USAID
FROM THE AMERICAN PEOPLE

GENDER AND SOCIAL INCLUSION ANALYSIS COLOMBIA

May 2021

Local Health System Sustainability Project – Colombia Activity

Task Order 1, USAID Integrated Health Systems IDIQ

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity. In Colombia, the project is known as *Comunidades Saludables* (Healthy Communities).

Recommended citation: Otero Galindo, Pilar. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. May 2021. *Gender and Social Inclusion Analysis*. Rockville, MD: Abt Associates.

Date: May 2021

Submitted to: Nora Maresh, Deputy Director
Venezuela Response and Integration Office (VRIO)
USAID Colombia

USAID Contract No: 7200AA18D00023 / 7200AA19F00014

This report was made possible by the support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of the authors and do not necessarily reflect the views of USAID or the United States government.

TABLE OF CONTENTS

ACRONYMS

ADS.....Automated Directives System

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

BDUA.....Base de Datos Única de Afiliados (Unique Affiliates Database)

CONPES.....Consejo Nacional de Política Económica y Social (National Council for Economic and Social Policy)

DANE.....Departamento Administrativo Nacional de Estadística (National Administrative Department of Statistics)

DNP.....Departamento Nacional de Planeación (National Planning Department)

EPS.....Entidades Promotoras de Salud (Health Promoting Entities)

GIFMM.....Grupo Interagencial sobre Flujos Migratorios Mixtos (Interagency Group on Mixed Migration Flows)

GESI.....Gender Equality and Social Inclusion

IPS.....Instituciones Prestadoras de Servicios de Salud (Health Service Provider Institutions)

STI.....Sexually Transmitted Infections

VTP.....Voluntary Termination of Pregnancy

LGBTI.....Lesbian, Gay, Bisexual, Trans and Intersex

MSPS.....Ministerio de Salud y Protección Social (Ministry of Health and Social Protection)

PDSP.....Plan Decenal en Salud Pública (Ten-Year Public Health Plan)

PEP.....Permiso Especial de Permanencia (Special Residence Permit)

PIC.....Plan de Intervenciones Colectivas (Collective Intervention Plan)

MISP.....Minimum Initial Service Package for Reproductive Health in Humanitarian Crisis Situations

PND.....Plan Nacional de Desarrollo (National Development Plan)

POS.....Plan Obligatorio de Beneficios (Mandatory Benefits Plan)

RAMV.....Registro Administrativo para los Migrantes Venezolanos (Administrative Registry for Venezuelan Migrants)

RIPS.....Registros Individuales de Prestación de Servicios de Salud (Individual Records of Health Services Provision)

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

SISBEN.....Sistema de Selección de Beneficiarios para Programa Sociales (Social Programs Beneficiary Selection System)

SRH.....Sexual and Reproductive Health

ICTs.....Information and Communication Technologies

USAID.....United States Agency for International Development

EXECUTIVE SUMMARY

The Colombian government faces a double challenge: on the one hand, providing social services to Venezuelan migrants fleeing their country due to social, political and economic instability and, on the other hand, responding to the COVID-19 pandemic.

As of September 2020, there were 1,715,831 Venezuelan migrants in Colombia (Colombian Migration, 2020), of which 769,207 are regular migrants[1] who entered the country legally and thus have a Special Residence Permit (PEP), while 946,624 are illegal migrants[2] (Colombian Migration, 2020) who do not have PEP.

The PEP entitles regular migrants to join the General Social Security Health System (SGSSS) and thus access the health services included in the Mandatory Benefits Plan (POS). However, only 39% of migrants with a PEP are enrolled with the SGSSS (ADRES, 2020), while irregular migrants are not entitled to enroll in the SGSSS, so they access it largely through emergency services.

To address these challenges, the Healthy Communities program of the United States Agency for International Development (USAID) will support the Colombian Government in strengthening the Colombian health system to include Venezuelan migrants and Colombian returnees and will increase its capacity to respond to current and future emergencies, including but not limited to the COVID-19 pandemic.

To achieve its objective, the Healthy Communities Program has defined four strategic components:

- Governance and management of the health response to the migrant population
- Promote sustainable financing of health services for migrants and host communities
- Empower the mechanisms to increase migrant and host communities access to appropriate and high-quality healthcare services
- Empower the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic

This gender and social inclusion analysis has been carried out under the requirements of the program and *taking into account the definition given by the Gender Equality and Social Inclusion* Strategy (GESI). The analysis seeks to gain an understanding of the gaps and disparities that exist based on gender differences related to the migrant population and host communities' access to health services, as well as the impact of these different needs on the health outcomes of women, men, and children.

The GESI analysis reviewed the information within the framework domains established by USAID Automated Directives System (ADS 205), namely: laws, policies and institutional practices; cultural norms and beliefs; gender roles, responsibilities and use of time; access and control of assets and resources; power and decision-making patterns. Each of these domains will be mentioned in the recommendations to project's four objectives.

[1] Regular migrant status "*corresponds to those people who entered the country through one of the checkpoints with an official document and are within the time limits determined by current regulations. This category also includes holders of documents such as visas and immigration cards, as well as recipients of the PEP who are authorized to remain in the territory for up to two years*". (CONPES 3950, 2018)

[2] Irregular migrant status "*includes individuals who exceeded the authorized time limit, as well as those who entered through unauthorized points of entry and are not registered in the RAMV.*" (CONPES 3950, 2018)

Between August and November 2020, the gender equality and social inclusion specialist conducted a review of 54 bibliographic sources, conducted 23 interviews, and four meetings with the program's target leaders to answer the analysis questions, counting on the perception of those from the four territories involved in the project during the first year of implementation: Bogotá, Cundinamarca; Cali Valle del Cauca; Riohacha, La Guajira; and Cúcuta, Norte de Santander.

FINDINGS

Objective 1: Governance and management of the health response to the migrant population

- The objective's main hurdle is the lack of gender and health policies, as well as the lack of migration and health policies with a focus on gender and social inclusion.
- There is very low participation on the part of the migrant population, women, and other vulnerable populations in the MSPS policies definition, as well as their territorial implementation.
- There is a lack of coordination between the national and territorial levels when implementing gender and migration initiatives.

Objective 2: Promote sustainable financing of health services for migrants and host communities

- The main barrier to this objective is the lack of resources to achieve enrollment in the SGSSS of the irregular population.
- Women have less financial means to join the SGSSS.
- The Government's strategy in terms of healthcare for the irregular migrant population is based on payment for each event (emergency care), which is more expensive for the system.

Objective 3: Empower the mechanisms to increase migrant and host communities access to appropriate and high-quality healthcare services

It was found that:

- The main barrier to this objective is that the health system has not achieved an adequate implementation of primary healthcare strategies for the Colombian population, which is heightened when it comes to the migrant population, especially women and vulnerable populations
- In general, the migrant population has little access to information about healthcare services, and women, in particular, also lack information on services related to gender-based violence (GBV).

Objective 4: Empower the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic

- During the COVID-19 emergency, cases of discrimination and xenophobia by health personnel toward the migrant population increased, as well as cases of GBV.
- The migrant population needs to have more and better access to information on both the SGSSS and on measures to prevent and adequately treat COVID-19.

RECOMMENDATIONS

Institutional empowerment

- There is a need for a migration and health policy with a gender and social inclusion approach, establishing specific indicators at the national and local levels.
- There needs to be better coordination between public, national, and territorial institutions, and social and international cooperation organizations concerning the efforts being made to guarantee the right to health of the migrant population and host communities.
- Healthcare institutions need to implement gender and differential approach strategies, where, in addition to creating spaces for training and awareness-raising of all their staff on gender, human rights, and migration issues, there is also an effort to increase the number of human resources working on these issues.

Organizational and community empowerment

- Social organizations need to strengthen their capacities in terms of primary healthcare, community health, and GBV in order to more effectively support the migrant population in general, women, and other vulnerable populations with whom they work.
- There need to be more spaces for participation and dialogue between national and territorial public institutions, and the migrant population, and host communities, so that they may more accurately communicate the difficulties, needs, and risks they face when accessing health services, as well as to contribute to develop initiatives to improve the guarantee of the right to health.
- The migrant and host communities need to improve their knowledge on gender, human rights, and associativity, to achieve a more active and effective participation in the areas for constructing public policies and decision-making.

Information and communication

- The migrant population needs to have a better knowledge about their rights and the mechanisms through which they can claim them (paths, channels, documents).
- Awareness campaigns are needed to reduce discrimination and xenophobia outbreaks against migrants in general, and women and vulnerable populations in particular.
- As a priority, we need to carry out a more in-depth health definition of the needs of the migrant population (men, women, and vulnerable populations), as well as update the databases to have precise information on causes of morbidity and mortality.

Insurance, primary healthcare and community health

- A real solution must be found to guarantee that the irregular migrant population is insured through the SGSSS, as this is the only effective way for them to obtain adequate healthcare.
- Primary healthcare services must be strengthened, integrating an approach based on health promotion and prevention.

NOTE: This analysis was carried out with a deadline set on January 31, 2021, which is why there is no information related to the announcement made by the Colombian national government on the Venezuelan Migrants Temporary Protection Statute (ETPV).

1. INTRODUCTION

1.1 Background

The Colombian government faces the double challenge of providing social services to people from Venezuela who emigrate from their country due to social, political, and economic instability and, at the same time, respond to the COVID-19 pandemic since March 2020.

Colombia's Constitution grants everyone the right to health, and the Colombian government is committed to integrating migrants and Colombians returning from Venezuela into the healthcare system without overburdening the receiving communities. At the same time, the COVID-19 pandemic is putting pressure on a healthcare sector that already has limited resources, and it is causing an economic recession.

There are two factors that add complexity to the challenge of sustainably meeting the healthcare needs of migrants. First, those departmental and municipal health institutions, which are responsible for implementing the national health policy, have a highly variable capacity to integrate migrants into the SGSSS; this is particularly visible among those jurisdictions along the Venezuelan border that have high concentrations of migrants and low development levels. Second, there are different types of migration, each with specific healthcare needs and challenges in accessing the health system.

As of September 2020, there were 1,715,831 migrants in Colombia(Migración Colombia, 2020), of which 769,207 are regular migrants who formally entered the country and have a PEP, which entitles regular migrants to enroll in the SGSSS and thus access the health services included in the POS. Although they have the right to enroll, only 39% of migrants with PEP are enrolled in the SGSSS (ADRES, 2020).

On the other hand, on that same date, there were approximately 946,624 irregular migrants (Colombian Migration, 2020), who are undocumented and largely access the SGSSS through emergency services. Of the total migrant population in the country, only 17.3% is enrolled in the SGSSS (ADRES, 2020) – (Migración Colombia, 2020).

To address these challenges, the USAID Healthy Communities program provides support toward strengthening the Colombian health system to integrate Venezuelan migrants and Colombian returnees and will increase its capacity to respond to current and future emergencies, including but not limited to the COVID-19 pandemic. The Healthy Communities program works with the Colombian government and local teams, focusing on four strategic components:

- Governance and management of the health response to the migrant population
- Promote sustainable financing of health services for migrants and host communities
- Empower the mechanisms to increase migrant and host communities access to appropriate and high-quality healthcare services
- Empower the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic

The GESI Strategy was developed within the framework of the Program, and it aims to integrate a gender approach and a differential approach in all project activities to maximize the effectiveness of project planning and empower the health systems with an inclusive perspective.

The Strategy for the project is consistent with the USAID Gender Equality and Women's Empowerment Policy and other key Agency and U.S. government policies aimed at guiding project activities, such as the 205 Automated Directives System(USAID - ADS 205, 2017).

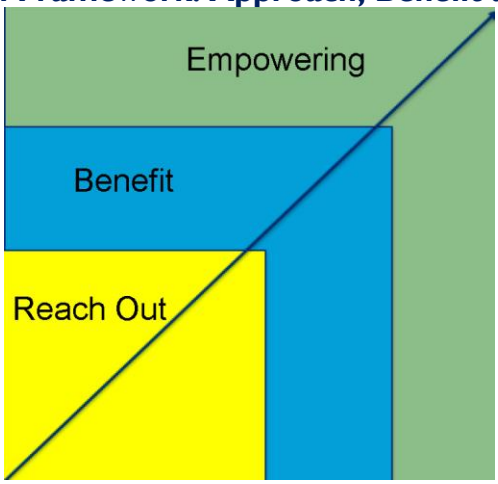
The GESI Strategy has six strategic components for its measures, namely:

- Statement of commitment to GESI by its partner countries
- Conduct a Gender Analysis
- Focus on staff development (recruitment, training, GESI focus points, etc.)
- Integrate GESI into planning and budgeting
- Include GESI in the monitoring, evaluation, and knowledge management
- Development of local capabilities.

Thus, this analysis constitutes the second step of the *GESI Strategy for Colombia* and is aimed at gaining an understanding of the gaps and disparities that exist based on gender differences and the migrant population's access to health services, as well as the impacts of these different needs on the health outcomes achieved by women, men, and children. The ultimate goal is to propose GESI measures for the four objectives of the project in Colombia.

Thus, the *GESI Strategy for Colombia* seeks to integrate gender equality and social inclusion issues into the project through an approach that not only seeks to reach women and other vulnerable populations but also to benefit and strengthen their capacity to make and implement strategic decisions to improve their and their communities health outcomes. The analytical framework shown in Figure 1 is used to achieve the desired results of approach, benefit, and empowerment.

Figure 1: Analytical Framework: Approach, Benefit and Empowerment



Source: GESI Strategy for the Healthy Communities Project - Colombia

1. Reach: These measures aim to have men and women participate in activities in a meaningful way, as well as to be included in the data collection.
2. Benefit: The measures are aimed at both men and women to benefit from the project's interventions, such as access to information, access to services, etc.
3. Empowering: These measures aim to empower women, men, and vulnerable populations so that they can make strategic life decisions that had previously been denied to them and put them into practice

In this sense, no individual intervention alone will lead to the empowerment of the migrant population and host communities. Each measure is a fundamental piece toward greater equality and greater empowerment of populations. Thus, this analysis seeks to provide project recommendations in order to achieve a real transformation of the situations that generate social inequalities.

1.2 Methodology

The general objective of the gender and social inclusion analysis of the Healthy Communities program is to identify the factors that contribute to gender barriers that affect health and the necessary areas of action to guarantee that men, women, and socially excluded groups have the same opportunities to participate and benefit from the project's activities.

Implementing the recommendations will contribute to the project's overall goals of providing support toward empowering the Colombian health system to integrate Venezuelan migrants and Colombian returnees, and will increase its capacity to respond to current and future emergencies, including but not limited to the COVID-19 pandemic.

The four questions considered in this analysis are directly related to the objectives of Healthy Communities:

Learning Questions	Project Objectives
What are the main gender and social-inclusion barriers to empower the governance and management of the health response to migrants?	Objective 1
What are the main gender and social-inclusion barriers linked to promoting sustainable financing of health services for migrants and host communities?	Objective 2
What are the main gender and social-inclusion barriers to empower the mechanisms to increase access to adequate and high-quality healthcare services for migrants and host communities?	Objective 3
What are the main gender and social-inclusion barriers to empower the capacity of the health system to respond to current and future crises, including the COVID-19 pandemic?	Objective 4

The gender equality and social inclusion specialist carried out an analysis of gender equality and social inclusion between September and December 2020. Information was collected on progress, gaps and opportunities in terms of gender and social inclusion in Colombia, using the following tools:

1. Review of secondary information literature, including public policy documents on health, gender, and migration as well as studies on the same topics from international organizations, universities, NGOs, articles, and other publications on gender, health, and migration (Annex 1: Bibliographic Review List)
2. Semi-structured interviews with key members from the Ministry of Health and Social Protection; the Presidency of the Republic; representatives of the regional governments and health institutions in Bogotá, Cali, Riohacha and Cúcuta; international cooperation organizations and national and local civil society organizations, including a migrant women's organization based in Riohacha. Table 1 provides more information on the 27 interviews and meetings that took place (20 women and 7 men).

The five domains of the Gender Analysis Framework included in USAID ADS 205 were considered for analyzing the data, namely:

- Institutional laws, policies and practices: The laws include formal statutory laws and informal and customary legal systems. Policies and regulations include formal and informal rules and procedures adopted by public institutions to make decisions and launch public actions. Institutional practices may be formal or informal and include behavior or standards related to human resources (hiring and firing), professional conduct (workplace harassment), and the like.
- Cultural norms and beliefs: Every society has cultural norms and beliefs (often expressed as gender stereotypes) about what are the appropriate qualities, life goals, and aspirations of men and women. Gender norms and beliefs are influenced by perceptions of gender identity and expression and are often supported and embedded in laws, policies, and institutional practices.
- Gender roles, responsibilities and time use: The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is the central social structure that characterizes male and female activity.
- Accessing and controlling assets and resources: It examines whether women and men own and/or have access and the capacity to use productive resources: assets (land, housing); income; social benefits (social security, pensions); public services (health, water); technology and necessary information to be a fully active and productive member of society.
- Power and decision-making patterns: It examines the capacity of women and men to decide, influence, and exercise control over material, human, intellectual and financial resources, in the family, the community, and the country. It also includes the ability to vote and run for public office at all levels of government.

Table 1. Summary of interviews conducted

Tool	Type of key players	Number
Semi-structured interviews	• National public entities • International cooperation organizations • Local governments • National civil society organizations • Local civil society organizations • Health institutions SUBTOTAL	2 3 4 6 3 6 23 (20 women and 3 men)
Meetings held	• Objective leader 1 Healthy communities project • Objective leader 2 Healthy communities project • Objective leader 3 Healthy communities project • Objective leader 4 Healthy communities project SUBTOTAL:	1 1 1 1 4 (4 men and 0 women)
TOTAL		**20 women and 7 men**

It is important to mention that requests for interviews were made at the institutional level, without specifying the need to specifically speak with a man or a woman, but rather in terms of people who knew/worked with gender and/or migration issues. In this sense, we found that there are more women

than men working on gender issues at all levels (national, territorial, and international). Out of 100% of the interviews and meetings conducted, 74.1% were with women and 25.9% with men.

As a result of the GESI analysis, recommendations are presented so that the country may advance in the inclusion of a gender and differential approach as part of a public migration policy and, as such, the recommendations are focused on the four strategic objectives of the Healthy Communities project.

2. FINDINGS

2.1 Laws, policies and institutional practices in the health sector

2.1.1 Gender and migration policies

As shown in Table 2, the existing regulatory framework in the country is broad. It should be noted that Colombia has a document issued by the National Council of Economic and Social Policy (CONPES) 3950, which defines Colombia's public policy on migration. Moreover, we have the Health Sector Response Plan to Migration; however, this plan should not be viewed as a public policy on migration and health since its fundamental focus is the situation in the border areas, not the phenomenon of migration per se

According to the perception of the civil society organizations interviewed, there is a fundamental need for a public policy on migration and health that will focus on gender equality and social inclusion to achieve a coordinated effort for improving healthcare for the migrant population.

> "*The migrant population must be included in the health policy; since the country was not a recipient of migration, the health system focused on the Colombian population, but the assumptions have changed. What we need is a migration and healthcare policy*"
>
> —international Organization team member

> "*... There is no clear and comprehensive policy addressing the rights of migrants, and specifically women ... the existing indicators do not allow for clear monitoring of what is happening in the territory ... the staff from local and national governments lack training on the rights of migrants, even though the country's status as a recipient of the migrant population has changed*"
>
> —Women's NGO team member

> "*There's been little discussion about the issue of migration and gender, and how the response to migration can reinforce gender stereotypes has not been reviewed*"
>
> —National NGO team member

Table 2. Legal Framework on Gender and Migration

Standard/Policy	Purpose	Responsible Entity
Law 985 of 2005	The law establishes measures against human trafficking as well as regulations for the care and protection of victims. Its purpose is to adopt prevention, protection, and assistance measures necessary to guarantee human rights for the victims and potential victims of human trafficking, both residing or transferred within the national territory, as well as Colombians abroad, and to empower governmental measures against this crime.	Ministry of the Interior
Law 1098 of 2006	It establishes the Children and Adolescents Code. The purpose of this act is to guarantee children and adolescents the full and harmonious development they are entitled to so that they may grow up within their families and communities in an environment of happiness, love, and understanding. The recognition of equality and human dignity must prevail, free of any discrimination.	Colombian Institute of Family Welfare

Standard/Policy	Purpose	Responsible Entity
Law 1257 of 2008	It establishes standards of awareness, prevention, and punishment of forms of violence against women. The purpose of this law is to adopt regulations that guarantee a life free of violence for all women, both in the public and private areas; the exercise of rights as recognized by the domestic and international legal systems; access to the administrative and judicial procedures for their protection and treatment; and adopting public policies necessary for their implementation.	Council on Equality for Women
CONPES 140 of 2011	Amendment to CONPES 91 of 2005 "Colombia's Goals and Strategies for Achieving the 2015 MDGs". Objective 3: Promote gender equality and the empowerment of women.	National Planning Department
Resolution 459 of 2012	To adopt the Protocol and Comprehensive Healthcare Model for Victims of Sexual Violence. The purpose of this resolution is to provide health teams with a methodological and conceptual tool containing the basic and indispensable criteria for a comprehensive approach to victims of sexual violence that guarantees quality care and the restoration of victims' rights.	Ministry of Health and Social Protection
Law 1542 of 2012	It was enacted to ensure protection and diligence by the authorities when investigating alleged crimes of violence against women. Also, under this law, domestic violence and alimony non-payment cases no longer rely on victim-initiated complaints, and the charges cannot be dropped	Superior Council of the Judiciary and Office of the Attorney General of the Nation
Ten-Year Public Health Plan (PDSP) 2012 – 2021	Its objective is to guarantee the effective enjoyment of the right to health; improve the living and health conditions of the population; achieve zero tolerance in terms of preventable morbidity, mortality, and disability.	Ministry of Health and Social Protection
Borders for Prosperity Plan 2013	Its objective is to promote the social and economic development of the populations living on the country's land and sea borders through generating economic opportunities and social inclusion, while strengthening integration with neighboring countries.	Ministry of Foreign Affairs
CONPES 161 of 2013	Gender equality for women	High Council on Equality for Women
National Policy on Sexuality, Sexual Rights and Reproductive Rights of 2014	Its objective is to guide the development of sectoral and intersectoral measures in matters of sexuality and to guarantee the exercise of sexual and reproductive rights, within the framework of primary healthcare.	Ministry of Health and Social Protection
Law 1761 of 2015	Whereby the criminal offense of femicide is created as an autonomous crime and other provisions are enacted	Superior Council of the Judiciary and Office of the Attorney General of the Nation
Resolution 5797 of 2017	It created a Special Residence Permit	Ministry of Foreign Affairs
Decree 866 of 2017	Whereby Chapter 6, Title 2, Section 9, Book 2 of Decree 780 of 2016 - Sole Regulatory Decree of the Health and	Ministry of Health and Social Protection

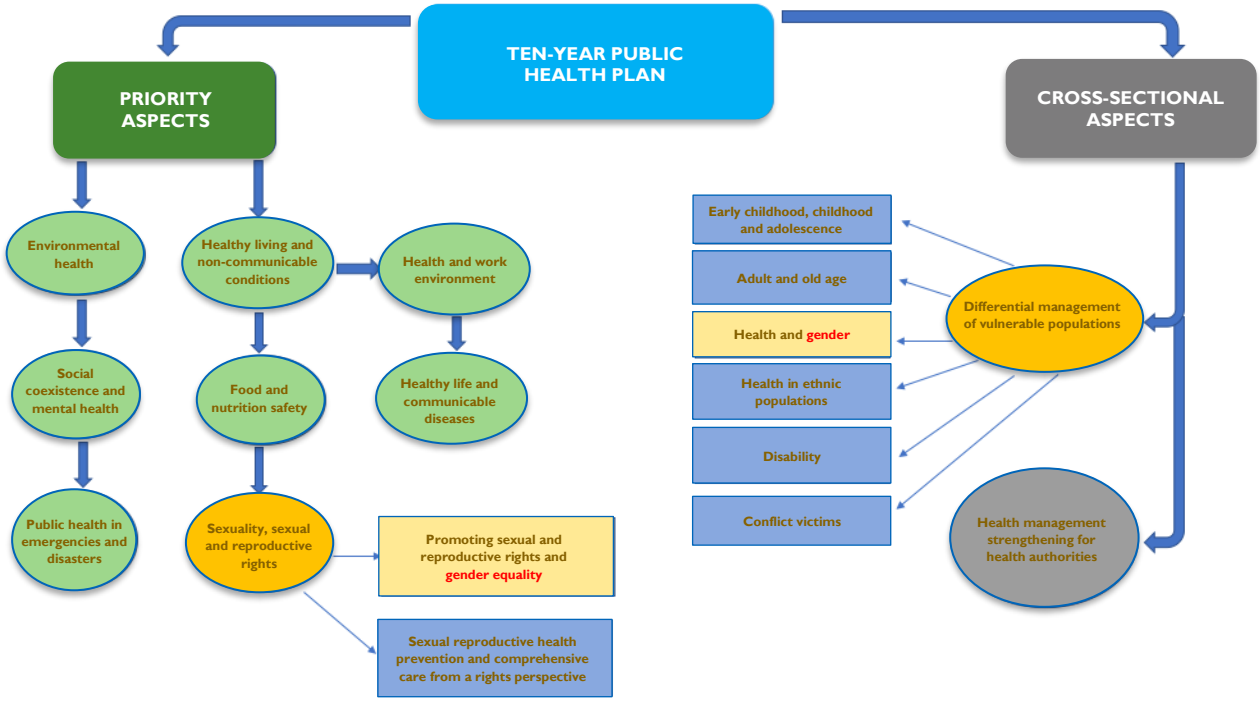
Standard/Policy	Purpose	Responsible Entity
	Social Protection Sector regarding the transfer of resources allotted to initial emergency care provided in Colombian territory to nationals of border countries is replaced	
Decree 1288 of 2018	Whereby measures to guarantee access by persons registered in the Administrative Registry of Venezuelan Migrants to the institutional offer, as well as other measures regarding the return of Colombians are enacted	Border Management of the Presidency of the Republic
CONPES 3950 of 2018	Healthcare Strategy Aimed at Migration from Venezuela	Border Management of the Presidency of the Republic
2018 Health Sector Response Plan to Migration	Its objective is to manage the health response to situations generated by migration in the receiving territorial entities, to develop relevant strategies, strengthen capabilities, promote social coexistence, and mitigate the impact during emergencies through the coordinated action of sector agents, including communities, other sectors, international agencies, and other organizations.	Ministry of Health and Social Protection

Furthermore, the country has established important initiatives to make gender issues part of health measures, as shown in Table 2. Such is the case of the *Ten-Year Public Health Plan (PDSP)* 2012 – 2021, in which the issue of gender is part of a component of the priority aspect "Sexuality, sexual and reproductive rights"; and part of the cross-sectional aspect "Differential management of vulnerable populations," if it is included as a component (See Figure 2). Notwithstanding the foregoing, a bigger effort is still required to include gender as a strategic axis of public health, as it is not considered a priority or as a cross-cutting dimension of the *PDSP 2012 – 2021*.

> "…*There is no specific policy aimed at health rights with a gender perspective. Within the framework of Law 1257, state actions have been developed, but public policies as such have not".*
>
> —Women's NGO team member

> "Law *1257 is 12 years old, and there is no adequate follow-up, no compliance, no actions, no socialization with women"*
>
> —Women's NGO team member

Figure 2: Inclusion of the Gender Approach in the PDSP 2012 – 2021



Source: Prepared by the healthy communities gender equality and social inclusion specialist, based on the review of (Ministerio de Salud y Protección Social, 2013)

On the other hand, more than half of the interviewees who mentioned the issue of sexual and reproductive health considered that gender actions in public health have largely focused on strengthening the reproductive role of women (priority attention to maternity health issues). This approach has left aside issues such as sexual health, access to contraceptives, voluntary termination of pregnancy (VTP), and gender-based violence, among others.

> "… *In general, health services are full of gender stereotypes that affect access to services such as VTP, sexual and reproductive health, obstetric health. There is a lot of xenophobia. There is a cultural bias that affects women in general and, in particular, those in situations of vulnerability, such as migrants*"
>
> —Women's NGO team member

> "… *Women's rights are not promoted enough, for instance, things such as voluntary termination of pregnancy; more emphasis is placed on maternal health. They fail to mention VTP and promote access to it, much less invite migrant women to attend prevention days*"
>
> —Women's NGO team member

2.1.2 Structure and budget

The management of gender-related issues is currently divided between two areas of the MSPS: the Office of Social Promotion and the Directorate of Promotion and Prevention. The first one is in charge of implementing the healthcare measures contained in article 19 of Law 1257 of 2008, and the second one is in charge of implementing the 2014 National Policy on Sexuality, Sexual Rights, and Reproductive Rights.

Notwithstanding the foregoing, within the structure of the MSPS, established in Decrees 4107 of 2011 and 2562 of 2012[3], there is currently no area officially in charge of gender issues. Therefore, the responsibility within the MSPS regarding the strategic management of health and gender is not clear.

In addition, since there is no office within the MSPS structure for gender issues, it is not possible to allocate exclusive operating resources except for the actions that are included as cross-cutting issues in each of the Ministry's policies.

> "*When allocating resources in local development plans, women at most remain as a transversal approach, which implies that national and territorial investment is not designed for women and their specific needs"*
>
> —Women's NGO team member

> "*For example, there is a different UPC for women of reproductive age, but difficulties persist for women living in rural areas. There is a lack of work on gender-sensitive budgets*"
>
> —National Entity team member

Regarding the handling of migration issues within the MSPS, there is no information on whether there is currently any person/department appointed to handle these issues. However, Decrees 4107 of 2011 and 2562 of 2012, which define the structure of the MSPS, no department was officially in charge of migration issues.

> "*There are budget difficulties to respond to the needs of the migrant population; there is no allocation of resources or a clear regulatory framework that defines responsibilities in allocating resources ... there is neither differential nor gender focus in allocating resources"*
>
> —international Organization team member

> "*There is a giant budget gap when it comes to migrants. Public hospitals, which are the ones that attend migrant emergency cases, have pending debts which create barriers to medical care"*
>
> —National Entity team member

On the other hand, it was found that although the costs of healthcare for the migrant population are lower when it is accessed through insurance, and that access to services per event through the provision of services to the uninsured population implies higher costs(DNP, 2018): the migrant population accesses the SGSSS at a rate of 82.7% per event and 17.3% by insurance (ADRES, 2020) – (Migración Colombia, 2020).

> "*In order to strengthen the preventive health approach, more budget is required. Hospitals are allocated a budget that is insufficient with the aggravating factor that the allocated resources do not reach them"*
>
> —Women's NGO team member

2.1.3 Access to health services

In Colombia, every citizen or foreigner has the right to receive emergency healthcare. In the case of the migrant population, the right to access healthcare services is subject, as is for the Colombian population, to being enrolled in the SGSSS. However, the migrant population faces an additional barrier, since to be able to enroll in the SGSSS they must have a document of legal permanence in the country, i.e., they need

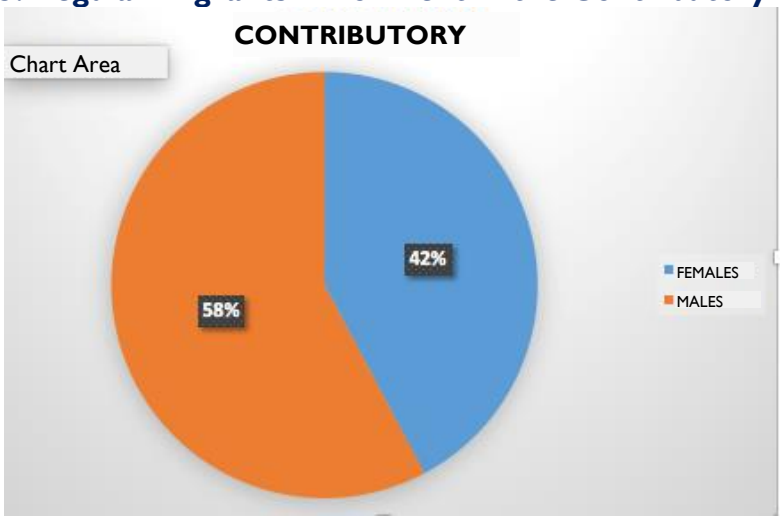
[3] Both decrees are found on the Ministry of Health and Social Protection's website in the organizational chart section.

to be regular migrants (FUPAD, 2019). Of the 1.7 million migrants living in the country as of September 2020 (Migración Colombia, 2020), only 17% are enrolled in the SGSSS (ADRES, 2020).

The regular migrant population, in addition to having a Colombian residence permit, must also have the financial means to be able to enroll in the contribution-based regime; otherwise, they need to answer the SISBEN survey and be classified as level 1 and 2 to qualify for the subsidized regime. Notwithstanding the foregoing, even with a document such as the Special Residence Permit (PEP), only 21.94% of regular migrants are enrolled in the SGSSS (Profamilia-USAID, 2020).

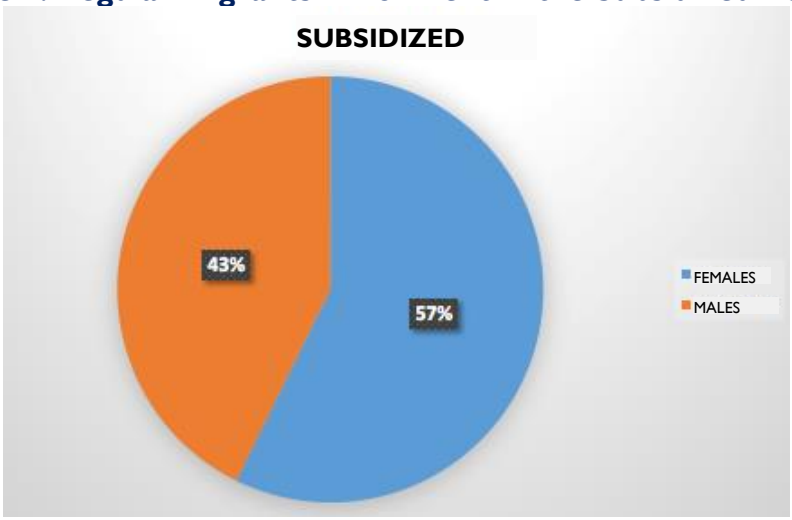
Although in terms of regulations there is no distinction between men and women, nationals or foreigners, the possibility of enrolling in the SGSSS, of the total migrant population affiliated to the SGSSS (297,028) there are more men (150,107) than women (146,921) affiliates (ADRES, 2020) (See Figures 3 and 4).

Figure 3: Regular Migrants Enrollment in the Contributory Regime



Source: (ADRES, 2020)

Figure 4: Regular Migrants Enrollment in the Subsidized Regime



Source: (ADRES, 2020)

According to the perception of more than half of the interviewees who mentioned the subject, the aforementioned situation occurs because women face more barriers both in the enrollment process and in accessing healthcare services.

> "*... there are many prejudices and gender stereotypes that are manifested when health personnel provide care, which are related to very marked gender roles ... when sexual violence occurs, there is also stigmatization"*
>
> —Women's NGO team member

> *"If issues such as the feminization of poverty are taken into account, access to healthcare is more precarious for women".*
>
> —international Organization team member

In the case of the irregular migrant population, since they cannot enroll in the SGSSS, they can only access health services through initial emergency care. If irregular migrants have the means they must pay for the care provided; and if they do not have the ability to pay, the care must be covered by the territorial entity where care is being provided (Profamilia-USAID, 2020).

This prevents the irregular migrant population without the ability to pay from accessing health services such as medical consultations, diagnostic exams, checkups, surgeries and/or treatments.

However, it should be noted that the irregular migrant population can benefit from public health plans that have been developed by municipalities and departments, as well as accessing the services offered by social organizations that work to support the migrant population (FUPAD, 2019).

2.1.4 Sexual and Reproductive Health

In Colombia there is the *National Policy on Sexuality, Sexual Rights and Reproductive Rights* of 2014; however, we find that women in general, and migrant women in particular, do not have sufficient knowledge about their sexual and reproductive rights (Profamilia, 2019).

> "*One of the services where there is more discrimination is in sexual and reproductive healthcare".*
>
> —international Organization team member

Many of the organizations interviewed believe that this is a result of cultural norms and beliefs related to machismo, gender relations and roles, and that as a result, women's access to reproductive rights has been prioritized.

> "…*There are many barriers related to sexual and reproductive health, for example, women who want to access treatments or procedures to avoid having children are faced with the health personnel's views on the woman-motherhood relationship."*
>
> —National NGO team member

In terms of sexual health, issues such as access to contraceptive methods or effective access to VTP, encounter significant obstacles from healthcare provider institutions.

"…*On issues of sexual and reproductive health there is work to be done on VTP. Gender roles continue to be perpetuated..."*

—National Entity team member

It is worth mentioning that there is a lack of coordination between the health departments and the gender/women departments at the territorial entities. For example, one of the territorial team members interviewed- in charge of gender issues-responded the following when asked about existing rights for women regarding access to health services:

"*I don't know, the truth is I don't know the specific law. I don't know it, because I know about* ***sexual and reproductive rights****, since* ***they are the matters that concern the female population****; other than that, I don't know specifically what the laws are.*"

—Territorial Entity team member

The migration process "*creates dynamics that directly affect the sexual and reproductive rights of migrants, especially women, girls, and boys. This is reflected in the rise of sexual violence, the limited availability of contraceptive methods, a higher number of unwanted pregnancies, the increase in unsafe abortion rates, and sexually transmitted infections (STIs), among other things*". (Profamilia, 2019, p. 15).

Greater and better comprehensive sexual education is essential, as well as greater knowledge on the part of the migrant population and organizations about the Minimum Initial Service Package for Sexual and Reproductive Health during Humanitarian Crisis Situations (PIMS) and other sexual health services offered by health institutions (Profamilia, 2019).

2.1.5 Gender-based violence

The country has made significant progress in including GBV as a public health issue, which is demonstrated by the enactment of Law1257 of 2008, the creation of the healthcare model for victims of sexual violence, and the creation of the Gender Violence Information System (SIVIGE). The main challenge in this matter is to achieve effective care for victims of gender violence.

"*In terms of sexual violence, care is needed to prevent unwanted pregnancies, abortions, and emergency contraception, as well as the psychosocial and/or mental healthcare that the victims require*".

—Civil Society Organization team member

Additionally, there is a need for greater dissemination of the existing care systems, both at the justice and health levels.

"*Women ... are not aware of GBV, which are services that all female victims can access regardless of their nationality, and there is no information about the risks of migration, such as xenophobia or human trafficking*".

—Women's NGO team member

"*The GBV focus has been turned into a judicial system: first people are advised to report and then seek healthcare, and sometimes not to seek healthcare at all. The police don't have enough training in GBV issues, and that ends up generating health consequences on the affected women*".

—Civil Society Organization team member

"…it was found that the information that migrants receive is not accessible, and when it is, it is only related to security and regularization issues. There are no clear mechanisms for informing migrants that they have rights, regardless of their immigration status. "They are not aware of GBV, which are services that all female victims can access regardless of their nationality, and there is no information on the risks of migration, such as xenophobia or human trafficking".

—Civil Society Organization team member

It is possible that information is being underreported because migrant women —most of them irregular—fear the possible consequences of being included in the official information systems once they enter the country (USAID - ONUMUJERES, 2020).

According to SIVIGE, as of September 15, 2020, there have been 3,197 cases of GBV against the migrant population, of which 57% of the victims are of African descent, and 31% of the victims belong to the indigenous population.

"*Reprimanding is done through violence. Violence has become a corrective method: the aggressor feels no guilt, nor feels shame or remorse, "if I hit her, it is because she did something wrong, and as a man, it is up to me to set her straight...*"

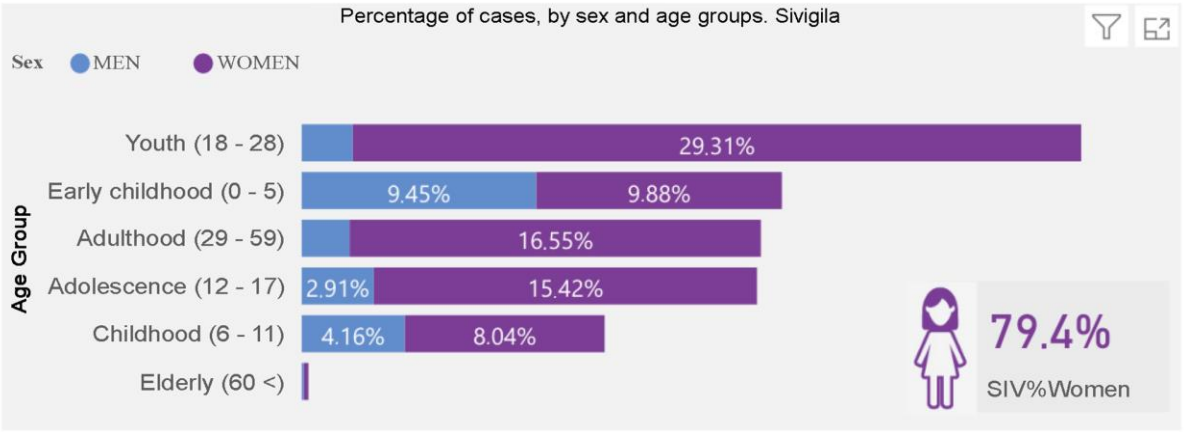
—Territorial Entity team member

We also found that the COVID-19 pandemic increased the number of cases of domestic violence (See Figure 5), which is why there was an increase in calls to 155[4] in 2020 as compared to 2019 (USAID - ONUMUJERES, 2020).

"*...there is a high component of psychological, physical and sexual violence, and these were the most reported during the pandemic lockdown...*"

—Territorial Entity team member

Figure 5. GBV Cases Among the Migrant Population as of 09/15/2020, by Sex and Age Group

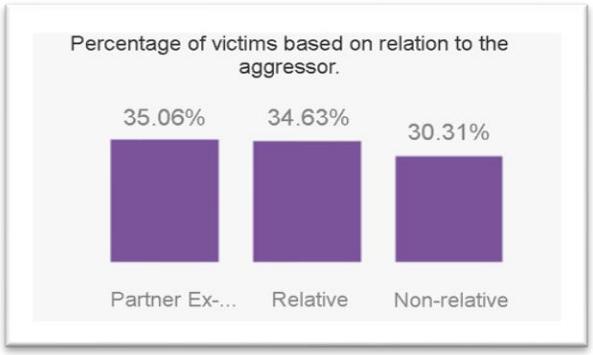


Source: (SIVIGE, 2020)

One of the differences found between the Colombian population and the Venezuelan population is the percentage of gender-based violence where the aggressor was not a relative, being in the case of the Venezuelan population 5.89% higher than for the Colombian population (See Figures 6 and 7).

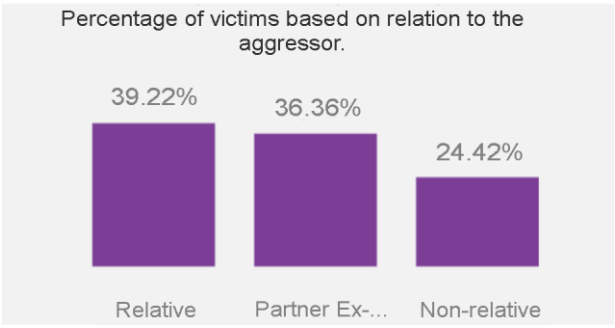
[4] That is the national helpline for women who are victims of violence. Initiative of the Presidential Council on Equality for Women.

Figure 6. Percentage of Migrant Population Victims of GBV Based on Their Relation to the Aggressor



Source: (SIVIGE, 2020)

Figure 7. Percentage of Colombian Population Victims of GBV Based on their Relation to the Aggressor



Source: (SIVIGE, 2020)

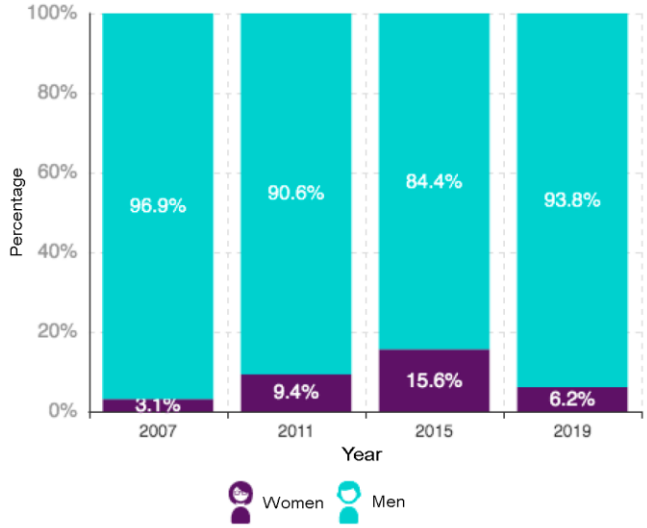
2.2 Gender roles, responsibilities and time use

2.2.1 Participation

Colombia has one of the lowest rates of women participating in politics in Latin America (USAID, 2019). According to one of the indicators established for *Sustainable Development Goal 3: Promote Gender Equality and the Empowerment of Women*, the goal was that by 2015 the gap in the female participation rate would be 20%(DNP, 2011).

However, this goal was not achieved. In fact, the percentage of women governors (see Figure 8) was 6.2% in 2019. On the other hand, women city mayors was 12% for the same year (Vice-presidency, 2020).

Figure 8. Percentage of women governors in Colombia



Source: (Vicepresidencia , 2020)

At the national level, the percentage of women occupying ministerial positions is 50%. This shows that women face the most challenges in terms of participation at the local level.
In the case of the migrant population, those who have a regular status can exercise the right to vote in municipal or district elections and consultations, but they cannot exercise the right to vote for president, members of congress or governors (FUPAD, 2019). Moreover, only the regular migrant population can access certain popular-vote positions, with the exception of those established in article 28 of Law 43 of 1993[5].

According to most of the organizations and institutions interviewed, men have more participation than women, who have historically been excluded from forums of participation and politics. Interviewees suggested that cultural stereotypes indicate that men are believed to have the capacities and abilities to lead and that women are too emotional to be leaders.

> *"There is a view that public office belongs to men, and that there are feminine attributes that are not suitable for leadership. There are false ideas about women's leadership; also, there is a lack of access to positions of power, both in the public and in the private sphere, due to the difficulty of juggling work and family life, and the burden of caregiving assigned to women is doubled or tripled when they access positions of power. There is a glass ceiling where they have to choose either their career or their family".*
>
> —Women's NGO team member

---

*"**ARTICLE 28. RESTRICTIONS TO OCCUPYING CERTAIN POSTS.** Naturalized Colombians may not hold the following public posts:*
1. President or Vice President of the Republic (Articles 192 and 204 N.C.)
2. Senators of the Republic (article 172 N.C.)
3. Magistrates of the Constitutional Court, Supreme Court of Justice, Superior Council of the Judiciary (Articles 232 and 255 N.C.)
4. Attorney General of the Nation (article 267 N.C.)
5. Members of the National Electoral Council and National Registrar of Civil Status (Articles 264 and 266 N.C.)
6. General Comptroller of the Republic (article 26 N.C.)
7. Attorney General of the Nation (Article 280 N.C.)
8. Minister of Foreign Affairs and Minister of National Defense.
9. Member of the Armed Forces as officers and NCOs.
10. Directors of intelligence and security agencies.
11. As determined by law."

However, although the country has overcome some obstacles in terms of participation and representation in leadership positions, further progress is still required to face the growing decision-making challenges for women. For example, the increased burden of caregiving when women access positions of power.

2.2.2 Decision-making

Men and women make decisions depending on the roles that have been culturally assigned to each. Society determines a life project and specific capabilities for women and men, thereby influencing the way in which they must make decisions both in the private and the public fields.

In almost all the interviews conducted where decision-making issues were mentioned, the perception of the interviewees is that women make the decisions that have to do with caring for children and the home, and the economic decisions are made by men. According to the interviewees, this has to do with the social contract that determines that important decisions of the household are those related to money, and that these must be made by men.

> *"…The decision to move to another place or city is usually made by the male. It is more difficult to accept that if the woman found a better job, the man should move to another place".*
>
> —Civil Society Organization team member

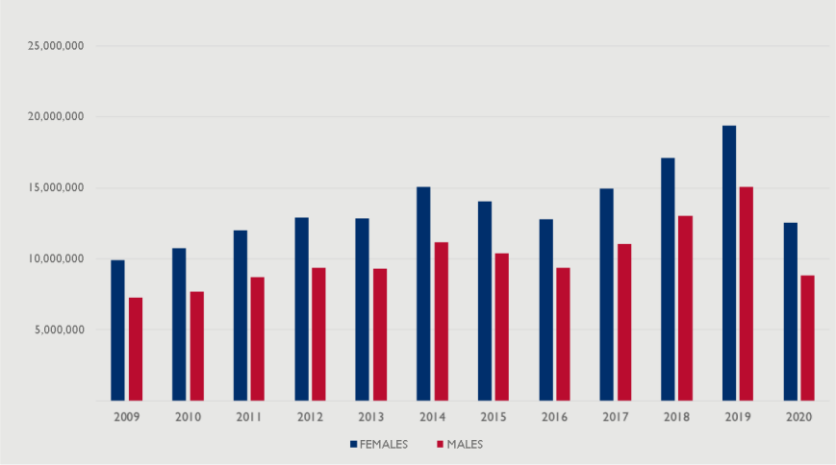
For health-related decisions, in all the interviews where the subject was mentioned, participants indicated that men decide investments in healthcare; for example, which EPS to join; however, women spend more time taking care of their health and that of their children. The interviewees mentioned cases where mothers with young children even sacrifice going without food to feed their children or sacrifice taking care of their own health to have the resources and time that will allow them to take care of the health of the other household members.

> "*In general, men have more economic resources than women, but women invest more in terms of time in all health-related matters. Men worry less about health; they don't seek care since within the imaginary gender roles, they are more concerned with solving the household's economic issues*".
>
> —Civil Society Organization team member

However, when women have the time and resources to take care of their own health, they go to the doctor more often than men (See Figure 9) and maintain their treatments for a longer period of time.

> *"Men spend less on their health, due to the same macho stereotypes in society that make them look weak. Men believe that worrying about their mental health is effeminate and makes them look less like manly".*
>
> —Civil Society Organization team member

Figure 9. Number of Healthcare Events by Gender



Source: Prepared by the authors using data from RIPS 2020

According to the perception of the persons being interviewed, the differences in the decision-making process of the migrant population are related to the time of migration and the people with whom they migrated. Men tend to migrate first since the sexual division of labor reinforces their role as providers, so they must first secure an income and later bring their wives and children:

> *"…In migratory flows, it has been shown that women stay behind with the children or stay in border areas, while men go out to seek employment in the interior of the country, hoping that they'll gain greater stability so that women and children can travel. The issue of caretaking has historically been associated with women, and both men and women go out to look for work*".
>
> —Civil Society Organization team member

> " *…in the migratory flow, the men migrate first and the women with children follow…*".
>
> —National Entity team member

One of the non-governmental organizations at the national level reported that according to their perception, adolescents migrate less often, perhaps because they are at a critical point in their lives and have no desire to leave their country so that most of the time women end up migrating with young children and/or seniors.

2.2.3 Caregiving

Communities

Within the household, the distribution of roles in society is reproduced, where caretaking[6] is the responsibility of women (See Figure 10), including caring for children's health and other family members, as well as housework and housekeeping.

[6] "*…unpaid work performed in the home, related to housekeeping, caring for other people in the home or the community, and supporting the paid workforce. This unpaid household work includes domestic, personal and care services generated and consumed within the home, for which no direct economic remuneration is received*". (Article 2, Act 1413 of 2020)

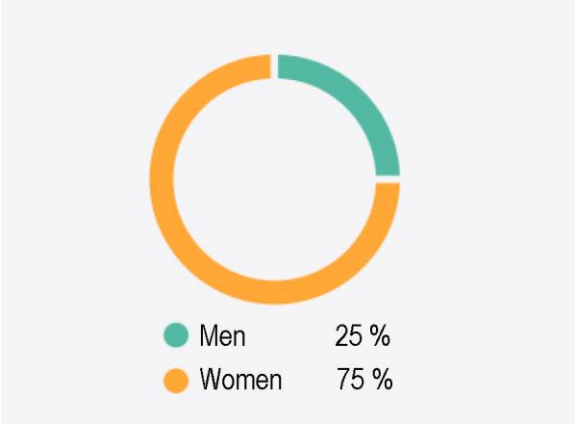
"*...the caretaker burden is associated with women or gay men, due to the feminization that society makes of these tasks; it is thought that if a man does childcare or household chores, he is less of a man*".

—National NGO team member

"*Venezuelan families are more numerous than Colombian families, so the burden of care increases...*".

—National Entity team member

Figure 10. Distribution of Persons Employed in Paid-Caretaker Activities – Second Quarter of 2020



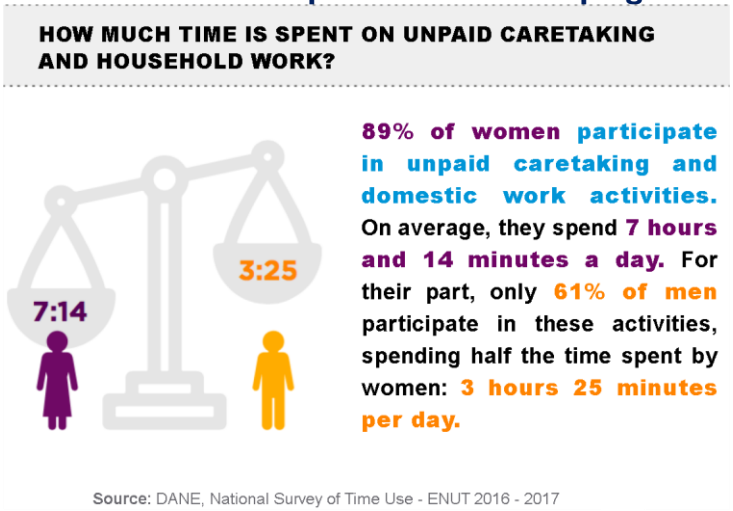
Source: (DANE, 2020)

Within the feminization that society has made of caregiving, there is an undervaluation of these activities, which is why they are generally unpaid tasks. (see Figure 11).

"*Women spend less money and time in taking care of their own health, but they use that time and money to take care of the health of others, and that is part of the stereotypes that must be transformed; the fact that women have to be at the service of others and feel guilty if they spend time or resources on their own care.*"

—Women's NGO team member

Figure 11. Number of Hours Spent on Housekeeping and Caregiving



Source: (DANE, 2020)

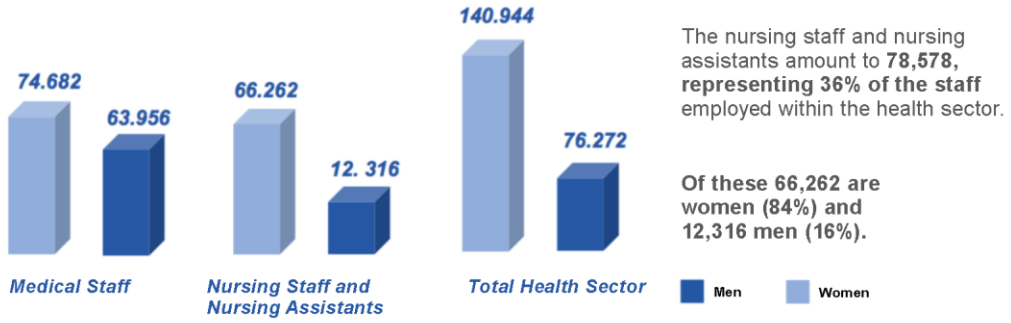
Healthcare professionals

In Colombia there are 217,216 professionals in the health sector (medical, nursing and auxiliary nursing staff), of which 65% are women and 35% are men (See Figure 12).

In the case of medical staff, women represent 56% and men 46%. Of the registered nurses and assistant nurses, 84% are women and 16% are men. The above presents a difference of 7.8% between men and women in the first case, versus 69% in the second case.

Thus, we see that the gap is evident in the registered and assistant nursing staff in terms of the type of work assigned to women in the health sector, and which is related to care-giving tasks.

Figure 12. Medical Staff and Nursing Staff by Sex



Source: GEIH – DANE. 2019

> "*There is a glass ceiling that generates labor differences in terms of hiring and remuneration; additionally, due to the reinforced caregiving burden on women, it is not so easy for them to access leadership positions.*"
>
> —National Entity team member

2.2.4 Support networks

One of the greatest difficulties faced by the migrant population is the lack of a support network, as they leave their family and friends back home; however, in all the interviews where the issue was mentioned, we found that within the context of the migratory process, the sense of the collective is strengthened, and these dynamics of community solidarity are greater in the migrant population than in host communities.

> "*…among women coming from Venezuela, there is more of a collective sense when they need to go get health services, at that time they support each other by taking care of the children through community support. The community network also protects women against gender-based violence than in Colombia*"
>
> —international Organization team member

In the areas where there are illegal armed groups, control is exercised by fulfilling gender roles, and there are situations of corrective violence and violence as an example against women and the transgender population (Caribe Afirmativo, 2019).

"*In a society in the midst of an armed conflict, the illegal armed soldiers reprimand and punish behaviors that are not considered appropriate, including women with a different sexual orientation; the political participation of women ... is done through displacements, threats (where the community abandons them), corrective sexual violence…*".

—Women's NGO team member

In this regard, one of the international cooperation organizations that was interviewed expressed the importance of achieving joint cooperation between the migrant population and the host communities to strengthen community ties in joint empowerment exercises.

"*...migrants move in networks, which facilitates access to information.*"

—territorial NGO team member

2.3 Access and control over assets and resources

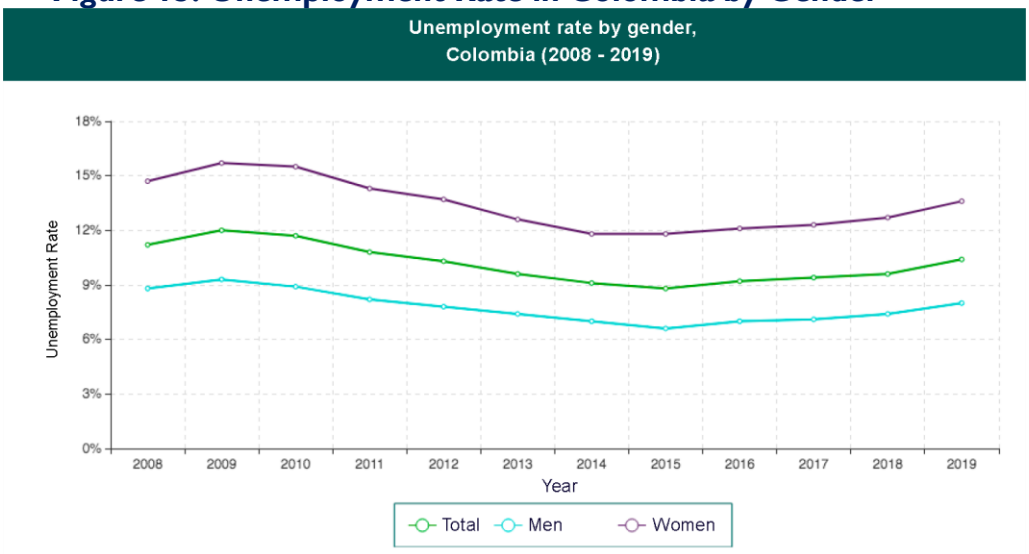
2.3.1 Employment and financial resources

The unemployment rate among women in Colombia is higher than the national average (see Figure 13), a situation that also affects migrant women. This is how "…domestic service and caregiving work are beginning to be an employment alternative for many Venezuelan migrants, particularly for girls and women (Arbeláez Jaramillo, 2018, taken from Profamilia, 2019).

"*In the case of women who are engaged in paid household work there is a wage gap, because they don't know their rights, and there are women who also resort to transactional sex.*"

—National Entity team member

Figure 13. Unemployment Rate in Colombia by Gender



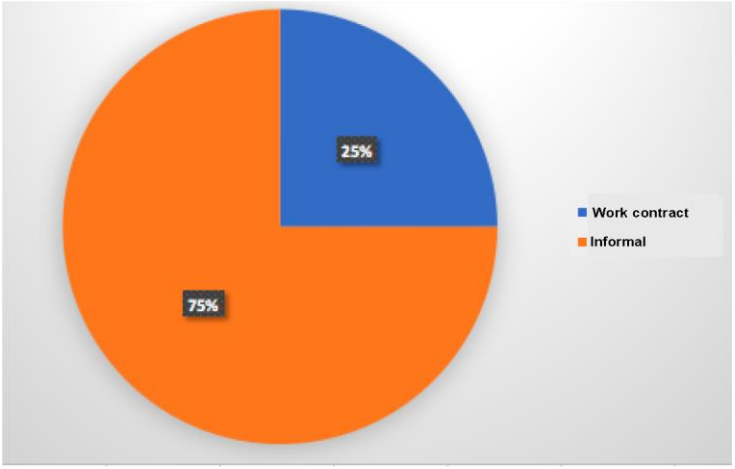
Source: Colombian Women's Observatory, 2020

"*Men have more access to economic resources; women have greater difficulties. Rural women do not have bank accounts or land titles, which prevents them from accessing credit. Women do not have access to the flow of capital.*"

—National Entity team member

In the case of the migrant population, in 2019 the unemployment rate was 15.3%, and the wage gap between Colombians and migrants was 12% for self-employed workers and 10% for salaried workers (El tiempo, 2020). In the case of the regular migrant population, they have more access to financial resources, since they have the possibility of accessing a formal job. However, only 25% of the regular migrant population has a work contract (see Figure 14), despite the fact that they work up to 6 hours or more a week, compared to the Colombian population.

Figure 14. Access by Regular Migrant Population to a Work Contract vs. Informal Work



Source: Prepared by the authors based on figures from the study "Labor Outlook of Venezuelan Migrants in Colombia 2014 – 2019". Universidad Externado de Colombia.

In turn, the irregular population lives from informal market activities, which leads to very precarious working conditions, and together with situations of discrimination and xenophobia, as mentioned in several of the interviews conducted, exacerbates the risks of labor exploitation, sexual and human trafficking.

> "*Most of the migrant population works in the informal sector, even at a higher rate than the Colombian population*".
>
> —National Entity team member

> "*…there was a moment during the health crisis last year, (because the healthcare provided to migrants dropped a little during that year) that every time someone came in for medical attention it was a Venezuelan; one time when a Colombian woman came in and had a baby, everyone clapped, so I think some services are overloaded, and the borders have also contributed to some discrimination when providing services*".
>
> —IPS team member

Moreover, one of the international cooperation organizations we interviewed expressed the importance of differentiating prostitution from transactional sex activities, since the first one is related to income generation (regardless of whether it is ideal or not), while the second one has to do with survival, and could be related to sexual exploitation.

Sometimes, the migrant population is the beneficiary of monetary transfer programs by national, territorial or international cooperation entities. This is a difficulty for the irregular migrant population, which, since they don't have the required documentation, do not have access to bank accounts. In the case of women, this situation is aggravated due to a lack of knowledge or technological tools.

> "*In the context of the pandemic… something peculiar happened, and it was that the money orders were made through bank branches, but most of the beneficiaries… when the money order was sent, when they received the message, they didn't know how to download the application, which revealed a digital divide … as a result of this, a basic ICT education module for women was established...*"
>
> —Territorial Entity team member

On the other hand, the LGBTI migrant population faces a great impossibility to get a job, despite their qualifications. Therefore, sometimes they must hide their sexual orientation and gender identity in the face of existing employment discrimination. Hence, the LGBTI population works mainly in an informal labor market, which increases the risk of being exploited. The LGBTI population is forced to resort to sex work, increasing their exposure to sexual exploitation or human trafficking, and even illegal activities such as micro-trafficking (Caribe Afirmativo, 2019).

The Healthcare Sector

The healthcare sector has been characterized by having a strong sexual division of labor, which is why women's jobs are more often associated with general care, palliative care, and men's jobs with specialized and managerial medicine. In Colombia there are 66,262 female nurses and nursing assistants, compared to 12,316 male nurses and nursing assistants (Vice-presidency of Colombia, 2020).

> "*…generally, training in Human Rights and gender issues is relegated to very specific sectors (psychology, social work, etc.), but there is no concern to have extensive training on these issues for all health personnel. These topics should be in the academic curricula of all health careers, especially issues of gender-based violence, since legal medicine does not cover the entire territory*".
>
> —international Organization team member

There is also an average wage gap of 29% between men and women in the Colombian health sector (see Figure 15).

Figure 15. Wage Gap between Men and Women. Personnel Employed in the Healthcare Sector

	MEN	WOMEN	WAGE GAP
Nurses, certified and non-certified midwives, optometrists, physiotherapists, radiology technicians, surgical instrument technicians	2,865,244	2,085,908	27%
Doctors, surgeons, medical assistants, dentists, dental assistants, veterinarians, veterinary assistants, pharmacists, nutritionists	4,898,056	3,449,677	30%
Total Health Personnel	7,763,300	5,535,585	29%

Source: GEIH-DANE, 2019

2.3.2 Information and Communication

The country has the health sector *Response Plan* to the migration phenomenon, aimed at managing the health response to situations generated by migration. However, within the plan, there is no component or activity related to the need to establish a communications strategy so that health information reaches the migrant population effectively.

More than half of those interviewed indicated that a greater inclusion of the gender and social approach is required in the health sector's communications strategy. Although the MSPS publishes information on its website, and although they should be disseminated by systems such as health departments, the EPS, and the IPS, there is no adequate information shared with the migrant population due to "*…lack of resources at the gender offices to implement strategies for giving information to the community"* (USAID - ONUMUJERES, 2020).

In this regard, it was found that there is no adequate dissemination of information on rights, access and care paths, procedures for claims, enrollment documents, etc., for the migrant population. The MSPS has focused its efforts on communicating macro information, but it does not directly reach the migrant population or host communities at the local level, so there is a need to disseminate the information through social networks (for example WhatsApp and Facebook are of vital importance), word of mouth, and community networks that are very strong among the migrant population.

> "*The healthcare sector has a long way to go before it achieves effective communication within the migrant population in general, and with women in particular*".
>
> —National Entity team member

> "*…for Venezuelan women it is not easy to understand the Colombian dynamics simply through a brochure or a poster, since the models of governmental presence are very different between Venezuela and Colombia, and the logic of access to rights is different, so it requires more outreach and capacity building*".
>
> —international Organization team member

According to the perception of the people interviewed, there is a need for greater coordination between the national and territorial levels on the information that should reach the population. In this regard, there is a burden on civil society and international cooperation organizations, who have been in charge of designing communication strategies and campaigns aimed at the migrant population—both regular and irregular, as well as women and vulnerable populations.

> "*The information is delivered through territorial entities, but more work is needed at the national level. More interagency work is required.*"
>
> —National Entity team member

> "*…women have less access to cell phones, and when they do, it is at the lowest level in relation to the rest of the family. They have less access to technology but they don't have the means for recharging and lack connectivity. There are difficulties in terms of technological skills; there is technological illiteracy.*"
>
> —Women's NGO team member

> "*…they receive support from international cooperation agencies that serve the migrant population, but they don't include the information in the RIPS because they don't need*

to be reimbursed, and this is very serious because valuable decision-making information is being lost."

—international Organization team member

Given this, one of the territorial public institutions reported that during the pandemic monetary transfers were made to vulnerable populations, and it was found that it was more difficult for women to download the apps to receive payments.

2.4 Cultural norms and beliefs

Concerning this, it is important to mention that the analysis was integrated into the findings mentioned in each of the other domains, since norms and beliefs influence all areas of people's lives, due to the specific assignment that society makes when it comes to appropriate, adequate and valued behaviors, which are considered different for men and women. However, for this domain, it is important to highlight that the most important finding is related to discrimination and xenophobia.

2.4.1 Discrimination and xenophobia

In addition to the legal and administrative barriers that the migrant population must face to achieve adequate access to health services, this population permanently suffers from discrimination and xenophobia by the general public, and in a very high proportion by the EPS and IPS health and administrative personnel.

"…the attitude of the health personnel includes xenophobic and discriminatory practices; there is also a great lack of knowledge about rules and policies. Work needs to include office and administrative staff"

—Civil Society Organization team member

Most of the interviewees mentioned that there is discrimination in the healthcare services toward the migrant population. Examples were given of situations where the security guards of the institutions do not allow migrants to enter, often not even when they go due to an emergency. With the crisis brought on by COVID-19, these situations of discrimination have been aggravated, to a large extent because the health personnel was suffering from exhaustion, especially those in the public network, which is where the majority of migrants for emergencies.

"…the healthcare personnel show attitudes that constitute barriers, such as discrimination, xenophobia, ignorance of the rights of migrants. Oftentimes, even if the migrant has the legal documents or has the legal right to access, they are denied entry, or they're asked for papers that are not required, or they block them with some other additional obstacles to accessing the services"

—National Entity team member

"…migrants are always looking for business and not health, or care … here we've been too nice when dealing with everyone, even though many Venezuelans are rude and treat us badly because they believe that they have many rights here in Colombia, so sometimes we have to stop and push back, because it's good to be a decent but not go overboard either"

—IPS team member

Moreover, we found that discrimination against the migrant population is more pronounced in the case of women.

> *"For migrants, one of the strongest forms of violence is xenophobia… for women it is connected with "glamorizing" where they are viewed as sexual objects; they are called husband stealers, and they are associated with prostitution, which increases the risk of sexual violence and femicide"*
>
> —international Organization team member

> *"There is an intersection between discrimination for being a migrant and for being a woman; there are these ideas that the women are prostitutes, that they have AIDS, that they come to steal the husbands of Colombian women..."*
>
> —National Entity team member

> *"…there is resistance on the part of health workers. There is xenophobia, competition for aid between migrant population and host communities. There are gender and racial stereotypes. Pregnant migrant women are discriminated"*
>
> —National NGO team member

Finally, it is important to mention that discrimination permeates even the institutions, and it also affects access other rights, such as education, where for example Venezuelan children (regular and irregular) have free access to public education; however, irregular migrants cannot graduate because they lack documents such as a visa or PEP.

2.5 CONCLUSIONS

Objective 1: Strengthened Governance and Management of the Health response to Migrants

It was found that:

- The main barrier to this objective is the lack of gender and health policies, as well as a lack of a migration and health policies focusing on gender and social inclusion.
- The MSPS does not have a department to manage gender issues, and therefore there is no specific allocation of resources in this area.
- There is very low participation on the part of the migrant population, women, and other vulnerable populations in defining the MSPS policies, as well as in their territorial implementation.
- There is a lack of coordination between the national and territorial levels implementing gender and migration actions.
- Civil society organizations are currently the ones who best know the needs of the migrant population.

Objective 2: Promote Sustainable Financing of Health Services for Migrants and Host Communities

It was found that:

- Women have less financial capacity to join the SGSSS.
- There is low SGSSS enrollment on the part of the regular migrant population.
- There is no SGSSS enrollment strategy on the part of the irregular migrant population.
- The main barrier to this objective is the lack of resources to achieve enrolling the irregular population into the SGSSS.
- The Government's strategy in terms of healthcare for the irregular migrant population is based on payment per event (emergency care), which is more expensive for the system.

Objective 3: Strengthen Mechanisms to Increase Access of Migrants and Host Communities to Appropriate and High-Quality Healthcare Services

It was found that:

- The main barrier to this objective is that the health system has not achieved an adequate implementation of primary healthcare strategies for the Colombian population, which is exacerbated when it comes to the migrant population, especially women and vulnerable populations.
- In general, the migrant population, has little access to information on healthcare services, and women, in particular, also lack information on services related to GBV.
- There is an overload of women in the areas of health care and a wage gap between men and women in the health sector.

Objective 4: Strengthen the Resilience of the Health System to Respond to Current and Future Emergencies, Including the COVID-19 Pandemic

It was found that:

- During the COVID-19 pandemic, cases of discrimination and xenophobia by health personnel toward the migrant population increased, as well as cases of GBV.
- The main barrier to this objective is exhaustion among health personnel due to work overload and lack of financial and human resources.
- The migrant population needs to have more and better access to information on both the SGSSS and on measures to prevent and adequately treat COVID-19.

3. RECOMMENDATIONS

As a result of the interviews carried out and a review of the literature, as well as analyzing the information gathered by the GESI specialist, we found that the main recommendations for the inclusion of a gender and differential approach in the migrant population and host communities healthcare are directed at four lines of action, where each recommendation is related to the project's objectives.

3.1 STRENGTHENING INSTITUTIONAL CAPABILITIES

3.1.1 PUBLIC INSTITUTIONS

3.1.1.1 The country needs a migration and health policy with a gender and social inclusion approach, that establishes specific indicators at the national and local levels. To this end, there must be an allocation of resources aimed at the effective integration of the migrant population into the health system, taking into account the different health care needs of women, men, and vulnerable populations. (Objective 1: Governance and management of the health response to the migrant population)

3.1.1.2 There needs to be better coordination between public, national, and territorial institutions and social and international cooperation organizations concerning the efforts to guarantee the right to health of the migrant population and host communities. (Objective 1: Governance and management of the health response to the migrant population; Objective 2: Promote sustainable financing of health services for migrants and host communities)

3.1.1.3 It is important that the MSPS defines internally the responsibility for managing migration and gender issues in a strategic manner, to achieve an adequate appropriation of these issues at the territorial level, for which a much more coordinated work between the MSPS, the governors' and mayors' offices is required. (Objective 1: Governance and management of the health response to the migrant population)

3.1.1.4 The MSPS and the territorial entities could have a greater allocation of resources for gender and health issues, as well as for migration and health issues. (Objective 2: Promote sustainable financing of health services for migrants and host communities)

3.1.1.5 To achieve a true inclusion of the gender and human-rights approach in the health sector, it would be important to include in the academic curriculum of all health careers a subject related to these topics; this would require a coordinated work between the MSPS, the Ministry of National Education and the universities. (Objective 1: Governance and management of the health response to the migrant population)

3.1.2 HEALTHCARE INSTITUTIONS

3.1.2.1 Healthcare institutions can implement gender and differentiated approach strategies, where, in addition to creating spaces for training and awareness-raising of all their personnel regarding gender, human rights, and migration issues, there is also an effort to increase the number of human resources working on these matters. This will be more conducive to guaranteeing the right to health, not only in terms of the care received, but also in terms of humanity, quality and warmth of the service. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to proper and high-quality healthcare services)

3.1.2.2 The burden faced by public hospitals with the largest influx of migrant population needs to be alleviated, especially the overload on women healthcare workers. This can be achieved with a better distribution of hospital networks for the migrant population; improve the working conditions of healthcare workers, reduce the existing wage gaps, and achieving optimal working conditions, as well as an increase in health personnel. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to proper and high-quality healthcare services)

3.1.2.3 It is important that the Ministry of Health and the Ministry of Labor collaborate to narrow the existing wage gap between men and women, which could contribute alleviating the stressful conditions that women face due to work overload, and also for women to find greater incentives to studying these careers, which are in significantly high demand due the COVID-19 pandemic. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to proper and high-quality healthcare services; Objective 4: Strengthen the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic)

3.2 ORGANIZATIONAL AND COMMUNITY STRENGTHENING

3.2.1 National and territorial public entities, through greater coordination with civil society organizations as well as with international cooperation organizations, can achieve better healthcare for the migrant population, and especially for women on issues such as sexual- and reproductive-health rights, or mental health, among others. For this reason, social organizations need to strengthen their capabilities in terms of primary healthcare, community health, and GBV to support more effectively the migrant population in general, and women and other vulnerable populations, in particular, with whom they work. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

3.2.2 There need to be more forums for participation and dialogue between national and territorial public institutions with the migrant population and host communities, and to achieve significant participation of women, the LGBTI population, indigenous communities, the disabled population, the elderly, children, and adolescents, so that they may more accurately communicate the

difficulties, needs and risks they face when accessing healthcare services, as well as to contribute to the development of initiatives to guarantee the right to healthcare. (Objective 3: Strengthen the mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

3.2.3 The migrant and host communities need to improve their knowledge on gender, human rights, and association to achieve a more active and effective participation in forums for developing public policies and decision-making. (Objective 3: Strengthen the mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

3.3 INFORMATION AND COMMUNICATION

3.3.1 The health sector requires a communications strategy aimed at the migrant population that will allow them to gain greater and better knowledge of their rights and the mechanisms through which they can claim them (paths, channels, documents). For this, it is important to understand the differences in access to information between men and women to establish different communication strategies, like for example through an ICT education program specifically catered for women. (Objective 1: Governance and management of the health response to the migrant population)

3.3.2 The Ministry of Health and Social Protection as well as the territorial entities should carry out awareness campaigns aimed at reducing discrimination and xenophobia outbreaks endured by migrants in general, and migrant women in particular. It is important to mention that discrimination against the migrant population and women occurs both among citizens, and internally within public and health institutions, which is why awareness strategies are also required at the institutional level. (Objective 1: Governance and management of the health response to the migrant population)

3.3.3 As a priority, we need to carry out a more in-depth health definition of the migrant population (men, women, and vulnerable populations) needs, as well as updating the databases to have precise information on causes of morbidity and mortality. (Objective 1: Governance and management of the health response to the migrant population; Objective 4: Strengthen the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic)

3.4 INSURANCE, PRIMARY HEALTHCARE AND COMMUNITY HEALTH

3.4.1 The country needs a strategy to make sure that the irregular migrant population is insured through the SGSSS, as this is the only effective way for them to obtain adequate healthcare. This will have a direct effect on improving the health conditions of women and vulnerable populations since right now they are the ones who face the most difficulties in terms of accessing

resources and employment. Similarly, the SGSSS costs on services aimed at the migrant population for emergencies would decrease significantly, which in turn would provide relief to public hospital resources. (Objective 2: Promote sustainable financing of health services for migrants and host communities)

3.4.2 Primary healthcare services must be strengthened with an approach based on promoting health and preventing illness which would, in turn, lead to significantly improve the health of men and women from both host communities and migrant populations, as well as adequate attention to issues such as GBV, among others. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

3.4.3 National and territorial public entities, as well as health institutions, could develop participatory community health processes to bring together migrant and host communities to empower support networks and community work. This, in turn, will help to identify the potential of people in the community to manage the health of the communities. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

3.4.4 It is important to achieve greater women's participation in health issues, and strategies must be developed aimed at empowering women through comprehensive, joint efforts by public institutions, health institutions, and international cooperation organizations, considering the gaps women face when assuming leadership roles. (Objective 3: Strengthen mechanisms to improve access by migrants and host communities to appropriate and high-quality healthcare services)

ANNEX 1 BIBLIOGRAPHIC REFERENCES

ADRES. (2020). *ADRES*. Recuperado el 29 de enero de 2021, de https://bit.ly/3th14Cy

Ardila, M. P. (19 de junio de 2020). La lucha por la reivindicación de las mujeres en la cultura wayuu. *El Espectador*. Recuperado el 29 de enero de 2021, de https://bit.ly/3oBA8K5

Caribe Afirmativo. (2019). *Situación de las personas LGBT migrantes de Origen Venezolano en Territorios.* Recuperado el 29 de enero de 2021, de https://bit.ly/39DDbNL

DANE. (2020). *Cuidado no remunerado: La igualdad de género inicia en el hogar.* Recuperado el 29 de enero de 2021, de https://bit.ly/3pIHlto

DANE. (2020). *INFORME SOBRE CIFRAS DE EMPLEO Y BRECHAS DE GÉNERO*. Recuperado el 29 de ENERO de 2021, de https://bit.ly/39FR8uF

DNP. (2011). *Documento CONPES social 140.* Recuperado el 29 de enero de 2021, de https://bit.ly/2YNzcrP

DNP. (2018). *CONPES 3950.* Obtenido de https://bit.ly/3oF5Zte

El tiempo. (26 de febrero de 2020). 3 de cada 4 venezolanos trabajan en Colombia sin un contrato laboral. *El Tiempo*. Recuperado el 29 de enero de 2021, de https://bit.ly/36xD8B6

FUPAD. (2019). *El acceso a los derechos de los migrantes en Colombia.* Recuperado el 29 de enero de 2021, de https://bit.ly/3oEu9UW

Migración Colombia. (2020). *Radiografía Venezolanos en Colombia corte a 30 de Octubre de 2020.* Recuperado el 29 de enero de 2021, de https://bit.ly/3rd2VXb

Ministerio de Salud y Protección Social. (2013). *Plan Decenal de Salud Pública.* Recuperado el 29 de enero de 2021, de https://bit.ly/3tgccj5

Profamilia. (2019). *Evaluación de las necesidades insatisfechas en salud sexual y reproductiva de la población migrante venezolana.* Recuperado el 29 de enero de 2021, de https://bit.ly/3ramAaa

Profamilia-USAID. (2020). *Desigualdades en salud de la población migrante y refugiada venezolana en Colombia.* Recuperado el 29 de enero de 2021, de https://bit.ly/3tgxNry

SIVIGE. (2020). *Sistema Integrado de Información sobre Violencias de Género*. Recuperado el 29 de enero de 2021, de https://bit.ly/3j7g8Op

USAID - ADS 205. (2017). *Integrating Gender Equality and Female Empowerment in USAID´s Program Cycle.* Recuperado el 29 de enero de 2021, de https://bit.ly/36xVCRY

USAID - ONUMUJERES. (2020). *Situación de las Violencias Basadas en Género de población colombiana y venezolana en el marco de la pandemia por COVID-19 en Cartagena - Bolívar.* Recuperado el 29 de enero de 2021, de https://bit.ly/2YGMjut

Vicepresidencia . (2020). *Observatorio Colombiano de las Mujeres*. Obtenido de https://bit.ly/3j6m7D0

ANNEX II: GENDER EQUALITY AND SOCIAL INCLUSION ACTION PLAN

Gender equality and social inclusion will be integrated into the Project through:

- Gender analysis recommendations
- Staff development (hiring, training, etc.)
- Integrate GESI in planning and budgeting
- Incorporate GESI in monitoring, evaluation and knowledge management
- Development of local institutional, organizational and community capabilities

ACTIVITIES	2021 – 2024				Responsibility	Relevant project indicators
	Y1	Y2	Y3	Y4		
RESULT 1: Integrate gender equality and social inclusion issues in the project, including men, women, and other vulnerable populations, strengthening their capacity to make and implement strategic decisions that allow them to improve their health outcomes and those of their communities						Number of training and capacity-building activities carried out with the support of the United States Government in public institutions and health institutions in priority territories, which are designed to promote knowledge of gender equality and human rights
Intermediate Result 1.1: Governance and management of the health response to the migrant population **ACTIVITIES:**						Number of communication pieces developed with the support of the United States Government that are designed to prevent discrimination and xenophobia towards the migrant population in the prioritized territories
Include the GESI chapter in the national healthcare policy for the migrant population			X		Target 1 Leader and GESI Specialist	Policy or Document with the GESI chapter included
Inclusion of women and vulnerable populations in the defined participation forums to be defined		X	X	X		Attendance lists
Include issues of gender equality, human rights and gender-based violence in the capacity-building strategy that also reduces the risk of discrimination.		X				Number of GESI training sessions carried out
Inclusion of women and vulnerable populations when conducting surveys and technical assistance to prioritized local media		X				Survey results
Include messages to promote gender equality, human rights and prevention of gender-based violence (routes), as well as sexual and reproductive rights			X			Number of communication tools with GESI messages included
Intermediate Result 1.2: Promote sustainable financing of healthcare services for migrants and host communities						Number of counseling activities carried out with

ACTIVITIES:						the support of the United States Government that are designed to promote greater SGSSS enrollment of women and vulnerable populations
GESI training for territorial insurance consultants		X			Target 2 Leader and GESI Specialist	Training carried out
Encourage participation forums with the migrant population to promote affiliation to the SGSSS		X	X	X		Number of forums with migrant population participation
Include gender approach in the work of the consultants and in the information collection instruments		X	X	X		Instrument with sociodemographic variables included
Design and dissemination of communication pieces to increase the information of the migrant population about insurance, as well as awareness about issues of discrimination and xenophobia in the territories		X	X			Communication pieces designed and disseminated
Design of the guidelines for the implementation of a basic package of assistance focused on maternal and child health		X	X			Guidelines designed
Intermediate Result 1.3: Strengthen Mechanisms to Increase Access of Migrants and Host Communities to Appropriate and High-Quality Healthcare Services **ACTIVITIES:**						Number of capacity building activities with institutions, migrant population and host communities, carried out with the support of the United States Government, which are designed to promote knowledge in primary health care
Promote equitable participation (men, women, vulnerable population) in the activities of the component		X	X	X	Target 3 Leader and GESI Specialist	Number of men participants vs. Number of women participants
Inclusion of women healthcare workers in the IHI courses		X	X			Participation lists
Inclusion of women health workers in mixed-methods studies		X				Study results
Develop information collection instruments that include a GESI approach		X	X			Information collection instruments developed
Resilience strategy with gender approach			X			Document with gender approach included
Develop actions of capacity building in community health for migrants and host communities			X	X		Strengthen capacities actions developed
Intermediate Result 1.4: Strengthen the resilience of the health system to respond to current and future emergencies, including the COVID-19 pandemic **ACTIVITIES:**						Number of people with follow-up under the PRASS strategy
GESI Training for Rapid Response Teams		X				Training carried out

Within the framework of the workshops carried out by the RRT articulate with the territorial entity the presentation of GBV attention routes		X	X		Target Leader 4 and GESI Specialist	Workshops with information of GBV developed
Manage with the territorial entity the identification and inclusion of civil society and community organizations that may contribute to greater participation of migrant population, especially women and vulnerable populations in training workshops on COVID-19		X	X			Participation lists

ANNEX III: LIST OF DOCUMENTS CONSULTED

1. National Public Policy Guidelines for Women's Gender Equality, 2012. High Presidential Advisory Office for Women's Equality. http://www.equidadmujer.gov.co/Documents/Lineamientos-politica-publica- equidad-de-genero.pdf
2. CONPES SOCIAL 161: Gender Equality for Women. 2013. DNP https://colaboracion.dnp.gov.co/CDT/Conpes/Social/161.pdf
3. National Demographics and Health Survey, 2015. Ministry of Health and Social Protection https://profamilia.org.co/wp-content/uploads/2019/06/Resumen-Ejecutivo-Encuesta-Nacional-De-Demografia-Y-Salud-ends-2015.pdf
4. National Development Plan. 2018 – 2022. DNP https://colaboracion.dnp.gov.co/CDT/Prensa/Resumen-PND2018-2022-final.pdf
5. What do we know about sexual violence against LGBT people in the context of the Colombian armed conflict?. 2020. Caribe Afirmativo y Colombia Diversa https://colombiadiversa.org/colombiadiversa2016/wp-content/uploads/2020/05/25M-Final-Esp.pdf
6. Even if they try to erase us: report on human rights violations of LGBT people in Colombia. 2018. Colombia Diversa https://colombiadiversa.org/colombiadiversa2016/wp-content/uploads/2020/03/Aunque-intenten-borrarnos.pdf
7. Provision of Affirmative Health Services For LGBT Persons. 2010. Colombia Diversa. https://colombiadiversa.org/colombiadiversa2016/wp-content/uploads/2017/07/provision-de-servicios-salud-1.pdf
8. Colombia Gender Analysis and Assessment final report. 2019. USAID
9. Colombian Women's Observatory. http://www.observatoriomujeres.gov.co/
10. Nurses Day in the face of the pandemic. 2020. Vice Presidency of Colombia. http://www.observatoriomujeres.gov.co/archivos/publicaciones/Publicacion_17.pdf
11. Women at the core of the fight against COVID-19 crisis. 2020. OECD https://read.oecd-ilibrary.org/view/?ref=127_127000-awfnqj80me&title=Women-at-the-core-of-the-fight-against-COVID-19-crisis
12. National Population and Housing Census. 2018. DANE https://www.dane.gov.co/index.php/estadisticas-por-tema/demografia-y-poblacion/censo-nacional-depoblacion-y-vivienda-2018
13. Promoting the health of refugees and migrants. 2017. WHO https://apps.who.int/gb/ebwha/pdf_files/wha70/a70_24-sp.pdf
14. Proyecto Migración Venezuela. Semana magazine https://migravenezuela.com/
15. Health Sector response plan to the migration phenomenon. 2019. Ministry of Health and Social Protection
16. Migration from Venezuela to Colombia. 2018. World Bank.
17. Act 1257 "It establishes standards of awareness, prevention, and punishment for violence and discrimination against women". 2008. Congress of the Republic of Colombia https://oig.cepal.org/sites/default/files/2008_col_ley1257.pdf
18. Gender Analysis Toolkit for Health Systems. 2016. Jhpiego https://gender.jhpiego.org/analysistoolkit/
19. Women's progress in Colombia. 2018. UNWOMEN
20. Care time: the figures on inequality. 2020. DANE - UNWOMEN

21. Infographic: Unpaid care: gender equality begins at home. 2020. DANE - UNWOMEN.
22. Colombia Gender Assessment. 2019. World Bank https://openknowledge.worldbank.org/bitstream/handle/10986/32006/Colombia-GA.pdf?sequence=5&isAllowed=y
23. Gender differences in poverty in Colombia. 2018. World Bank. 2018 http://documents1.worldbank.org/curated/en/194171560759064726/pdf/Gender-Differences-in-Poverty-in-Colombia.pdf
24. Evaluation of unsatisfied needs in sexual health and reproductive health of the Venezuelan migrant population in four cities on the Colombian-Venezuelan border. 2019. Profamilia.
25. Health inequalities among the migrant and refugee population in Colombia. 2020. Profamilia – USAID.
26. CARE Rapid Gender Analysis: Latin America & Caribbean: Venezuelan Migrants & Refugees in Colombia. 2019. Kalyanpur, A.
27. Integrated Information System on Gender Violence - SIVIGE https://app.powerbi.com/view?r=eyJrIjoiNWQ0NTA4NmEtMjdiYi00MmUyLWE4Y2YtMGU4NzYxNTBhY2EwIiwidCI6ImE2MmQ2YzdiLTlmNTktNDQ2OS05MzU5LTM1MzcxNDc1OTRiYiIsImMiOjR9
28. Addressing gender-based violence in communities affected by migration. 2019. maciej, c. https://www.agrilinks.org/post/addressing-gender-based-violence-communities-affected-migration
29. Deep wounds: sexual violence in Colombia. 2020. rivillas, jc. https://es.calameo.com/read/0062290242fec0f4d62d7
30. The labor labyrinth of migrant women in Colombia. 2020. Medina, M. https://www.elespectador.com/noticias/economia/mas-del-90-de-las-trabajadoras-venezolanas-en-colombia-estan-en-la-informalidad/
31. ADS Chapter 205: Integrating gender equality and female empowerment in the USAID Program Cycle. 2017. USAID
32. CONPES 140: The 2015 amendment to CONPES social 91: Colombia's Goals and Strategies for achieving the 2015 Millennium Development objectives. 2011. DNP
33. CONPES 3950: Healthcare strategy for migrants from Venezuela. 2008. DNP
34. Gender mainstreaming in health: progress and challenges in the Americas. 2019. OPS. https://iris.paho.org/bitstream/handle/10665.2/51809/9789275321614_spa.pdf?sequence=1&isAllowed=y
35. Gender Equality and Female Empowerment Policy. 2012. USAID
36. Joint needs assessment COVID-19. 2020. GIFMM
37. Monitoring the health situation of Venezuela's migrant population. 2019. MSPS
38. Discrimination, a never-ending war. 2017. Colombia Diversa
39. Act 1719 "By which some articles of laws 599 of the year 2000 and 906 of 2004 are amended, and measures are adopted to guarantee access to justice for victims of sexual violence, especially sexual violence due to the armed conflict, as well as other provisions". 2014. Congress of the Republic of Colombia
40. Act 51 "By which the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is ratified". 2981. Congress of the Republic of Colombia
41. Migrant women and sexual and gender-based violence at the Colombia-Venezuela border. 2020. Calderon, M., Parra, D., Forero, LJ.
42. Ten-Year Public Health Plan. 2013. MSPS
43. Borders for Prosperity Plan. 2013. Ministry of Foreign Affairs
44. National Policy on Sexuality, Sexual Rights and Reproductive Rights. 2014. MSPS
45. Resolution 459 "Model of Healthcare for Victims of Sexual Violence". 2012. MSPS
46. Use of contraceptives among migrant population. 2020. University of Antioquia

47. The struggle for women's vindication in the Wayuu culture]. 2020. Ardila, MP. https://www.elespectador.com/noticias/nacional/la-lucha-por-la-reivindicacion-de-las-mujeres-en-la-cultura-wayuu/
48. Political participation of migrants. 2017. Pisani, M https://www.nacion.com/opinion/foros/participacion-politica-de-los-migrantes/LQKIJZY4SFELRMJXSLYYPRJ6EA/story/
49. Access to migrant rights in Colombia]. 2019. PADF https://www.oas.org/es/sadye/documentos/FUPAD_CartillaDerechos.pdf
50. The Work Reality of Venezuelans in Colombia. 2020. Nieto, J. https://www.eltiempo.com/economia/sectores/realidad-laboral-de-venezolanos-en-colombia-466664
51. Situation of gender-based violence among the Colombian and Venezuelan population during the COVID-19 pandemic. 2020. USAID – UNWOMEN
52. Reconstructing the social fabric: Venezuelan and Colombian migrant women eliminating cultural barriers. 2019. UNWOMEN https://colombia.unwomen.org/es/noticias-y-eventos/articulos/2019/12/dialogos-de-mujeres
53. Report on employment figures and gender gaps. 2020. DANE https://www.dane.gov.co/files/investigaciones/boletines/ech/Informe-sobre-cifras-de-empleo-y-brechas-de-genero-10-2020.pdf
54. The situation of LGBT migrants from Venezuela in Colombian border territories. 2019. Caribe Afirmativo http://caribeafirmativo.lgbt/wp-content/uploads/2019/06/Situaci%C3%B3n-de-las-personas-LGBT-migrantes-de-Origen-Venezolano-en-Territorios-Fronterizos-de-Colombia.pdf