Colombia.

Preparation and planning to address the emergency. Emergency preparedness in terms of HIV prevention and treatment is weak; just half of the organizations carried out preparatory activities. The Aids Healthcare Foundation (AHF) in Cúcuta is prepared for the emergency through the allocation of financial

resources, identification of focal points on HIV care, development of IEC activities, collection of HIV indicators contemplated in the MISP (adherence, availability of free condoms, access to antiretroviral treatment and mother-child vertical prevention), advocacy work, and technical capacity development. In Riohacha, the District Health Office prepared by assigning HIV-devoted focal points, developing IEC materials and collecting data on HIV indicators, and the Profamilia clinic in Riohacha prepared by developing IEC materials and purchasing quick test.

Health financing and resource mobilization. Two of the organizations reported receiving funds for HIV response during the crisis through internal resources or foundations. However, only one organization stated that they had sufficient resources to meet the MISP HIV goals. This raises concerns regarding response capacity for HIV prevention and care during the emergency.

Vulnerable groups and equality-oriented approaches. Five of the six organizations made efforts to engage LGBTI people in the HIV program through active participation in meetings, training and voluntary participation in the field.

Availability of supplies for HIV prevention and treatment. These organizations primarily have focused their work on the supply of condoms and less on safe blood transfusions. One of the interviewed organizations pointed out that they face difficulties getting enough supplies due cost. These results show the need to increase the availability of supplies and to improve coordination and commitment in the affected communities. Regarding public health interest diseases, some public and private hospital officials reported concerns about the increase of Venezuelan patients, such as homeless people, asking for medications for contagious diseases (HIV/AIDS, STIs) without a previous diagnostic.

3.3. Availability of SRHS in healthcare facilities to meet migrant's needs

This section summarizes the services offered by the healthcare facilities assessed in the four cities. A brief explanation of the Colombian healthcare system is provided along with a description of SRH availability in each city.

3.3.1. Colombia's Healthcare System

Health insurance schemes

The contribution to the national healthcare system is mandatory for formal workers and other people with payment capacity to cover the contributors and

their dependents. The system is financed by a payroll contribution of 12.5%, where formally employed workers contribute 4% and employers the remaining 8.5%. Self-employed workers pay the full 12.5%.

The unemployed, informal sector workers and the poor (as determined by a social average test), including their dependents do not financially contribute to the system, rather, their participation is funded by 17 different sources, mainly general taxes. Those paying the payroll tax subsidize a small portion of the participation of those who not contribute, equivalent to 0.17% of the payroll, deducted from the total 12.5% contribution (Guerrero et al., 2015).

Health Service Promoters

In 1993, Law 100 transformed revenue collection, pooling, purchasing and the service delivery structure in Colombia (Guerrero et al., 2015). As a result, the health sector has multiple insurance models and arrangements in place to sell health services: i) Health promotion agencies in the contributive, subsidized and special regimes (in Spanish, EntidadesPromotoras de Salud –EPS), ii) Subnational governments, which may include departments, municipalities, districts, indigenous territories and occasionally regions and provinces; each subnational government may acquire health services to cover the needs of the poorer population; iii) MOH may purchase via the Administrator of the Resources of the General Social Security Health System (Spanish acronym, ADRES) and the Strategic Fund of the Pan American Health Organization; iv) The National Procurement Agency (Colombia Compra Eficiente), and v) Voluntary health insurance agencies.

However, the main health service purchaser in Colombia are the EPS, which may be either public or private and cover 85% of health services. The EPS contributive scheme covers 20,760,123 million people (44%), the EPS subsidized scheme covers 22,882,669 million people (46%), and the special and exempted health insurance scheme covers approximately 2,226,973 million people (4%). On the other hand, subnational governments are primarily responsible for public health actions under the supervision of the central government, and they cover the health needs of the 2,736,365 uninsured poor people (6%) and the Venezuelan migrants in extreme vulnerability (MOH, 2017).

3.3.2. Main unmet SRH and MNH needs and availability of specific services in the healthcare facilities

This section presents the findings of the healthcare assessment carried out to evaluate the health services provided to the migrant population. The following table describes the services offered by healthcare institutions in the four cities.

This table compiles information about equipment, healthcare staff, coordination with communities and vulnerable populations, access to contraception methods, maternal and neonatal health care and abortion and post-abortion services. Those in green mean good service availability; yellow means mediocre availability, and red means poor or limited availability. ***(See Table 3)***

In general, facility equipment at each facility was good, but there are insufficient beds availability; but many are primary and basic level healthcare facilities, and would not be expected to meet this need. Regarding staffing, most respondents consider the staff adequate, but there were important gaps in terms of obstetrics, gynecology or pediatric services and the availability of 24/7 services, meaning that the facilities are not properly prepared to provide emergency services, particularly in obstetrics.

Regarding relationships with the communities and vulnerable populations, it is worth noting that the facilities assessed in Cúcuta are well prepared; in the remaining cities such as Arauca, the dissemination of information about health services at the community level needs to be strengthened. In Arauca, Riohacha and Valledupar work needs to be done to provide services to meet the needs of youth and people with disabilities.

In general, there are insufficient contraceptive services and methods, maternal and newborn healthcare, abortion and post-abortion services, HIV prevention and care (except in Cúcuta), and GBV services. This assessment found that equipment is not the problem, but the scale and breadth of SRH needs related to the emergency are not properly acknowledged.

Table 3 – Services offered by healthcare institutions in four cities in the Colombia-Venezuela border, 2018.

Service / Municipality	Arauca	Cúcuta	Riohacha	Valledupar
Equipment				
Referral system	5/5	6/6	3/5	2/5
Transportation to referral	5/5	5/6	5/5	5/5
Communication systems	5/5	6/6	5/5	5/5
Basic sanitation (drinking water, sewage and restrooms)	5/5	5/6	5/5	5/5
Bed availability	1/5	5/6	1/5	1/5
Human Resources				
Considers that staffing is adequate	5/5	6/6	5/5	4/5
Hasgeneral physicians or general nurses	5/5	6/6	5/5	3/5
Hasobstetrics, gynecology or pediatric services	1/5	0/6	2/5	2/5
Staff is available 24/7	1/5	4/6	1/5	3/5
Relationship with the community and vulnerable populations				
Dissemination of information on health services to the community	5/5	6/6	3/5	4/5
Healthcare services for adolescents and young people	2/5	6/6	3/5	3/5
Healthcare services for people with disabilities	4/5	6/6	4/5	2/5
Gender-based Violence				
Clinical management of sexual violence	3/5	4/6	3/5	2/5
Dissemination of service availability information to the community	2/5	3/6	3/5	3/5
HIV prevention and care				
Sexually Transmitted Infections (STI) management and care	1/5	6/6	4/5	3/5
Blood transfusion best practices	1/5	0/6	1/5	1/5
Distribution of free condoms	4/5	4/6	0/5	2/5
Access to antiretroviral treatment (ART)	0/5	2/6	1/5	1/5
Antiretroviral treatment to prevent vertical HIV transmission (mother-child)	0/5	4/6	1/5	1/5
Maternal and newborn healthcare				
Healthcare of natural births with qualified personnel	1/5	4/6	1/5	1/5
Cesarean deliveries with qualified personnel	1/5	0/6	1/5	1/5
Basic obstetric emergency care services	1/5	4/6	1/5	1/5
Healthcare personnel trained for newborn care	1/5	5/6	2/5	2/5
Abortion and post-abortion services				
Abortion	1/5	0/6	2/5	1/5
Post-abortion care	1/5	0/6	2/5	1/5
Available contraception methods				
Male condoms	3/5	4/6	4/5	2/5
Female condoms	3/5	0/6	1/5	0/5
Oral contraceptives	3/5	4/6	4/5	1/5
Injectable contraceptives	3/5	3/6	4/5	1/5
Emergency contraceptives	3/5	3/6	0/5	1/5
Intra-Uterine Devices (IUDs)	3/5	4/6	0/5	2/5
Subdermal implants	3/5	2/6	3/5	2/5

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

3.3.1 Arauca (Department of Arauca)

Graph 13 shows the top 10 unmet needs in sexual, reproductive, maternal and newborn health in Arauca, Colombia in 2018, along with a description of the services required to fully cover them.

Sexual and Reproductive Health Services

- Overall, equipment in the institutions is adequate: they all have referral systems, referral transportation, communication systems, distances from reference hospitals vary from 8 to 60 km; they also have energy, drinking water, sewage, and restrooms. In Arauca, the San Vicente Hospital has 76 beds, while the other healthcare facilities have no availability.

- Four of the five healthcare facilities consider their personnel adequate. All offer general medicine and nursing; one offers 24/7 obstetrics or gynecology and pediatric services.

- All healthcare facilities state having informed the community about available sexual and reproductive health services; two have services for adolescents and provide services without prior parental consent; 4 of the 5 institutions provide health services oriented to the needs of people with disabilities.

Prevention of and care for Gender-Based Violence

- Three institutions offer healthcare services for victims of sexual violence: confidential history and examination, collection of forensic evidence, provision of post-exposure prophylaxis for HIV within 72 hours, provision of emergency contraception within 120 hours, prophylaxis for STIs, counseling or psychosocial consultation and care for children survivors of sexual violence.

- Two institutions have informed the community about the availability of these specific healthcare services for victims of sexual violence. Affected women, men and children not always use the available services, maybe because they do not know them or because, as pointed out in the focus groups, health facilities have not provided enough information about the importance of health services after a sexual assault.

- Two institutions reported incidents of sexual violence within the migratory context. It is worth noting that women did not seek services within five days of the assault, maybe because of the belief, evidenced in the focus groups, that sexual violence is primarily treated as a criminal event and not as a medical emergency.

Graph 13 – Top 10 unmet needs in sexual, reproductive and maternal and newborn health in Arauca, Colombia, 2018

#	Need	Details	Category
1	**Safe abortion and post-abortion care services**	• Safe abortion, counseling and post-abortion care. • Anti rumor campaigns and delivering high quality information.	Most urgent needs
2	**Access to contraceptive services**	• Emergency contraceptives. • Female condoms. • Oral contraceptives. • Intra-uterine devices (IUDs). • Subdermal implants. • Male condoms.	Most urgent needs
3	**Effective access to maternal and newborn healthcare services**	• Prenatal care. • Skilled birth attendance. • Basic obstetric emergency care. • Healthcare staff trained in newborn.	Most urgent needs
4	**Prevention of teenage pregnancy and youth-friendly services**	• Health care services for adolescents and youngsters. • Advisory, information and communication campaigns	Urgent needs
5	**Effective and comprehensive care of sexual violence**	• Clinical care for sexual violence, referral/counter referral systems, effective access to protection and justice services. • Comprehensive care beyond health .	Urgent needs
6	**Effective access to antiretroviral treatment**	• Screening and access to antiretroviral treatment (ART). • Vertical HIV transmission (mother-child) prevention. • High quality information, anti rumor campaigns.	Urgent needs
7	**Information and communication on offer and location of SRHS for migrants**	• Dissemination of key information about availability of health services. • healthcare campaigns and mobile brigades.	Other important needs
8	**Protection and prevention of sexual and gender-based violence**	• Effective access to protection and justice services. • Notification of cases through the public health surveillance system. • Follow-up.	Other important needs
9	**Information on services for victims of sexual violence**	• Dissemination of key and high quality information about availability of health services. • Campaigns and mobile brigades.	Other important needs
10	**Comprehensive sexuality education**	• Intersectoral coordination. • Rights-based and gender-focused approaches to comprehensive sexuality education. • High quality information and guidance.	Other important needs

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

HIV care and prevention

- Only one institution provides STI care and management services and has authorized blood transfusion services from an external bank with safety protocols in place; blood is tested for HIV, syphilis, and hepatitis B and C. Four of the five facilities distribute condoms free of charge.

- None of the institutions have antiretroviral treatments available for permanent users, and only one delivers antiretrovirals to mothers and newborns. Two do not have enough supplies to provide care for all the cases they receive (for example, Meridiano 70 reported 290 patients who received treatment for STIs over the past three months). However, there is no data on how many Venezuelan migrants were screened and received the treatment.

Maternal and Newborn Health

- One institution provides vaginal or cesarean section delivery care with qualified personnel and provides basic obstetric emergency care services: antibiotics and use of Misoprostol for postpartum hemorrhage.

- One institution has trained personnel and qualified services for newborn care: breastfeeding promotion (early and exclusive); management of neonatal infections; thermal care, sterilized cutting of the umbilical cord and subsequent care; Kangaroo Program for low-birth-weight babies, special birth care practices to prevent HIV transmission from mother to child, as well as consultation and advice for exclusive and immediate breastfeeding.

- In the month prior to the assessment, 120 newborns were admitted to the institutions for neonatal sepsis, 63 for low birth weight/preterm births and 30 for neonatal asphyxia. Cases of maternal and perinatal mortality have been reported in the migrant population. Contrasting this information with surveillance data from the National Health Institute, INS, there is an increase in cases of perinatal and neonatal mortality, 83% of which are reported in Venezuelan migrants (INS, 2018). On the other hand, data on maternal deaths as of August 2018 only shows 2 cases of Venezuelan maternal mortality.

Abortion and post-abortion services

Two institutions offer services that include counseling, post-abortion contraceptive access, and safe abortion care, and only one of them provides services for post-

abortion care, pharmacological abortion and dilation and evacuation (D&E). Lastly, one institution reported a maternal death related to abortion among Venezuelan migrant women.

Available contraception methods

Four of the five institutions offer some contraceptive methods including male condoms, female condoms, oral contraceptives, injectable emergency contraceptives, and DIUs. None distributes supplies for menstrual hygiene. Table 4 presents a description of the methods provided in the past month in Arauca.

Table 4 – Contraceptive methods provided in Arauca, Colombia, in the last month, 2018

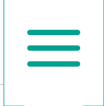
Method	Institution 1	Institution 2	Institution 3	Institution 4	Institution 5
Male condoms	N / A	395	1000	0	N / A
Female condoms	N / A	0	50	0	N / A
Oral contraceptives	0	0	200	0	N / A
Injectable contraceptives	N / A	0	200	0	N / A
Emergency contraceptives	N / A	0	0	0	N / A
Implants	N / A	0	0	0	N / A

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018

3.3.2. Cúcuta (Norte de Satantander)

Graph 14 shows the top10 unmet needs in sexual, reproductive, maternal and neonatalhealth identified in Cúcuta, Colombia, in 2018, along with a description of the services required to fully cover them.

Cúcuta has faced numerous tensions between host communities and the migrant population arriving through migratory points or trails that have become popular since the beginning of the crisis. In addition to the existence of settlements and many Venezuelan migrants arriving in local receiving communities, the metropolitan area is the closest to the border and receives migrants who come for a short period of time (between one and two days) for health supplies and services, particularly child vaccination, and sexual and reproductive health services such as contraception, STI prevention, comprehensive sexuality education, and abortion services.



Focus group participants frequently pointed out widespread discrimination and xenophobia. At the same time, migrants praised the quality of healthcare providers and were grateful for the chance to access essential healthcare services, which currently are almost non existent in Venezuela.

Graph 14 – Top 10 unmet needs in sexual, reproductive, maternal and newbornhealth in Cúcuta, Colombia, 2018.

#	Need	Details	Priority
1	Access to contraceptive services	• Emergency contraceptives • female condoms • injectable contraceptives; oral contraceptives • intra-uterine devices (IUDs) • subdermal implants; male condoms	Most urgent needs
2	Prevention of Sexually Transmitted Infections	• Screening and access to medicine • distribution of free condoms	Most urgent needs
3	Comprehensive sexuality education	• Intersectoral coordination • rights-based and gender-focused approach to sexuality education • High quality information and guidance.	Most urgent needs
4	Safe abortion services and Post-abortion care	• Safe abortion, advisory and Post-abortion care • Anti rumor campaigns and delivering high quality information	Urgent needs
5	Information and communication on offer and location of SRH for migrants	• Dissemination of key information about availability of health services • and health care campaigns and mobile brigades.	Urgent needs
6	Effective access to antiretroviral treatment	• Screening and access to antiretroviral treatment (ART) • vertical HIV transmission (mother-child) prevention • high quality information • anti rumor campaigns	Urgent needs
7	Information on services for victims sexual violence	• Dissemination of key and high-quality information about availability of health servicesVcampaigns and mobile brigades.	Other important needs
8	Protection and prevention of sexual and gender-based violence	• Effective access to protection and justice services; notification of cases through the public health surveillance system • follow-up.	Other important needs
9	Combined response in HIV management and care	• Create synergies between budgets; equity-oriented approaches to reach the agency's most vulnerable groups • inter-sector coordination.	Other important needs
10	Prevention of teenage pregnancy and youth friendly services	• Health care services for adolescents and young people • Advisory, information and communication campaigns	Other important needs

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

Sexual and reproductive health services

- Overall, equipment and infrastructure are adequate, but spaces for providing care are limited. Healthcare facilities have adequate reference protocols and communication systems (platforms, internet, and national calls). All the healthcare facilities have drinking water, electricity and restrooms, and between two and 25 beds available.

- All the institutions consider their staffing conditions adequate and sufficient, and four have 24/7 medical personnel including at least one general practitioner and nurse available. All the institutions have informed the community about SRH services available for people with disabilities and adolescents, and five of them provide services without the need for parental consent.

Prevention of and care for Gender-Based Violence

- Four institutions provide healthcare for victims of sexual violence; private rooms for patients are available, and only two provide clinical care and follow up for these cases. They have informed the community about these available services.

- Five institutions have comprehensive care and referral routes in operation for victims of sexual violence with other healthcare providers. Each institution reported the referral of at least one individual in the past month.

- Health services have treated incidents of sexual violence against migrant population; however, as in other cities, it seems that people often fail to seek care within the first 72 hours after the assault due to fear of being deported, misinformation and rumors.

HIV care and prevention

- All institutions have standard protocols and precautions in place; they also have enough supplies for STI diagnosis and management. Four offer free condoms, while none are qualified for safe blood transfusions. Two institutions provide antiretroviral treatments for permanent users, with a referral system and treatment for the prevention of mother-to-child transmission.

Maternal and newborn health.

- Four of the six institutions provide skilled birth attendance, while none provide cesarean sections. More than half provide care for obstetric emergencies through prenatal medications, removal of products retained from conception, assisted vaginal delivery, and maternal and newborn resuscitation and misoprostol for postpartum hemorrhage.
- Two institutions offer services for the newborn and five have received training about consultation and counseling for exclusive and immediate lactation, thermal protection, infection prevention, management of sepsis in newborns, management of low birth weight/preterm infants, infection management and prevention of vertical HIV transmission.
- Among admissions in maternal and neonatal healthcare, newborns have been treated for neonatal sepsis and birth asphyxia in the past 30 days. Similarly, six newborn deaths and no maternal deaths have been reported in this scenario.

Abortion and post-abortion services

Four institutions provide abortion services, counseling and post-abortion contraception access. No institution has post-abortion care or safe abortion methods. Healthcare providers have not reported abortion-related maternal deaths among Venezuelan migrant women.

Available contraception methods

- All healthcare providers have contraceptive methods available. Two provide male condoms, oral contraceptives, emergency contraceptives, IUDs, injectable contraceptives and implants. While in the others, only male and female condoms, implants, and IUDs are supplied. No institution provides menstrual hygiene supplies.
- In general, four of the six institutions have a wide range of contraceptives. However, in the focus groups attention was drawn to the difficulty accessing these methods, and the limited options they have if they choose to use modern long-duration methods; particularly, a high demand for subdermal implants was identified.

Table 5 – Contraceptive methods provided in Cúcuta, Colombia, in the past month, 2018

Method	Institution 1	Institution 2	Institution 3	Institution 4	Institution 5	Institution 6
Malecondoms	DK	36	70	500	26	N / A
Femalecondoms	DK	N / A	N / A	N / A	DK	N / A
Oral contraceptives	DK	36	43	1500	390	N / A
Injectable contraceptives	DK	0	1	2	N / A	N / A
Emergency contraceptives	DK	5	6	50	N / A	N / A
Intrauterine devices (IUDs)	DK	194	36	800	N / A	1
Implants	DK	0	DK	59	N / A	N / A

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

3.4.3 Riohacha, La Guajira.

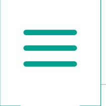
Graph 15 shows the top10 unmet needs in sexual, reproductive and maternal and neonatalhealth identified in Riohacha, Colombia, in 2018, along with a description of the services required to fully cover them. ***(See Graph 15)***

Riohacha is one of the most important migratory routes close to Venezuela through Maicao, one of the areas with the highest volume of irregular and circular migration. Recently, migration has intensified and, as a result, the demand for sexual, reproductive, maternal and neonatal health services has significantly increased, particularly prenatal care consultations by pregnant women who subsequently return to Venezuela.

While the Ministry of Health and Social Protection subnational office has made important efforts to address the Venezuelan migrant population, in the focus groups access costs to basic healthcare, waiting times, discrimination or denial for migrants seeking care, disinformation and rumors about HIV and sex work by migrant women were identified as the main barriers for accessing essential health services.

Sexual and reproductive health services

- In general, the necessary equipment and infrastructure is available for operation: all institutions have information and communication systems, basic utilities (drinking water, electricity and sewage) and ambulance services, and three have referral protocols. One of the facilities has 60 beds available for the entire municipality. The time needed to reach the nearest reference hospital varies between five minutes and one and a half hours.



Graph 15 – Top 10 unmet needs in sexual, reproductive, maternal and neonatalhealth in Riohacha, Colombia, 2018.

#	Need	Details	Priority
1	**Access to contraceptive services**	• Emergency contraceptives • female condoms • injectable contraceptives • oral contraceptives • intra-uterine devices (IUDs) • subdermal implants; male condoms	Most urgent needs
2	**Prevention of Sexually Transmitted Infections**	• Screening and access to medicines, distribution of free condoms	Most urgent needs
3	**Prevention of teenage pregnancy and youth friendly services**	• Health care services for adolescents and young people • advisory, information and communication campaigns.	Most urgent needs
4	**Safe abortion and post-abortion care services**	• Safe abortion, advisory and Post-abortion care • anti rumor campaigns and delivering high quality information.	Urgent needs
5	**Effective access to maternal and Newborn health care services**	• Abortion; Skilled Births Attendance • Basic of obstetric emergencies care • health staff trained in newborn care	Urgent needs
6	**Effective and comprehensive care for sexual violence**	• Clinical care for sexual violence, referral/counter referral systems, effective access to protection and justice services.	Urgent needs
7	**Information on services for victims of sexual violence**	• Dissemination of key and high-quality information about availability of health services • campaigns and mobile brigades.	Other important needs
8	**Protection and prevention of sexual and gender-based violence**	• Effective access to protection and justice services • notification of cases through the public health surveillance system • follow-up.	Other important needs
9	**Information and communication on offer and location of SRHS for migrants**	• Dissemination of key information about availability of health services • and health care campaigns and mobile brigades	Other important needs
10	**Combined response in HIV management and care**	• Create synergies between budgets • equity-oriented approaches to reach the agency most vulnerable groups • inter-sector coordination.	Other important needs

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

- All organizations consider their staff training adequate, depending on the complexity of each healthcare provider's case load. All have at least one general practitioner and one general nurse, while the institutions prepared for

higher complexity have obstetric or gynecology services. One institution even provides services 24/7. Three of the five institutions reported the availability of reproductive health services in general for people with disabilities and youth.

Prevention of and care for Gender-Based Violence

- Three institutions provide healthcare services for Venezuelan migrant survivors of sexual violence; they have a private and secure office and one has all the necessary services for the care of these cases.

- One institution has a person trained to provide all healthcare services to victims of sexual violence; in the other institutions, several services were partially provided. Only three institutions inform the community about the availability of services for victims of sexual violence.

- Four institutions have standardized processes for the referral of victims of sexual violence, and all have referred at least one survivor of sexual violence. Cases of sexual violence against Venezuelan migrant women and girls are frequent: one to four cases in the past 30 days and around fourteen victims of sexual violence over the past three months.

HIV care and prevention

- Four institutions have some standard precaution protocol, provide STI diagnosis and management, but have insufficient supplies. However, only one institution performs blood transfusions and has a protocol and a monitoring system enabled to ensure its application during transfusions.

- One institution has antiretroviral treatment for permanent users, access to treatment protocols and a referral system for ongoing users of antiretrovirals, including people living with HIV, and treatment for the prevention of mother-to-child transmission.

- This shows that prevention of HIV transmission through sexual contact and patient treatment is insufficient, and only two institutions provide antiretroviral treatments to mothers and newborns in the delivery room.

Maternal and newborn health

- One institution offers cesarean delivery and delivery services provided by qualified medical personnel. In the same institution, the following basic

obstetric emergency services are also provided: parenteral medications, removal of retained products from conception, assisted vaginal delivery, newborn resuscitation and use of misoprostol for postpartum hemorrhage.

- While only one facility can provide high complexity maternity services, no maternal deaths have been recorded in the past 30 days; this means that, in general, these needs can be met.
- Two institutions received training in newborn care and one institution provides qualified newborn care: breastfeeding stimulation (early and exclusive); management of neonatal infections; thermal care, sterilized cutting and proper care of the umbilical cord; Kangaroo Program for low birth weight, special birth care practices to prevent HIV transmission from mother to child.
- One institution provides all newborn care services. Regarding the newborn admission conditions, one reported the admission in the past 30 days of a child with neonatal sepsis. Another facility reported knowledge of 14 newborn deaths of Venezuelan migrant mothers. Some women reported that they find it difficult to breastfeed due to lack of food.
- It is worth noting that, as in Arauca, the Ministry of Health is responding to the migrant population emergency via the public network.

Abortion and post-abortion services

Three facilities have post-abortion counseling and contraceptive services; two institutions have treatment for retained products and safe abortion care. Only two institutions provide post-abortion careservices, and both have pharmacological abortion services and manual vacuum aspiration.

Available contraception methods

Four institutions provide counseling, advisory and distribution services for different contraception methods: male condoms, oral contraceptives, emergency contraceptives, IUDs, injectables and implants. Two institutions provide supplies for menstrual hygiene to women and girls of reproductive age, including adolescents, which was not seen in the other cities of the research.

Table 6 – Contraceptive Methods provided in Riohacha, Colombia in the past month, 2018.

Method	Institution 1	Institution 2	Institution 3	Institution 4	Institution 5
Malecondoms	850	1185	40	400	N / A
Female condoms	N / A	N / A	N / A	200	N / A
Oral contraceptives	100	39	17	100	N / A
Injectablecontraceptives	251	10	24	400	N / A
Emergencycontraceptives	N / A	N / A	N / A	N / A	N / A
Intrauterine devices(IUDs)	N / A	N / A	N / A	N / A	N / A
Implants	74	20	138	N / A	N / A

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

3.4.4 Valledupar, Cesar

Graph 16 shows the top10 unmet needs in sexual, reproductive and maternal and neonatalhealth identified in Valledupar, Colombia, in 2018, along with a description of the services required to fully cover them. ***(See Graph 16)***

Valledupar is a municipality near the border that has received a significant number of people from Venezuela, as a result of the migratory flow through La Guajira. Valledupar, unlike the other cities, does not have enough health providers to meet the needs of the migrant population in terms of sexual, reproductive, maternal and neonatal healthcare at the local level. The most common access barriers are the denial of maternal and newborn services in public hospitals, healthcare costs, misinformation, lack of documents and discrimination through psychological violence by healthcare personnel.

Sexual and Reproductive Health Services

- In general terms, all the facilities have adequate equipment: energy, drinking water and sanitary services. Rosario Pumarejo de López Hospital has 350 beds available; other facilities do not have beds available for patients, but instead offer stretchers. All have communication and transport systems, and two have a referral protocol. Distances to the nearest referral hospital range between 2 km and 4 km.

- Four of the five institutions consider their staff adequate. In general, Valledupar has obstetrics, gynecology, pediatrics, and nursing care. One institution provides general medical services. Three institutions have night and weekend schedules.

Graph 16 – Top 10 unmet needs in sexual, reproductive and maternal and newbornhealth in Valledupar, Colombia, 2018.

#	Need	Details	Priority
1	**Access to contraceptive services**	• Emergency contraceptives • female condoms • injectable contraceptives; oral contraceptives • intra-uterine devices (IUDs) • subdermal implants • male condoms	Most urgent needs
2	**Safe abortion and post-abortion care services**	• Safe abortion, advisory and post-abortion care • anti rumor campaigns and delivering high quality information	Most urgent needs
3	**Prevention of Sexually Transmitted Infections**	• Distribution of free condoms	Most urgent needs
4	**Prevention of teenage pregnancy and youth-friendly services**	• Health care services for adolescents and young people • Advisory, information and communication campaigns	Urgent needs
5	**Effective access to maternal and child care services**	• Abortion; skilled birth attendance • basic obstetric emergency care • health staff trained in newborn care.	Urgent needs
6	**Effective and comprehensive care for sexual violence**	• Clinical care for sexual violence, referral/counter referral systems, effective access to protection and justice services	Urgent needs
7	**Effective access to sexual and reproductive healthcare for migrants**	• Effective access to clinical care. Implementation of the MISP	Other important needs
8	**Protection and prevention of sexual and gender-based violence**	• Effective access to protection and justice services; notification of cases through the public health surveillance system • follow-up	Other important needs
9	**Information and communication on offer and location of SRHS for migrants**	• Dissemination of key information about availability of health services • and health care campaigns and mobile brigades.	Other important needs
10	**Funding for sexual, reproductive, maternal and newborn health.**	• Inter-sectoral coordination • SRH leadership.	Other important needs

Source: Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela Border: Arauca, Cúcuta, Riohacha, and Valledupar. Profamilia–IPPF, 2018.

- Four institutions have informed the community about the sexual and reproductive health services they offer; three offer services for adolescents without parental consent; and two serve the needs of people with disabilities.

Prevention of and care for Gender-Based Violence

- Two institutions offer comprehensive healthcare for victims of sexual violence. Four institutions have a private and secure office for the victims, attention guidelines and protocols, referral systems, and at least three have referred at least one recently assaulted person. Finally, three institutions inform the community about the availability of assistance services for victims of sexual violence.

- Two institutions reported knowledge of at least six cases of sexual violence against migrant women in the past 30 days, and a total of 26 during the past three months, 10 of which accessed healthcare services within five days of the sexual assault.

HIV care and prevention

- Three of the five institutions have some standard precaution protocol, STI care and management; two distribute free condoms and one uses sterilization processes for equipment for STI management; in terms of resources, two have enough supplies.

- One institution performs blood transfusions, and the supply source is its own blood bank, or blood collected from relatives and friends, depending on the needs (live transfusion); there is also a monitoring protocol for safe blood transfusions. Additionally, blood is screened for HIV, syphilis, hepatitis B, hepatitis C and malaria.

- One institution provides antiretroviral treatment for permanent users, controlled by a protocol and referral system, people with HIV and treatment for the prevention of mother-to-child transmission, who are referred to their corresponding EPS. One provides antiretroviral treatment for mothers and newborns.

Maternal and newborn health

- Basic care services for obstetric emergencies include parenteral medications, removal of retained products from conception, newborn resuscitation, and use of Misoprostol for postpartum hemorrhage. Two maternal deaths have been reported in the past 30 days.

- Two institutions are qualified for and have training in newborn care: breastfeeding stimulation (early and exclusive); management of neonatal infections, thermal care, sterilized cutting and proper care of the umbilical cord, Kangaroo Program for underweight babies and prevention of HIV vertical transmission from mother to child.

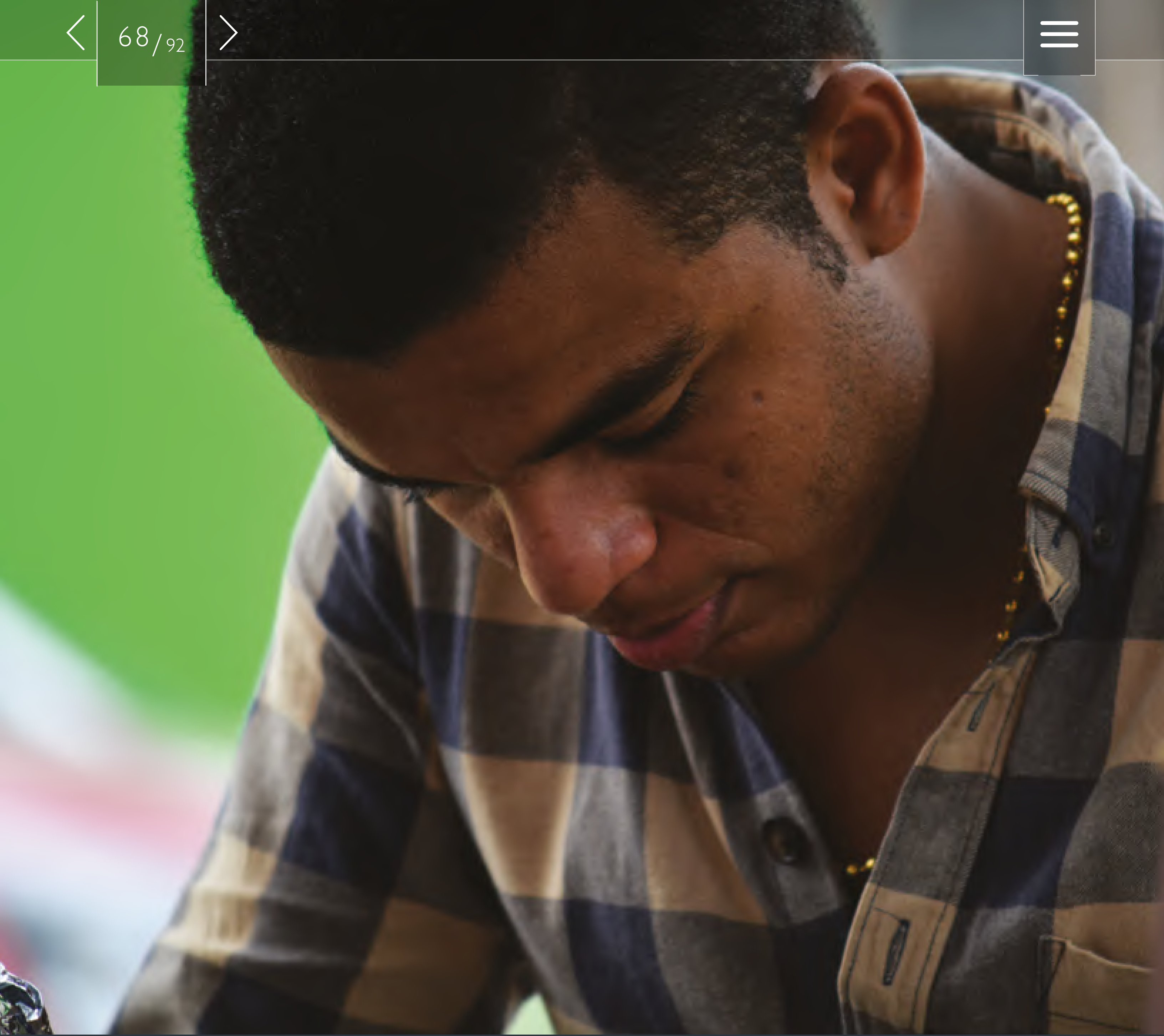
- Institutions reported the admission of 40 cases for neonatal sepsis, 10 for low birth weight/preterm births and 25 for perinatal asphyxia, and two institutions reported knowledge of newborn deaths of migrant mothers in the past 30 days.

Abortion and post-abortion services

Two institutions provide these services; one offers counseling services and the other provides treatment for retained products, counseling, post-abortion contraception and safe abortion care. One institution uses dilation and evacuation (D & E) for post-abortion care and medical abortion care. Two institutions reported a total of two maternal abortion-related deaths.

Available contraceptionmethods

Supply of contraceptive methods is limited; two institutions distribute some contraceptive methods. No institution receives or distributes supplies for menstrual hygiene. Compared to the other cities, Valledupar has major needs regarding the availability of contraceptive methods.



"I know a friend who was going to have a baby here but couldn't. She had to return to Venezuela because she was being charged with 1 million Colombian pesos to have her baby here (...)".

Venezuelan migrant woman | **Focus Group: 18 to 24** | **Arauca**

4. Discussion

This assessment is the first attempt to evaluate the degree of implementation of the Minimal Initial Service Packages (MISP) in Reproductive Health within humanitarian crisis in Colombia, due to the Venezuelan migratory flow.

Given that the MIPS has not being fully implemented in this crisis in order to approach Venezuelan migrant population needs, are emerging social inequalities in health, inefficiency in the decision making, and an unmet need in essential services of sexual and reproductive health for Venezuelan migrants in Colombia.

The need for SRH leadership to guide and assist the actions, decisions and the mobilization of resources in the Colombian border should be prioritized, in particular to promote implementation of the MISP.

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP

Key interview respondents showed poor knowledge ofthe MISP (only 2 of 23 had heard about it) and a lack of capacity for implementation (only 1 has received related training). However, the actions of different agencies and organizations in territories dealing with the migratory crisis and attending some of the sexual and reproductive health needs of the Venezuelan migrant population should be acknowledged. All the cities -except one- are aware of the emergency and are taking some actions to ensure the services needed by migrants; in Valledupar the context is marked by a lack of response to the emergency, the weak presence of the organizations and by the fact that the work of that the institutions present in the territory is not focused on the Venezuelan migratory crisis.

Prevent sexual violence and respond to the needs of survivors

Although this is the second objective of the MISP, the actions and services related to it are not strong enough. Several barriers were found: focus groups showed that Venezuelan migrants do not usually think of sexual violence as a medical emergency; on the other hand, key respondents about GBV were aware of its occurrence during the crisis (6 of 7 interviewed reported having heard about sexual violence cases in the crisis setting); 3 of the 4 cities have organizations working on GBV, and in all of them at least some health facilities provide clinical care services for sexual violence.

Given that the MIPS has not being fully implemented in this crisis in order to approach Venezuelan migrant **population needs, are emerging social inequalities in health, inefficiency in the decision** making, and an unmet need in essential services of sexual and reproductive health for Venezuelan migrants in Colombia.

This relative installed capacity is undermined by the lack of information about these services and their importance among the migrant population, as well as the lack of a strong, connected, interagency referral network and a survivor centered referral mechanism at all levels. While it is a generalized problem in the four cities, in Valledupar it is deepened by the lack of organizations working with migrant survivors of sexual violence. The individual interviewed on this matter said that institutional actions are not focused on the migrant population.

Prevent the transmission of and reduce morbidity and mortality due to HIV

In terms of HIV transmission, none of the cities have enough prevention or treatment services. The worst conditions were identified in Arauca, Riohacha and Valledupar; although key respondents identified that new cases appear almost daily, these places do not have not enough supplies, particularly condoms, and not all institutions are using proper referral systems for HIV+patients. In Cúcuta, because of its higher HIV rates, more institutions and services to prevent and reduce HIV were found, but the detection of new cases is not always followed by treatment. On the other hand, focus groups evidenced an important stigma and lack of knowledge about HIV.

Regarding this matter, 4 out of 6 organizations that work on this issue said they have been aware of HIV transmission incidents in the context of the migratory crises, new cases appear daily, and there are difficulties for these people to gain access to treatment. In this migratory context, concerns regarding the spreading of the virus have been present since the beginning, which are usually related to the lack of antiretroviral and continued treatment in the neighboring country.

Prevent excess maternal and newborn morbidity and mortality

In all the assessed cities there is at least one institution that provides healthcare for pregnant women (prenatal, natural and cesarean delivery) and basic care for obstetric and newborn emergencies. There is an institution in Cúcuta attending cesarean deliveries, but during the fieldwork this facility was not willing to participate in the assessment. Focus group participants were aware of the names and location of these facilities, but many barriers were pointed out, particularly that many pregnant women have suffered xenophobia and other forms of violence by healthcare providers.

Regarding abortion, none of the four cities provide enough services; furthermore, the facilities with abortion services are not focused on the procedure. However,

barriers are related to different issues: lack of knowledge about the Colombian legislation on abortion, lack of access to the facilities where it is available, stigma, and the use of unsafe techniques.

Plan for comprehensive SRH services, integrated into primary healthcare

Findings show that there is an important installed capacity in terms of equipment and human talent and that there are also healthcare facilities and institutions providing sexual and reproductive health services. However, there are still major gaps in the services needed in the four cities to guarantee the sexual and reproductive rights. In general, there is a major unmet demand for contraceptives, even though different methods are available in each city. On the other hand, there is an urgent need of information for the community in Riohacha and Valledupar and, according to the focus groups, it is very important to provide more information regarding the comprehensive sexual and reproductive health services, their location and costs.

"At least not here. Here, you must work and if you do not work you do not eat, because nobody will give you anything here; nobody helps you, nobody greets you here. Practically, we are losing our youth, adolescence; we would be studying. "

Venezuelan migrant youth | **Focal group: 14 to 17** | **Cúcuta.**

5. Profamilia actions and responses addressing the humanitarian crisis in the Colombia-Venezuela border

Profamilia is an institution committed to promoting and guaranteeing human rights, well known as the leader on sexual and reproductive rights in Colombia. In this regard, since the crisis in the Bolivarian Republic of Venezuela began in 2016, a series of strategies and actions have been developed and implemented to provide the Venezuelan migrant population with healthcare services and commodities, particularly sexual and reproductive healthcare services. These strategies have been guided by the understanding that the Venezuelan migration crisis features major differences from many other humanitarian crises, therefore with a unique complexity, such as the circular migration phenomenon or the massive return of Colombians who have lived in the neighboring country for many years.

Profamilia's response to the humanitarian crisis has included leveraging its installed capacity at the border and in other cities to meet the SRH needs of migrants. Utilizing this capacity, and relying on resources from external partners and donors as well as institutional funds, the organization is prioritizing Venezuelan migrant population and host communities, which are historically vulnerable and underserved. Profamilia is also designing and implementing research aimed at understanding how migration determines the sexual and reproductive health status in this context.

During this crisis, Profamilia's services have focused on delivering information, education and communication about healthcare in general; likewise, on providing contraceptives emphasizing access to long-term methods, addressing gender-based violence, including care for transgender population and people affected by human trafficking, a problem generally exacerbated in mass migration situations. Profamilia implements prevention and care programs for unintended unplanned pregnancies, particularly through safe abortion procedures (pharmacological with Mifepristone and Misoprostol, but also via manual vacuum aspiration) at any gestational age, in all its clinics. Finally, the organization provides counseling, assessment and orientation for people within the referral and counterreferral health carefor the attention of other needs that affect their general health, including pregnancy, childbirth and postnatal period.

Overall, it should be noted that: 1) Profamilia's services focus primarily on the adolescent and young population, under the philosophy of providing "friendly services" for this population group, without excluding other age groups. 2) The population is covered through clinics located throughout the country, but also via mobile brigades to reach different territories. 3) Most of the services provided to the migrant population are subsidized via donations or the organization's own resources.

On the other hand, and in alliance with international cooperation and within the framework of "Projects Without Borders Phase I and II", "She Decides", and "WYZ", Profamilia built a comprehensive strategy aimed at implementing its social intervention model based on providing comprehensive essential humanitarian sexual and reproductive health (SRH) assistance services in the departments of La Guajira (Riohacha, Maicao, Dibulla), Norte de Santander (Cúcuta, Villa del Rosario and Puerto Santander), Santander (Bucaramanga), Arauca (Arauca), Antioquia (Rionegro and Apartadó), Chocó (Quibdó, El Carmen del Atrato, Bahía Solano) and Córdoba (Montería). These geographical areas have been historically affected by social exclusion and extremely disadvantaged settings, such as armed conflict, post-conflict and recently Venezuelan migration flows.

This work model takes place directly in the field and transcends the provision of services and information, education and communication activities by including institutional strengthening strategies delivered to local organizations, thus ensuring capacity building and program continuity. It entails working with communities through social mobilization, consolidation of alliances and synergies for the implementation of advocacy actions that enablea more efficient use of resources. Finally, Profamilia's model engages in knowledge management processes to establish baselines, facilitate the implementation of guided actions, subsequent evaluation processes, lesson systematization and the documentation of best practices.

Profamilia's actions and responses aim to:

- Build and support environments that guarantee sexual and reproductive rights (SRR), especially through the provision of essential health services in clinics and extramural healthcare brigades, with emphasis on the prevention and care of unwanted pregnancies, including access to safe abortion services.

- Provide comprehensive and differential SRH care for vulnerable populations located in the border area under the Integrated Packages of Essential Services, with a specific focus on human rights.

- Strengthen the provision of SRH emergency assistance services.

- Train institutions and civil society groups on the approach to SRH in humanitarian contexts.

- Develop SRH-related promotion and prevention strategies.

All planned strategies are based on gender equality, social inclusion, differential, intersectional, territorial, ethnic and "Do No Harm"-oriented approaches. Furthermore, these strategies are aligned with sectoral policies, as an engine that contributes to the reconstruction of the social fabric and has enabled, from 2016 to date, to provide responses to nearly 2 million Venezuelan immigrants or Colombian returnees in different regions of the country.

6. Recommendations

In order to ensure the successful implementation of the Minimum Initial Service Package (MISP) for sexual and reproductive health in emergency situations, several challenge must be overcome at the national and territorial levels by the different institutional, civil society and international community actors responding to the crisis. The following actions are recommended:

- Acknowledge the crisis currently affecting Colombia: various organizations and institutions have made enormous efforts to provide timely responses and solutions to the needs of the Venezuelan migrant population, however, these are insufficient or are seen as isolated actions. That is why a public statement by the Colombian governmentor United Nations UN on the magnitude of the humanitarian crisis is needed to increase political commitment, to organize the response according to the expertise of the organizations involved, strengthen alliances and seek synergies among the different actors interested in supporting the highly vulnerable migrant population.

- Manage political will: national institutions headed by the Ministry of Health and Social Protection have called for collaboration and the definition of lines and levels of humanitarian response, this may only be achieved in the field. It is essential to coordinate the political will of the different institutional actors, international organizations and the civil society. These organizations are guided by their collective commitment to address the crisis and through improved coordination and guidance will be able to leverage their individual capacity to create an improved, comprehensive, and coordinated response.

- Monitor institutional response: there are large gaps in institutional capacity in different departments and municipalities receiving migrant populations. Local response capacity to the crisis and high decision-maker and technical staff turn over prevents consolidation and continuity of strategies and activities. Monitoring the response is key to ensure that the response is of universally high-quality, especially in locations with less local capacity to ensure accompaniment by external institutions, capable of follow-up activities and setting up control mechanisms for the efficient use of resources and the proper application of healthcare protocols in humanitarian crisis contexts.

- Increase service provision coverage: the high intensity of the migratory phenomenon means that a significant part of the migrant population has not been able to effectively access basic healthcare, including SRH services. This calls for increased efforts to provide care in rural areas or far from the municipal capitals where they have settled and where institutional services are absent.

- Strengthen referral and counterreferral systems: communication and articulation deficiencies among the different service providers, whether public, private or international, have had an impact on user-referral processes to the different levels of care. This has prevented the expected results, and therefore setting up local working groups, creating directories or routes and implementing follow-up mechanisms and information systems to ensure this traceability is required, as well as ensuring that all GBV-related referrals are survivor centered.

- Counteract misinformation on SRH care in crisis: the implementation of effective communication strategies to address misinformation on is crucial. It is important to recognize the social and cultural differences in SRH care among the migrant population to reduce stigma around abortion, gender-based violence, and contraception for minors, among many other issues. Conducting IEC campaigns about the SRH services provided inside Venezuela would help ensure that in the event of migration, people arrive with basic information and seek informed access to care.

- Engage the migrant population in the provision of services and community education: develop spaces and strategies for the migrant population with healthcare training to be able to join the interdisciplinary teams that are providing the humanitarian response. This could reduce cultural gaps and favor empathetic relationships, strongly needed to address SRH-related issues. Likewise, through the promotion of new youth leadership, volunteer assistance networks to support prevention processes may be created through the development of information, education and communication activities, particularly in remote or scattered communities.

- Position the MISP: this package should be widely recognized in Colombia, particularly in places experiencing the humanitarian crisis. The MISP was designed to save lives and guide actions to ensure sexual and reproductive health access, which is frequently neglected in crisis. Therefore, massive dissemination and capacity building are required to reach decision-makers, healthcare personnel and communities, include management practices for emergencies and to ensure processes exist to ensure the enforce ability of rights. Implementing the MISP provides a chance to verify the prevalence of other needs not covered in this assessment toolkit, but which are priorities for the SRH community, such as the needs and experiences of transgender and people with other sexual and gender identities.

- Identify a leading organization for the implementation of the MISP: given the technical specificities in terms of service and SRH care proposed by this package, an expert organization that operates at the national and territorial levels should lead the coordination of MISP activities and related advocacy.

- Prioritize gender-based violence, HIV/AIDS and the prevention and care of unintended pregnancy: awareness should be raised among the healthcare professionals who attend emergency situations and they should be trained in the identification and treatment of sexual and gender-based violence. It is urgent for the crisis-response agencies to mandatorily incorporate and implement the gender-based violence guidelines issued by the Ministry of Health and Social Protection.

- Provide comprehensive care for all forms of sexual violence: it is essential to redouble efforts to disseminate information about the prevention or management of the consequences of sexual violence, an issue largely unknown among the migrant population. During this evaluation migrants were not aware of the risks or possible consequences of SBV, including that it is a medical emergency that should be addressed immediately to reduce physical and psychosocial impact. Likewise, inter-institutional referral routes should be standardized and monitored, particularly those that provide SGBV case management for the migrant population, and access to HIV prophylactic kits in particular.

- Create synergies to address HIV risk: comprehensive and inter-agency strategies for HIV prevention, detection, and care in this humanitarian crisis need to be developed, disseminated, and implemented. The detection of new cases, which could be facilitated by self-testingand accompanied by timely access to quality healthcare and treatment. The reduction of barriers and stigma related to condom use access areas is essential.

- Reduce barriers for maternal and neonatal healthcare services: publicity about the availability of barrier-free services for maternal, prenatal, delivery, newborn and postpartum care should be increased. It is advisable to provide and have tools and training for healthcare professionals to ensure the provision of healthcare services focused on the needs and circumstances of migrant pregnant women and ensure full implementation of Colombian legislation regarding access to such services.

- Increase the supply and raise abortion service standards: in border areas, migrants have a limited access to abortion services, and even less access when in advanced gestational stages. This demands urgent attention including: capacity building in safe abortion practices according to Colombian guidelines; development of rapid referral systems for women in advanced gestation to other levels or centers of care; design of mechanisms to facilitate access and management of medicines such as Mifepristone and Misoprostol by healthcare personnel, and to group them in a recognized provider network; coordination of advocacy efforts to ensure regulatory compliance, and to ensure, and where necessary enforce, the right to abortion; strengthening of

post-abortion contraception and, in particular, a program for the prevention of unwanted or unplanned pregnancies, targeting the migrant population.

- Guarantee effective access to SRH services for the migrant population: despite the installed capacity of the institutions involved in this assessment, effective and timely access to comprehensive services is not guaranteed at present. Mobilizing and efficiently using resources is necessary to achieve this, as well as eliminating access barriers including xenophobia, adoption and implementation of national guidelines and broad adoption of the MISP, including an informed evidence base to guide actions.

- Apply differential approaches in addressing migrants' SRH needs: there are great inequalities between Venezuelan irregular or circular migrants compared to regular migrants, migrants in regularization process, and Colombian returnees. SRH responses and interventions should be differentiated according to the target population to ensure that services provided align with the needs and circumstances and depending particular populations, especially the most vulnerable and marginalized.

- Strengthen healthcare provider capacity in border areas: some of the detected barriers preventing Venezuelan migrants from gaining access to services are attitudinal, reinforced by stereotypes and xenophobia. There is an urgent need to strengthen people-centered care and dignified treatment of migrants by healthcare professionals, while working on dispelling myths and stigma.

Finally, access to basic sexual, reproductive and maternal and neonatal health care services can have a transformative effect, not only on the lives of Venezuelan migrants but also on their families and on health and development indicators in host communities. Sexual and reproductive healthcare in humanitarian crises must be ongoing and without barriers. Meeting the health needs of migrating populations is essential to achieving the 2030 Sustainable Development Agenda and the 2021 Ten-Year Public Health Plan.

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Appendix A: Regulatory framework regarding the Venezuelan migrant population

Colombia's Political Constitution of 1991 sets forth that all residents in the Colombian territory have fundamental rights and duties that must be respected in equal conditions. Article 13 of the Constitution states that "All individuals are born free and equal before the law, shall receive the same protection and treatment from the authorities, and shall enjoy the same rights, freedoms and opportunities without any discrimination based on sex, race, national origin or family, language, religion, political or philosophical opinion". Thus, the Constitutional Court itself has acknowledged that" (...) the fundamental rights guarantee does not depend on the condition as citizen, but on the condition of being human; on being an individual who inhabits the national territory (Ruling T-2010 of 2018).

Colombian migration policy has various instruments, both internationally and at the national level. Among the main international instruments, there are commitments the country has made upon ratifying some of the international law instruments that protect migrant populations, which include:

- Universal Declaration of Human Rights (1948).
- International Covenant on Economic, Social and Cultural Rights (1966).
- Convention on the Elimination of All Forms of Discrimination against Women (1979).
- Convention on International Cooperation on Administrative Assistance to Refugees (1985).
- Convention on the Rights of the Child (1989).
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).
- Resolution of the UN Human Rights Commission 1999/44–Human Rights of Migrants (1999).
- Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (2000).
- Protocol against the Traffic of Migrants by land, sea and air, (2000).

- International Health Regulations (2005) (Colombia Migration, 2013).
- Montevideo Consensus on Population and Development (2013).
- Sustainable Development Goals (2015).

Colombia has adopted a broad regulatory framework to respond to both migration policies and to the recent needs and demands of the migrant Venezuelan population and returning Colombians. In the national order, Article 100 of the Political Constitution of Colombia states that "foreigners will enjoy the same civil rights as Colombians" (Const., 1991). However, to enter Colombian territory" foreigners must submit to the entry, stay and exit requirements imposed by the State through the immigration policy" (Guerra, 2016, p.138).

Document 3603 of 2009 of the National Council on Economic and Social Policy (Conpes), also known as the Comprehensive Migration Policy (Política Integral Migratoria- PIM) gave rise to: i) Law 1465 of 2011 that creates the National Migration System and issues rules for the protection of Colombians abroad; ii) Law 1565 of 2012, which establishes incentives for the return of Colombians living abroad; and iii) Decree 1067 of 2015, which regulates the Foreign Relations Administrative Sector, as well as the migratory flows entering the country (Ciurlo, 2015). Following the unprecedented exodus from Venezuela to Colombia, new regulatory instruments were created, such as:

- Decree 1770 of 2015, declaringa national economic, social and ecological state of emergency for thirty days.
- Decree 1771 of 2015 removing some existing legal restrictions to include people affected by the situation in the Colombia-Venezuela border in the data records of social programs.
- Resolution 5797 of 2017 creatingthe Special Permanence Permit (PEP) in the Colombian territory for Venezuelans.
- Decree 542 of 2018 creating the Administrative Registry of Venezuelan Migrants (RAMV), basic input for the design of a comprehensive humanitarian assistance policy.
- Decree 1288 of 2018 adopting measures to guarantee the access of the individuals registered in the RAMV to the institutional offer and enacts specific measures to respond to the return of Colombians.

National Council on Economic and Social Policy (Conpes) Document 3950 of 2018

On November 23, 2018, the country adopted Document 3950 of the National Council on Economic and Social Policy (Conpes 3950) to identify the care and integration routes for the migrant population from Venezuela and strengthen existing attending institutions. Its action plan includes measures and strategies aimed at: i) addressing health, education, early childhood and labor insertion needs; ii) strengthening attending institutions in border areas and crossings, and responsible for migrant identification and registration, and iii) addressing situations that affect coexistence in areas of immigrant population concentration.

Healthcare and sexual and reproductive health regulations and jurisprudence

Regulations guaranteeing the right of the migrant population to healthcare have been recently issued; the following stand out:

- Decree 2228 of 2017 that provides health insurance to deported Colombians and their families.
- MOH Resolution 3015 of 2017 designating the Special Permanence Permit (PEP) as a valid document for enrollmentin the General Social Security Health System.
- Circulars 012 and 029 of 2017 that establish the register of healthcare for foreigners throughout the country.
- Circular 025 of 2017 that strengthens public health actions to respond to the migration from Venezuela.
- MOH Circular 040 of 2015 that provides health guidelines for the management of temporary accommodations.
- MOH and INS (National Health Institute) Circular 06 of 2018 with guidelines on prevention, attention and public health surveillance of diseases such as measles, rubella and diphtheria.

In the context of the crisis in Venezuela, the Ministry of Health issued the Health Sector Response Plan for Attention to the Immigration Phenomenon of 2018,

comprising three basic components: i) public health management, ii) healthcare strengthening and iii) financing, monitoring and evaluation. This response plan includes provisions for migrants in different immigration status modalities. In the case of non-regular migrants, the Ministry determines that certain groups should be prioritized for the progressive deployment of collective and individual actions in charge of the territorial entities and depending on resource availability. Thegroups to be prioritized are:

- Pregnant and lactating women (including cases of extreme maternal morbidity)
- Children and adolescents (including cancer care in this population).
- Transmissible events (deemed as of high externality): HIV and STIs, tuberculosis, and vaccine preventable conditions such as measles, rubella, diphtheria and polio, among others.
- Vector-transmitted diseases: malaria, chagas disease, dengue, leishmaniasis and yellow fever.
- Violence, especially gender-based, exploitation in all its forms and human trafficking, among others.
- Chronic conditions usually decompensated in migration: diabetes, hypertension and asthma, as well as mental illnesses and epilepsy, given the high psychosocial risk that occurs in this population.

Likewise, the response plan determines that care options such as vaccination and contraception will be considered.

In 2017, the MOH issued Circular 025 of 2017 to strengthen public health actions and responses to the situation of population migration coming from Venezuela (MOH, 2017, p.1). Among other issues, this circular insists on strengthening sexual and reproductive rights (number 1.6.2) and refers to compliance with current regulations by the departmental, district and municipal territorial entities.

Jurisprudence of the Constitutional Court

In turn, the Constitutional Court has also ruled on the guarantee of the migrants' right to healthcare. In ruling T-210 of 2018, the Court recognized that health is a fundamental right that cannot depend on migratory status. Nevertheless, the Court has clarified that following the constitutional obligation of respecting the State's duties, migrants may only have access to enrollment in the General Social Security Health System if they have regularized their immigration status, reason

for which they must have an identification document valid in Colombia. Thus, as a measure to guarantee migrants' enrollment in the system, Resolution 3015 of 2017 was issued, through which the Ministry of Health incorporated the Special Permanence Permit (PEP) as a valid identification document in the information database of the Social Protection System.

Additionally, the Court recognizes that based on social security regulations such as Law 1438 of 2011, no person, regardless of their payment capacity, may be denied basic emergency care. The definition of emergencies in migration contexts has been broadened by the Constitutional Court itself, stating that emergencies imply "not only to save human beings from the very fact of dying, but to protect them from any circumstance that makes their life unbearable and undesirable, and that prevents them from displaying the faculties they have been endowed with to develop in society in a dignified manner "(Ruling Su-677 of 2017 and T-210 of 2018). Likewise, it is understood that this emergency care" (...) seeks to preserve life and prevent critical, permanent or future consequences through the use of health technologies for the care of users who present physical, functional or mental impairment, for any cause, with any degree of severity that compromises their life or functionality" (Ruling Su-677 of 2017).

In the specific case of the sexual and reproductive health of migrants, the Court ruled in the case of an irregular migrant who was pregnant, and the health system considered she was not in a medical emergency. In this regard, the Court stated that such care is directly connected to women's dignity and that "(....) even if pregnancy has not been medically classified as an emergency, the petitioner did require urgent attention, because her health was at high risk due to the physical and psychological consequences arising from being pregnant and amid an irregular mass migration process" (Ruling SU-677 of 2017).

In ruling T-697 of 2016, the Constitutional Court studied the case of a pregnant minor who was not informed of her right to terminate her pregnancy and, despite being an alleged victim of human trafficking, by decision of the Colombian authorities was deported to Venezuela. In this case, the Court determined that nationality could not be a criterion for violating her sexual and reproductive rights.

Regulations for HIV prevention and treatment

Besides the HIV prevention-related actions, goals and indicators of the National Policy on Sexuality, Sexual Rights and Reproductive Rights (2014) and in the Ten-year Public Health Plan (PDSP), there are regulations in place in Colombia associated to its management (such as Decree 1543 of 1997), elimination (Conpes document 3918 of 2018), and prevention, diagnosis and treatment (Resolution 3442 of 2006).

Likewise, the country has technical and circular documents for the use of the post-exposure prophylaxis kit for HIV, STIs and emergency contraception for survivors of sexual violence; for the elimination of mother-to-child HIV transmission (Circular 016 of 2012); and for the safe transfusion of blood (Circular 0082 of 2011), among others.

Regulations for the prevention of and care forgender-based violence

Colombia has a robust regulatory framework on this matter. Besides Law 294 of 1996, which enacts regulations to prevent, remedy and punish family violence -and Law 360 of 1997- which modifies the penal code in relation to crimes sexual freedom and decency -a large number of laws, administrative acts, public policy guidelines and jurisprudence have been added. In this regard, the following are particularly relevant:

- Resolution 412 of 2000, Care guidelines for abused minors and women
- Law 984 of 2005 approves the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women adopted by the UN in 1999.
- Law 1257 of 2008 dictates regulations to increase awareness, prevent and punish forms of violence and discrimination against women and reforms the Penaland Penal Procedure Codes and Law 294 of 1996, as well as its regulatory decrees (Decrees 4463, 4796 and 4799 of 2011).
- Law 1542 of 2012 guarantees the protection and the diligence of the authorities in the investigation of alleged violent crimes against women, and eliminates the option to object or desist crimes of domestic violence and failure to provide food assistance.
- Resolution 459 of 2012: Model and Protocol of Comprehensive Healthcare for Victims of Sexual Violence that recognizes care for survivors of violence as a medical emergency and states that emergency contraception and abortion must be part of basic healthcare.
- Social Conpes document 161 of 2013 creates the National Gender Equity Policy.
- Writ 028 of 2013 implements the program for the prevention of sexual violence against displaced women and comprehensive care for survivors.
- Law 1761 of 2015 is a milestone that typifies femicide as an autonomous crime.

- Ruling 754 of 2015 provides a protocol for comprehensive and free healthcare for survivors of sexual violence.

- Unifying ruling 659 of 2015 defines the action of protection against judicial orders for the special protection of women and the fight against gender-based violence.

Furthermore, regulations associated to human trafficking and sexual exploitation (Law 679 of 2011, Law 1336 of 2009, Law 985 of 2005, Law 1329 of 2009) and sexual violence (Law 1146 of 2007 and Law 1719 of 2014) are in place, emphasizing on prevention and comprehensive care for women, children and adolescents.

Profamilia