

THE BIG QUESTIONS IN FORCED DISPLACEMENT AND HEALTH

COLOMBIA COUNTRY REPORT

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LIST OF ACRONYMS

ADI	Acute diarrheal illness
ADRES	Health Resources Administration Agency
ARI	Acute respiratory infection
COVID-19	Coronavirus disease 2019
DANE	Departamento Administrativo Nacional de Estadísticas (National Administrative Department of Statistics)
DNP	Departamento Nacional de Planeación (National Planning Department)
DVP	Displaced Venezuelan Population
EAPB	Entidades Administradoras de Planes de Beneficios (Benefit Plan Management Entities)
ELN	National Liberation Army
EMM	Extreme maternal mortality
EmONC	Emergency obstetric and newborn care
EPS	Entidades Promotoras de Salud (Health Promoting Entities)
FARC-EP	Revolutionary Armed Forces of Colombia-People's Army
FCV	Fragility, conflict, and violence
FGD	Focus group discussions
GDP	Gross domestic product
GIFMM	Grupo Interagencial sobre Flujos Migratorios Mixtos (Interagency Group on Mixed Migratory Flows)
HAU	Health attention unit
HFA	Health facility assessment
HIV	Human immunodeficiency virus
HP	Host population
ICD-10	International Classification of Diseases, Tenth Revision
IDI	In-depth interview
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally displaced persons
IDP	Internally displaced population
IETS	Instituto de Evaluación de Tecnologías de Salud (Institute for the Evaluation of Health Technologies)
IFC	International Finance Corporation
INS	Instituto Nacional de Salud (National Health Institute)
INVIMA	Instituto Nacional de Vigilancia de Medicamentos y Alimentos (Food and Drug Administration)
IOM	International Organization for Migration
IPS	Instituciones Prestadoras de Servicios (Service Provider Institutions)
KII	Key informant interview
LMIC	Low- and middle-income countries
M-19	19th of April Movement
MERCOSUR	Southern Common Market

MoH	Ministry of Health and Social Protection
NCHM	Centro Nacional de Memoria Histórica (National Centre for Historical Memory)
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organization for Economic Co-operation and Development
PAI	Amplified Immunization Schedule
PAPSIVI	Programa de Atención Psicosocial y Salud Integral a Víctimas (Victims' Psychosocial Care and Integral Health Program)
PEP	Permit of Permanence
PIC	Complementary Collective Interventions
TPP	Temporary Permanence Permit
RAMV	Registro Administrativo de Migrantes Venezolanos (Official Venezuelan Migrant Registry)
RIPS	Registro Individual de Prestaciones de Servicios de Salud (Individual Registry for the Provision of Health Services)
RMRP	Plan Regional de Respuesta para Refugiados y Migrantes de Venezuela (Regional Response Plan for Venezuelan Refugees and Migrants)
SGSS	Sistema General de Seguridad Social (General System of Social Security)
SGSSS	Sistema General de Seguridad Social en Salud (General System of Social Security in Health)
SISPRO	Social Protection Information System
SIVIGILA	National Epidemiological Surveillance System
SNS	Superintendencia Nacional de Salud (National Superintendence of Health)
STD	Sexually transmitted disease
SWIHSS	SubRed Integrada de Servicios de Salud Sur-Occidente (South-West Integrated Health Service Sub-Network)
THE	Total health expenditure
TMF	Tarjeta de Movilidad Fronteriza (Border Mobility Card)
TPS	Temporary Protection Statute
UNASUR	Union of South American Nations
UNHCR	United Nations High Commissioner for Refugees
UPC	Unidad de Pago por Capitación (Payment per capitation unit)
USA	United States of America
WHO	World Health Organization

INTRODUCTION

Displaced persons and host populations in fragile settings affected by conflict and violence are often inadequately served by equally fragile and dysfunctional health systems. These systems are quickly overwhelmed by the influx of large numbers of refugees and internally displaced persons (IDPs). In the acute phase of a humanitarian response, global implementing partners often navigate this challenge by establishing parallel systems for preventive and curative health services. In protracted crises, and where displaced persons settle within established host communities, the transition from acute humanitarian response to development support requires careful coordination to avoid duplication of services, inefficiency, or increased inequity and service gaps.

At each stage, host country health systems may be present alongside services offered by non-state actors and private sector providers. It can be especially difficult for health service/program planners to anticipate and respond to health needs in such complex and pluralistic environments; and harder still for individuals and families to navigate systems and meet their health needs. As the numbers of people displaced remains at historic levels worldwide, and as protracted crises become the norm, the global community is challenged as never before to find new solutions to dealing with this “humanitarian-development” nexus. And yet, this is also a moment of opportunity. The resounding endorsement by states of the Global Compact on Refugees and the global commitments to meeting the Sustainable Development Goals and realizing universal health coverage create an opening to test innovative approaches to addressing the health needs of displaced populations, alongside those of host populations. Ensuring that public sector health and development partners do not overlook the needs of displaced persons in pursuit of coverage targets, and that humanitarian actors do not destabilize already fragile government-run health systems, demands cooperation, collaboration and attention from actors working on both sides of the “humanitarian development” equation.

This Country Case Report was produced as a part of the *Big Questions in Forced Displacement and Health* project, conducted by a research consortium led by the Program on Forced Migration and Health at Columbia University, and involving joint efforts from researchers affiliated to: the Schneider Institutes for Health Policy at the Heller School for Social Policy and Management at Brandeis University; Georgetown University; the Global Health Institute at the American University of Beirut; and the School of Government at the

Universidad de Los Andes.¹ The main objectives of the research project were: (i) to identify and characterize the common trends, similarities and differences in the health needs of forcibly displaced populations and host communities in various geographical, social and demographic contexts of countries experiencing fragility, conflict and violence (FCV) facing protracted displacement conditions (beyond the initial emergency response); (ii) to present the available empirical evidence, lessons learned, and good practices, on optimal ways for host countries and development partners to be better prepared and to develop mechanisms to systematically identify, prioritize, plan and deliver health services at all levels of care for both host communities and displaced populations; and (iii) identify and describe which are the most cost-efficient mechanisms for financing health services for forcibly displaced populations and host communities.²

Box 1: A note on terminology

From its inception, the *Big Questions* study prioritized incorporating and representing various types of displacement in the study, including refugees registered with UNHCR, unregistered internationally displaced individuals, displaced Venezuelans, and internally displaced persons (IDPs). Throughout this report, the authors have utilized “displaced populations” inclusively to refer to any of these communities. Additional clarification and differentiation regarding type of displacement is made when necessitated by the data or context.

- 1 This work was part of the program “Building the Evidence on Protracted Forced Displacement: A Multi-Stakeholder Partnership”, which is funded by UK Aid and managed by the World Bank Group (WBG) in partnership with the United Nations High Commissioner for Refugees (UNHCR). The scope of the program was to expand the global knowledge on forced displacement by funding quality research and disseminating results for the use of practitioners and policymakers. This report does not necessarily reflect the views of UK Aid, the World Bank Group or UNHCR.
- 2 The arrival and persistence of the COVID-19 pandemic created unique challenges and opportunities in this research. Upon recognizing that the initial approach to research, including a heavy reliance on international travel, would need to be addressed, the researchers – in coordination with the World Bank – determined how the project might incorporate the substantial impacts of the pandemic on displaced and host communities while simultaneously retaining a central focus on the systemic challenges of health responses in protracted crises. In response, the primary data collection methodology was adapted to enable greater localization of collection and analysis, and the qualitative interview guides and quantitative surveys were rewritten to incorporate, and clearly differentiate, questions specific to the impact of the pandemic (Program on Forced Migration and Health n.d.; Harker Roa et al. 2020; Lau et al. 2020; Audi et al. 2020; Shepard et al. 2021)“URL”:<https://www.publichealth.columbia.edu/research/program-forced-migration-and-health/knowledge-briefs-covid-19-and-displacement>,”author”:[{“family”:[Program on Forced Migration and Health](http://zotero.org/groups/4613461/items/JAK83BGZ),”given”:[Program on Forced Migration and Health](http://zotero.org/groups/4613461/items/JAK83BGZ),”accessed”:{“date-parts”:[["2022",4,27]]}},{“id”:[9873](http://zotero.org/groups/4613461/items/JAK83BGZ),”uris”:[<http://zotero.org/groups/4613461/items/JAK83BGZ>],“uri”:[<http://zotero.org/groups/4613461/items/JAK83BGZ>],“itemData”:{“id”:[9873](http://zotero.org/groups/4613461/items/JAK83BGZ),”type”:[report](http://zotero.org/groups/4613461/items/JAK83BGZ),”abstract”:[The COVID-19 pandemic has heightened pre-existing gender inequalities, harmful social sentiments and several other risk factors leading to an increase in family violence, including intimate partner violence \(IPV.](http://zotero.org/groups/4613461/items/JAK83BGZ)

Colombia, Bangladesh, the Democratic Republic of the Congo, and Jordan were chosen as case studies for this analysis in order to incorporate and assess a wide variety of contexts which may factor into health service financing and provision. The selection criteria included system of delivery (camp, rural, and urban settings), provider type (non-governmental organization (NGO), local health system), host country context (active conflict, fragile, post-conflict), income level (low income, lower-middle income, upper-middle income), and displacement type (refugees and IDPs). Our selection also reflects a diversity of geographic regions and differing national policies towards refugees and the displaced and incorporates considerations of data availability and feasibility. For more information regarding the displacement context by country, see the project's Final Report.

In addition to the Final Report, the project has produced four country case studies and a series of knowledge briefs incorporating pandemic-specific challenges to health systems and health financing in humanitarian settings, including the prevention and mitigation of indirect health impacts of COVID-19, family violence prevention in the context of COVID-19, addressing the human capital dimension of the COVID-19 response in forced displacement settings, and the impact of the pandemic in Colombia on utilization of medical services by Venezuelan migrants and Colombian citizens.³

This case study focuses on the two coexisting protracted migration crises in Colombia: the internal forced displacement —caused by violence and the Colombian armed conflict —, and the external displacement from Venezuela. In practical terms, this means that the study's methodological approach — in terms of the primary data collection instruments, sample design and analysis plan — characterizes and compares the situation across Internally Displaced Population (IDP) and Displaced Venezuelan Population (DVP) in Colombia, whenever possible. As a reference point, this approach also includes the Host Population (HP).

An important note from this analysis is that, thanks to the affirmative action taken by the State (initiated by the mandate of the Constitutional Court and the consequent “Victims and Land Restitution Law” - Law 1448 of 2011), special policy mechanisms have granted IDP priority access to the country's social protection network and other public goods and services (like housing and entrepreneurship support). In particular, a cascade of special policies in the health sector have made it possible to almost reach

3 These briefs are publicly available on Columbia University's Program on Forced Migration and Health <https://www.publichealth.columbia.edu/pfmh-action-hub-covid-19-and-displacement>”.

universal health insurance coverage for all victims of the armed conflict in Colombia (93 percent coverage rate in 2018, according to the Ministry of Health and Social Protection (MoH)). In practical terms, even if there are important differences in the demographic and epidemiological profiles of the average internally displaced person and the average Colombian, this study has recurrently found that the experience in the health system (in terms of access, quality and funding) is not significantly different across these two population groups. In contrast, there are very salient differences when comparing the health needs of the DVP in Colombia, and their experience in the health system, with those of the IDP and the HP). The country case study has a proportionally heavier emphasis on understanding the challenges to better identify, prioritize, plan and deliver health services at all levels of care to displaced Venezuelans, and describing the need to improve mechanisms for financing health services for this population.

This report is divided into nine chapters. After this introduction, Chapter 1 describes the methodology, research instruments and sample design of the study. Chapter 2 presents an overview of the context of the protracted migration crises in Colombia, the historical context in Colombia and Venezuela, the evolution of the displacement history for both the internally displaced population (IDP) and displaced Venezuelans, and the neighbouring Nations' reaction to the Venezuelan diaspora. Chapter 3 provides a demographic and epidemiologic profile of the displaced populations (compared to the host population), and Chapter 4 a description of Colombia's health system and the system's response to the migration crises. Chapter 5 summarizes the structure of the health information and reporting systems in Colombia, showcasing how they have responded to the migratory crisis and outlining the challenges ahead. Chapter 6 presents an analysis on the response of the Colombian health system to migrant population. Specifically, using primary data collected through health facility assessments, in-depth interviews and key informant interviews, the analysis focuses on the availability of services and health facility capacity, access and barriers to healthcare, perceptions of health care appropriateness and quality, and the availability and integration of Venezuelan professionals. Using administrative data, Chapter 7 describes healthcare utilization, costs, and spending. Chapter 8 presents a discussion on the response of health financing for the displaced population. Finally, Chapter 9 presents the study's conclusions and lessons learned.

CHAPTER 1: METHODOLOGY AND RESEARCH INSTRUMENTS

Country case studies were conducted between 2019 and 2022. All studies began with an analysis of demographic datasets from secondary sources. The most recent available data and data disaggregated by age, sex, and location were prioritized. Also, to situate the findings of the studies and identify frameworks for interpreting results, integrative literature reviews, including academic and grey literature, were carried out.

For primary data collection, research teams in each country conducted focus group discussions (FGDs) with host and displaced community members, health facility assessments (HFAs) of purposively sampled health facilities, and semi-structured key informant interviews (KIIs). In Colombia, due to COVID-19-related restrictions, phone-based in-depth interviews (IDIs) were conducted in place of FGDs. Both FGDs and IDIs were constructed to generate information about the experience of displaced and host populations when using the health system. In all countries, the geographic (rural/urban) and type-of-context (camp/non-camp) distribution of FGDs, IDIs and HFAs varied and aimed to capture a snapshot of key features of the displacement situation. In all countries, FGDs and IDIs were stratified by gender.

1.1. Key informant interviews (KIIs)

Semi-structured in-depth interviews were conducted at each research site. To capture a range of perspectives, interviews were conducted with:

- a. Government officials, at both national and local level;
- b. Donors;
- c. Multilateral and intergovernmental organizations;
- d. International, national and local NGOs; and
- e. Civil society organizations and community leaders.

The selection of individuals was based on a literature review, expert suggestions, and organizational contacts. Although we interviewed only 13 of the 20 key informants initially aimed at, we believe the data achieved

enough saturation. The interview topics focused on the health needs and disease profiles of displaced and host populations, and how they have changed over time. It also included questions on epidemiological, economic, demographic and monitoring data and how this is collected and analyzed. In addition, the questions seek to understand the extent to which data is used to measure priorities in the health sector, public policy planning and implementation, and the organization and governance of the health system, with particular attention to human resources. The questions sought nuanced information on vulnerable populations and those with unmet health needs, as well as the use of informal healthcare systems.

1.2. In-depth interviews (IDIs)

Semi-structured interviews were conducted to generate information about the experience of displaced and host populations when using the healthcare system. All interview participants were adults over the age of 18 either from the host population, the Displaced Venezuelan population, or the internally displaced population. Interviews lasted approximately 90 minutes and were facilitated by trained local facilitators in five municipalities in Colombia: Bogotá, Barranquilla, Cucuta, Tumaco and Maicao. The sample distribution of the in-depth interviews is described in Table 1.1.

These sites were chosen because of the absolute or relative concentration of displaced Venezuelans or IDP. According to the Colombian Migration Agency, 1,842,390 Venezuelans had migrated to Colombia by August 2021. Of those, 393,716 lived in Bogotá (approximately 21 percent of the total diaspora in Colombia), 98,680 in Cucuta (5 percent), 93,321 in Barranquilla (5 percent), 40,208 in Maicao (2 percent) and 895 in Tumaco (1 percent). Data from the National Victims Registry in 2022 shows that 8,352,320 Colombians were forcefully displaced by the internal armed conflict. Of those, 317,873 lived in Bogotá (approximately 3.80 percent of the total IDP), 80,715 in Cucuta (0.97 percent), 71,616 in Barranquilla (0.86 percent), 13,132 in Maicao (0.16 percent) and 1,136 in Tumaco (0.01 percent).

Table 1.1 – IDIs sample distribution

Municipality	Actors			Gender		Total
	Host Population	Internally Displaced Population	Displaced Venezuelans	Male	Female	
Bogotá	2	3	2	4	3	7
Cúcuta	3	2	2	3	4	7
Barranquilla	3	2	2	3	4	7
Maicao	2	2	3	4	3	7
Tumaco	3	2	2	3	4	7
Total	13	11	11	17	18	35

Topic guides were developed in English and translated as appropriate. The questions address participants’ health needs, priorities and challenges, as well as their use, experience and perception of health services. The questions aim to generate nuanced information to identify vulnerable populations with unmet health needs and explore the use of informal health services that are the first point of contact with the health system in many settings and may not be adequately captured through documentation and literature review. Transcripts of the semi-structured interviews were then translated into English and uploaded into Dedoose® – a qualitative data analysis software. Three independent analysts produced the codification of the qualitative data.

1.3. Health Facility Assessments (HFAs)

HFAs were conducted to collect data about health system readiness, costing, and other health system indicators. Country research teams adapted these assessments from a standard tool according to local contexts. Facility selection was based upon various factors including delivery type (primary, secondary, or tertiary care); population served (host, displaced, or all); and setting (camp, rural, or urban). Inclusion in the sample was also based on the ability of the research team to obtain facility consent to participate and whether the security situation enabled research staff to travel to the facilities for data collection. The HFAs were not intended to be nationally representative nor comprehensive; instead, they are intended to provide a snapshot of the capacity and readiness of facilities across displaced and host population settings.

A health facility assessment tool was developed by the Columbia University team to be administered in health centers and hospitals in the four countries. This data collection tool is intended to provide evidence

to assess health system indicators, such as readiness and service costs. Previous to field work implementation, the tool was adapted for each context. Health centers and hospitals in Colombia were selected based on multiple criteria, including population served, to ensure that facilities serving both host and displaced populations are represented. In total, 20 health facilities were visited in the following municipalities: Bogotá, Barranquilla, Cali, Tumaco, Arauca, Maicao, Riohacha, Cartagena, Cucuta, Lebrija and Girón (see Table 1.2). On average two facilities per municipality were visited.

Health facilities in Colombia are classified depending on the complexity of services that they offer (low, medium and high). The first level offers general and basic care by general, technical and auxiliary personnel using low complexity technology. The second level facilities offer care by specialized personnel using medium complexity technology. The third level institutions provide specialized care by specialized and sub-specialized personnel and high-level technology. In the sample we selected facilities from all complexity levels considering that some municipalities only offer low and medium level services.

It is important to highlight that this is not a representative sample, neither at the municipality nor the national level. These hospitals were selected because of their relevance to the study, so the conclusions drawn from this sample will be relevant to the sample only. However, it is possible to say that the analysis of this data may give a certain insight into how migrant care is being provided in Colombia, given that these hospitals serve a large proportion of the host and migrant population. To explore the relevance of the health facilities chosen for the sample, a ratio was made between the total number of people that received any treatment in the municipality and the total number of people who received services at the selected health facilities. As shown in Table 1.3, this ratio ranges between 2 percent (Bogotá) and 33 percent (Tumaco) across the selected municipalities. In addition, the ratio of Venezuelan migrants treated at each *Instituciones Prestadoras de Servicios* (Service Provider Institutions) (IPS) over the total Venezuelan treated in the municipality, oscillates between 99 percent (Arauca) and 8 percent (Cartagena). This variation is partially explained by the size of the healthcare provision network in each territory: in small municipalities with few health facilities (such as Tumaco, Riohacha and Arauca), these ratios were relatively large.

Table 1.2 – Health facilities per municipality, level of complexity and population treated

Department	Municipality	Complexity Level	Population	Public	Private
Santander	Girón	Level 1	Migrants, IDP and host	x	
Santander	Lebrija	Level 1	Migrants, IDP and host	x	
Atlántico	Barranquilla	Level 3	No IDP	x	
Atlántico	Barranquilla	Level 3	Migrants, IDP and host		x
Bogotá	Bogotá	Level 3	Migrants, IDP and host	x	
Bogotá	Bogotá	Level 2	Migrants, IDP and host	x	
Bogotá	Bogotá	Level 2	Only IDP and Migrants	x	
Bogotá	Bogotá	Level 2	Migrants, IDP and host	x	
Bolívar	Cartagena	Level 3	Migrants, IDP and host		x
La Guajira	Riohacha	Level 3	Only host population		x
La Guajira	Riohacha	Level 2	Migrants, IDP and host	x	
La Guajira	Maicao	Level 2	Migrants	x	
La Guajira	Maicao	Level 1	Migrants		x
Nariño	Tumaco	Level 2	Migrants, IDP and host	x	
Nariño	Tumaco	Level 2	Migrants, IDP and host		x
Norte de Santander	Cúcuta	Level 1	Migrants, IDP and host	x	
Norte de Santander	Cúcuta	Level 1	Migrants, IDP and host	x	
Valle del Cauca	Cali	Level 2	Only host population	x	
Arauca	Arauca	Level 2	Migrants, IDP and host	x	
Arauca	Arauca	Level 1	Migrants		x
Total	20			14	6

Table 1.3 – Proportion of patients that received services at the health facilities in the sample, by municipality

Municipality	Total number of patients treated in the municipality (1)	Total number patients treated in the HFA sample (2)	Ratio (3) = (2) / (1)	Total number of Venezuelans treated in the municipality (4)	Total number of Venezuelans treated in the HFA sample (5)	Ratio (6) = (5) / (4)
Girón	na	na	na	na	na	na
Lebrija	na	na	na	na	na	na
Barranquilla	4.638.408	833.732	18%	23.911	17.203	72%
Bogotá	23.657.757	754.920	3%	203.943	29.767	15%
Cartagena	3.350.386	52.448	2%	40.484	3.294	8%
Riohacha	628.522	114.051	18%	na	na	na
Maicao	463.773	39.541	9%	31330	30.101	96%
Tumaco	281.485	94.007	33%	264	259	98%
Cúcuta	1.705.069	264.777	16%	62.278	16.077	26%
Cali	5.546.936	167.198	3%	66.218	9.649	15%
Arauca	178.937	34.243	19%	14.940	14.805	99%

1.4. Administrative data analysis

To analyze health service utilization, and patterns of morbidity and mortality, a unique dataset was constructed by extracting data from the Individual Registry for the Provision of Health Services - *Registro Individual de Prestaciones de Servicios de Salud* (RIPS), the SIVIGILA (National Epidemiological Surveillance System) and the births and deaths database. As mentioned before, all health providers are obliged to generate, transfer, organize and deliver the data to the health management organizations that pay for healthcare, known as Health promoting Entities -*Entidades Promotoras de Salud* (EPS). These organizations consolidate, organize, and upload information to the database, and then the MoH validates and publishes the data in accordance with current regulations. To compare the Colombian and Venezuelan populations, we added to the database population sizes at the municipality level: we used the census data from the National Administrative Department of Statistics - *Departamento Administrativo Nacional de Estadísticas* (DANE) and the census data recorded by the National Migration Entity.

The database consolidates variables that measure health service utilization at the municipality level, in Colombia, by month, for the years 2019 and 2020. Specifically, we used the number of consultations, hospitalizations, interventions, and emergencies recorded from March to July of both years. Additionally, the database includes morbidity measures for each type of health service provided. In this dataset the nationality of the person that uses the service is identified, as well as whether the person is in the official registry of victims of the internal armed conflict. Given the structure of this data, we can identify and compare the relative and absolute number of Venezuelan migrants and Colombians that use the health services, each year. Chapter 5 explains in more detail the structure and scope of the health information system in Colombia.

CHAPTER 2: UNDERSTANDING THE DISPLACED AND HOST POPULATION, AND THE POLITICAL CONTEXT OF DISPLACEMENT

2.1. General context of the protracted migration crisis in Colombia

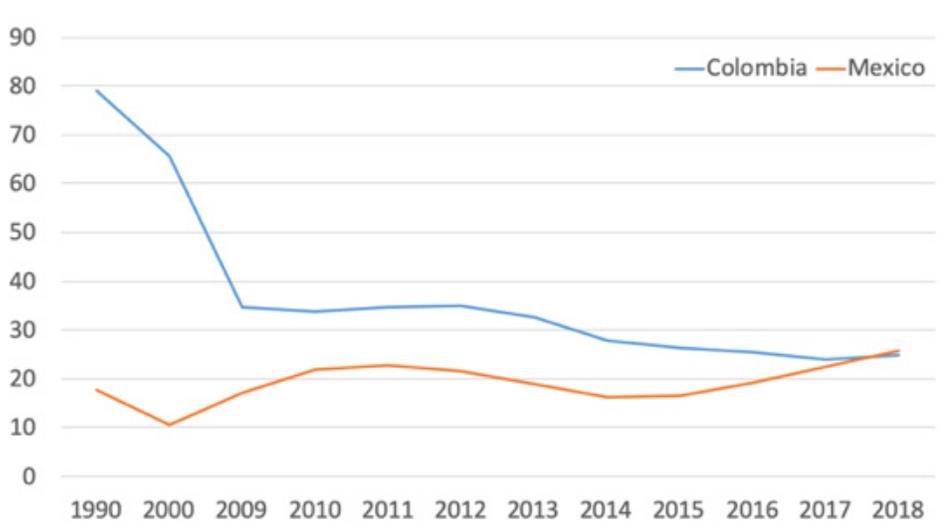
Figure 2.1 - Colombia: map and location



Colombia, located in the northwestern region of Latin America, is the fourth largest country in South America (after Brazil, Argentina, and Peru) and 16th in the world rankings. It has a surface area of 2,070,408 km² of which 1,141,748 km² corresponds to its continental territory. Colombia's broad range of climates and ecosystems is defined by extreme geographic features: the Los Andes Mountain system, crossing the entire country (from southwest to the extreme north) and reaching almost six kilometers of altitude; the Amazon basin wetlands and rainforests (covering the east and south of the country); and high precipitation rainforests bordering the Pacific Ocean (west); and flat coastal grasslands bordering the Atlantic Ocean (northwest). Given these characteristics, the country can be divided into five regions: Andean, Caribbean, Pacific, Orinoquía, and Amazon. Colombia shares extensive borderlines with five countries (see Figure 2.1): Venezuela (2341 km of borderline), Brazil (1790 km), Peru (1494 km), Ecuador (708 km), and Panama (339 km).

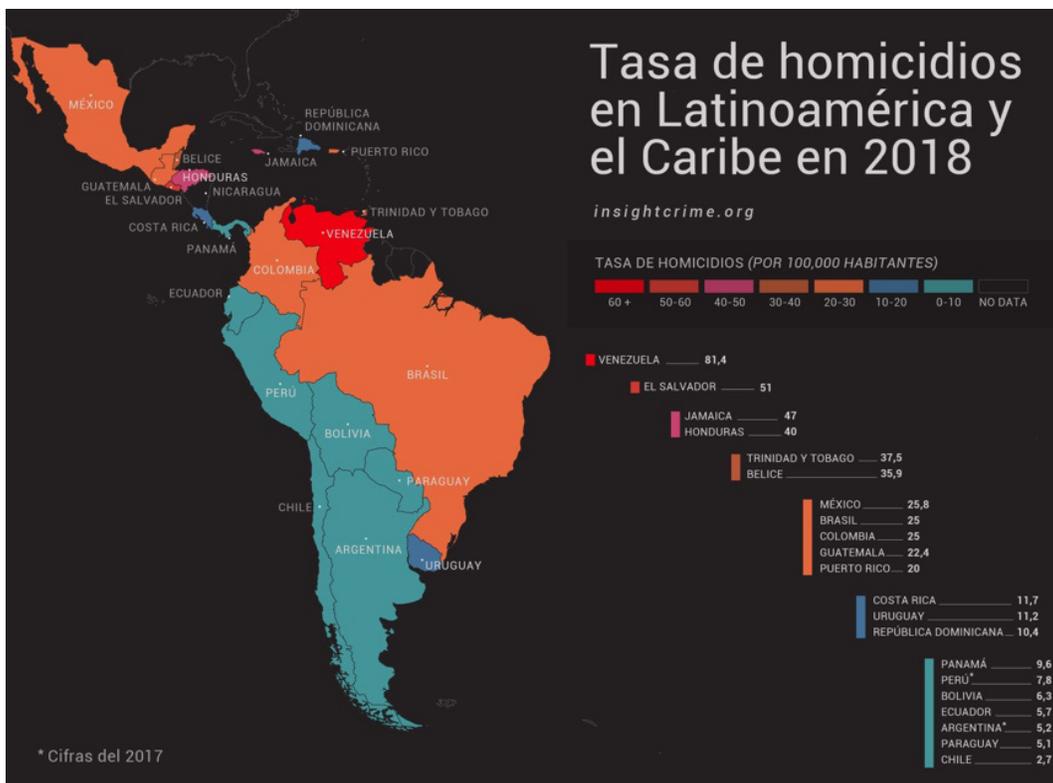
In 2020, Colombia joined the Organization for Economic Co-operation and Development (OECD), a milestone that recognizes the country's progress in terms of its social and economic development. However, Colombia faces urgent challenges due to the persistent social crisis fueled by widespread violence, the resulting internal forced displacement, and the recent influx of displaced Venezuelans that have fled their own country after its economic and social collapse. In 2018 the Gross Domestic Product (GDP) per capita in Colombia was US\$14,834 (adjusted by purchasing power parity), which represents about one fourth of this per capita average income measure in the United States of America (USA) (US\$62,886) and lies close to the Latin American average. However, more than one third of the population still lives below the poverty line, and income inequality is among the worst in the world – with a GINI index of 5.1 (12th highest in the world).

Figure 2.2 – Violent Deaths (rate per 100,000 inhabitants)



Source: World Data del Banco Mundial.

Figure 2.3 – Homicide rate in Latin America and the Caribbean (2017)



Source: insightcrime.org

After almost five decades of armed conflict between government forces and illegal groups —heavily funded by the drug trade, extortion and illegal mining — Colombia has made important strides towards peace. In 2006, after official negotiations, around 31,000 right-wing paramilitaries demobilized as a group (at least temporarily). In 2017, the Colombian government signed a peace accord with the largest left-wing insurgent group, leading to the demobilization of 14,000 men and women. The results of peace-building efforts and more effective national security strategies are evident in the decline of violence indicators during the last two decades (Figure 2.2). However, current levels of violence are still high, even compared to other countries with an ongoing internal conflict and the region (Figure 2.3). Since 1985, more than one million violent deaths and eight million victims of forceful displacement have been officially attributed to the internal conflict.

Adding to the challenge of providing aid and reparation to the internal armed conflict victims, during the last decade Colombia has had to respond to the sudden inflow of around half of the five million Venezuelan diaspora that fled the political, economic, and social crisis in their country. According to the most recent reports from the Colombian Migration Agency, Colombia currently hosts 2,029,758 displaced Venezuelans (*Migración Colombia*, March 10, 2022).

2.2. Historical Political context

2.2.1. Colombia

Colombia's history, as is the case for many nations, can be characterized by a sequence of violent events and armed conflicts. In 1499 Spaniards arrived in the South American continent to colonize the territory. Colombia was part of the Virreinato de la Nueva Granada, a collection of Spanish colonies that also included the current territories of Ecuador, Panamá, and Venezuela. These colonies were controlled by a governor appointed by the Spanish crown. The natives were forced to work for the crown, mostly in the extraction of precious metals and spices. With the accentuation of the colonization process, the native workforce became scarce, so the Virreinato started to rely on the African slave trade to support labor-intensive extraction activities. During the 16th and 17th centuries the colonies kept expanding their economic and geographic reach. Early in the 19th century, direct Spanish descendants (or Criollos) began to feel less represented by the Spanish crown, did not agree with the way Spain controlled and exploited the colonies, and consequently led the independence wars. In 1819 Colombia gained its independence, and in 1821 the independent country La Gran Colombia (The Great Colombia) was born, encompassing the other three countries that were part of the former Virreinato. Political differences within the governing class caused the division in 1830 into four countries: Venezuela, Colombia, Perú, and Ecuador.

Colombia was founded in the year 1831, and with it, two political parties emerged: the liberal and the conservative. These parties had deeply rooted opposing views on how to run the country (federalism versus centralism, big versus small government, heavily regulated markets versus *laissez faire*, etc.). As a result, every time the presidency pivoted, the incoming party challenged and shifted the policy agenda, which in turn affected the implementation of long-term endeavors. More importantly, the rivalry between extremist political views resulted in a series of civil wars and widespread bloodshed - with approximately 200,000 violent deaths in the period from 1947 to 1966 (Karl, 2017).

In an attempt to end civil violence, in 1957 —after a brief military coup — the leaders of the two political parties agreed to alternate power every four years. This period, called Frente Nacional (National Front), lasted until 1974. This alternating regime restricted political participation to the two traditional parties, resulting in an absolute lack of representation of minorities in government. As a response, in the 1960s communist guerrilla groups emerged, using violence to fight for the right to participate in the country's politics and government (Fajardo, 2015). The largest and most resilient guerrilla groups created in this period were the FARC-

EP (Revolutionary Armed Forces of Colombia-People's Army), the ELN (National Liberation Army), and the M-19 (19th of April Movement). These guerrilla groups took control over many rural territories where the State had little or no presence. In some regions, local communities responded by arming themselves and creating paramilitary groups, particularly during the 1970-1980 period.

Colombia's contemporary armed conflict began on November 6, 1985, when the members of the M-19 guerrilla group sieged the Palacio de Justicia (Colombia's national courthouse). This milestone marked a new and more violent phase of the conflict, characterized by the fact that both guerrilla and paramilitary groups entered the illegal drug production and trade business to finance military activities (UNHCR, 2019). As a consequence, the reach and power of these illegal armies amplified, illicit crops and the drug trade expanded, and violence peaked in both rural and urban areas.

In 1990, a peace treaty was signed between the M-19 (the largest guerrilla group at that time) and the Colombian government. An agreement was reached to create a National Assembly to write a new constitution that would end the bipartisan political structure and effectively open participative spaces for a broader political spectrum. Unfortunately, even if the new constitution — consecrated in 1991 — represented a turn in the history of Colombia, the internal armed conflict did not end. In 1991 the homicide rate reached its historical peak: 79 violent deaths per 100,000 inhabitants. In 1992 the FARC-EP recorded the greatest number of attacks against civilians, law enforcement bodies and state infrastructure. To neutralize the progress of extreme right-wing sympathizers and the reach of paramilitary groups into the political arena, months prior to the 1998 local elections, FARC-EP forced the resignation of candidates in 162 municipalities (Benito & Niño, 2018). Moreover, in the year 2000, around 317.000 people were displaced due to illegal armed groups (*Red Nacional de Información*, n.d.).

The armed conflict reached a turning point when Alvaro Uribe Vélez was appointed as President in 2002 (until 2010). On the one hand, Uribe Vélez implemented a national security strategy that effectively reduced violent crime (such as kidnapping and extortion) and terrorist attacks. On the other hand, some of the political reforms and policies implemented during his rule (such as introducing presidential re-election and results-based monetary rewards for the military) eroded key institutions that protected the system of checks and balances and the civil rights of minorities and social leaders.

Peace negotiations between the government and the FARC-EP began under the leadership of President Juan Manuel Santos Calderón (2010-

2018). In 2015, President Santos met in Havana with the political leader of the FARC-EP (Rodrigo Londoño, a.k.a. Timochenko) to publicly shake hands on the agreement that a peace treaty would be signed no later than March 23, 2016. After the release and signing of the document that embodied the results of a complex negotiation process, later that year, the government carried out a national referendum that asked Colombian citizens if they approved the terms of the peace treaty. Given that the referendum resulted in a marginal majority against the written agreement (50.2 percent of votes), subsequently the peace treaty document had to be modified and approved by the Colombian Congress.

Even though the peace treaty (signed in November 2016) established the country's formal commitment to achieve the reintegration of former FARC-EP combatants (approximately 14,000 women and men) and move forward with long overdue structural reforms to reduce socioeconomic inequality, the implementation of the agreement remains a challenge and feels like a partially lost opportunity. Recent trends of violence and displacement are proof of this. According to the Office for the Coordination of Humanitarian Affairs (OCHA) (2020), between 2017 and 2019, 503,000 persons were forcefully displaced by conflict and violence and 30,500 violent attacks on civilians were registered. In addition, between 2017 and February 2020, the independent non-governmental organization INDEPAZ, reported the violent death of 796 social leaders and human rights advocates (González-Perafán and Delgado-Bolaños, 2020).

2.2.2. Venezuela

Venezuela has been a global oil exporting power since the 1920s. In the seventies the country became one of the most modern, egalitarian and educated countries in the world. However, in 1980, the economy started to suffer an important deterioration, clearly reflected in the country's socioeconomic indicators: by 1997, poverty reached 48 percent of Venezuelan families, almost doubling the prevalence observed 15 years earlier. The homicide rate, on the other hand, went from 8 per 100,000 inhabitants in 1986 to 20 in 1998. The inflation rate in 1996 reached 99 percent, and in 1997 and 1998 it was 50 percent and 33 percent, respectively (López, 2016).

Socioeconomic conditions and widespread discontent with the incumbent governing groups led to an extreme political shift in the country, that ultimately consolidated with the election of Hugo Chávez as president in 1999, and a referendum through which the Venezuelan electorate approved a new constitution (replacing the one from 1961). In 2001, President Chávez, reorganized Venezuela's government, shifted the economic regulatory framework (weakening or eliminating pro-market institutions) and implemented land redistribution measures, using exceptional direct

legislative powers (Telesur, 2017). These modifications to the law caused a national strike in 2003, which resulted in an unsuccessful referendum to revoke the President's mandate (the vote to not-revoke won with 59.1 percent of the votes). After the successful democratization and investment of oil revenues, poverty and inequality indicators improved (López Maya, 2016) and, in 2006, Chavez won the presidential elections for the third time with 63 percent of the votes, which led to a precipitous nationalization (and expropriation in many cases) of energy and telecommunication companies (Dinero, 2010).

In 2008, due to the plunge in global oil prices, a short but acute economic crisis began in Venezuela. At this point, the economy had suffered the loss of productive and market diversification and depended on the state's subsidies and spending, which in turn were funded by oil revenues. President Chavez ignored this alert regarding the country's dependence on the oil market and concentrated his efforts on extending his time in power by reforming the constitution. In 2009, Chavez won a referendum in which the limits on the terms in office for president, state governors, mayors, and deputies to the National Assembly were abolished.

Three years later, in 2012, Chavez won a fourth term in office with 54 percent of the votes and an attendance at the polls of 81 percent. Months later, he died of cancer, and Nicolás Maduro — one of his closest collaborators — assumed the presidency. The same year, oil prices fell again which meant that the Venezuelan state could no longer maintain its fiscal spending, causing shortages that affected the ability to meet people's basic needs and services throughout the country (López Maya, 2016). The extreme instability of the state and the resulting halt of the economy turned swiftly into a social and political crisis. Hyperinflation, lack of food and medicines, and large increases in crime rates caused the mass migration of almost eight million Venezuelans to other countries in the world, looking for better living and working opportunities.

2.3. Displacement history

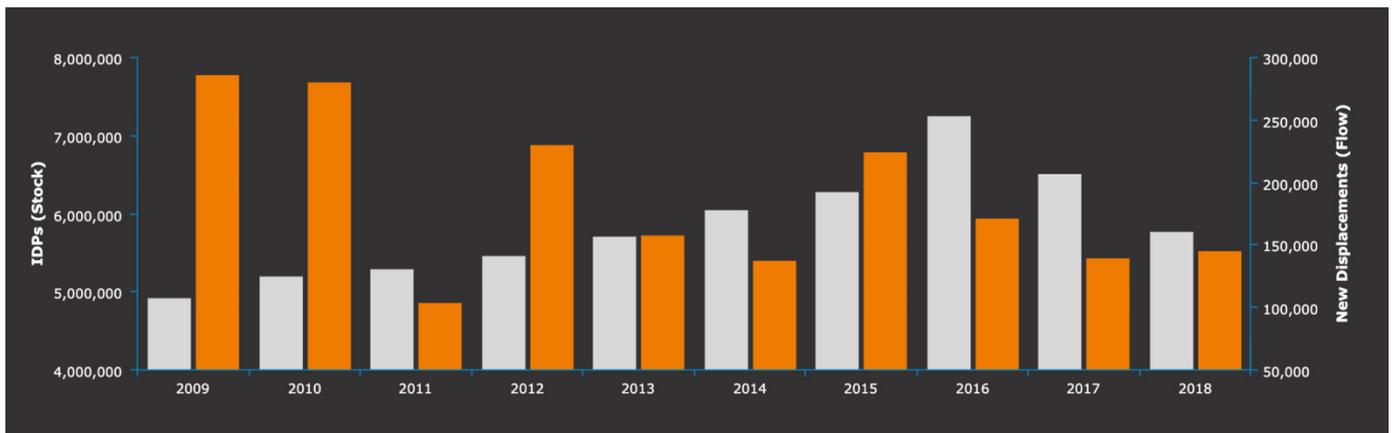
2.3.1. Internally displaced population (IDP)

The Colombian contemporary armed conflict began in 1985. Between 1985 and 2010, 4.9 million people were displaced. In 1985 alone, 14,635 people were displaced. This yearly flow continued to grow steadily until it reached a maximum of 350,000 in 2005. According to a report from Colombia's National Centre for Historical Memory -*Centro Nacional de Memoria Histórica* (NCHM)¹, in 2015 there were nearly 6.5 million displaced people in Colombia. Other sources, such as UNHCR, report that, by 2018, 7.7 million people had been victims of forced displacement in Colombia.

During 2019, around 68,436 people were displaced. According to the Internal Displacement Monitoring Centre (IDMC), as of 31 December, 2019, the total number of IDPs due to violence and conflict in Colombia reached 5,576,000 (Figure 2.4). Most forced displacements in Colombia are caused by both left- and right-wing illegal armed groups, (Ibañez and Velásquez, 2008), and have been reported in 90 percent of the Colombian territory. Although mass migration is not uncommon, most registered IDPs have migrated individually (75 percent of the total IDP officially registered).

Colombia has made enormous efforts to guarantee the assistance and reparation of internal armed conflict victims. These efforts –which formally started in 1997 – were eventually crystalized in the 2011 “Victims and Land Restitution Law” (Ley de Víctimas y Restitución de Tierras - Law 1448 of 2011). The law recognized the need to protect and compensate victims of the conflict and defined a concrete mandate to all government agencies to design and implement a multisectoral strategy to promote the recovery of victimized populations. A general result of this legal mechanism was that all agencies had to design specific strategies to include IDPs and other victims in the existing programs and services provided by the country’s social security network. For example, the MoH had to create mechanisms to guarantee the enrollment into the national health insurance system of all people that self-registered as victims. In addition, some sectors had to create tailor-made programs to satisfy the special needs of this population. For instance, the MoH led the design and implementation of the Victim’s Psychosocial Care and Integral Health Program - *Programa de Atención Psicosocial y Salud Integral a Víctimas* (PAPSIVI), the state’s primary mental health service strategy to support victims of the internal armed conflict.

Figure 2.4 - Flow and Stock of IDPs in Colombia



Source: IDMC - <https://www.internal-displacement.org/countries/colombia>

2.3.2. Venezuelan migration and the neighboring nations' reaction

The political, social and economic crisis has had profound and long-lasting scars for Venezuela. For instance, a recent World Bank report reveals that, in 2017, Venezuelans lost in average 11 kilos in bodyweight, 89 percent of the population lived in poverty, infant mortality rate rose to 26 per 100,000 live births, and the country has now the second highest homicide rate in Latin America and the Caribbean (89 per 100,000 inhabitants). As a consequence, approximately 5.2 million Venezuelans have fled to countries in Latin America and the Caribbean (UNCHR and IOM, n.d.; see Figure 2.5). Data from the Colombian Migration Agency shows that, by August 2021, about one third of this diaspora (1,842,390 persons) arrived in Colombia to stay temporarily or permanently. Currently, the government estimates that 19 percent of the Venezuelan migrant population is “regularized” (having an official residence permit, more on this below), 64 percent are in process of regularizing their status, and 17 percent have yet to legalize their migratory status (Migración Colombia, 2021).

It is important to note two additional migration phenomena. First, a significant number of migrants transit through Colombia to other countries. According to the Colombia Migration Agency, during the first nine months of 2018, 724,036 Venezuelans transited through the country (Figure 2.5). Second, there is a substantial population traveling in and out of Colombia on the same day, known as “pendular migration” (see Box 1). On average, 50,000 Venezuelans transit between Colombia and Venezuela every day. To regulate this pendular migration, the Colombian state created the Border Mobility Card - Tarjeta de Movilidad Fronteriza (TMF), which allows the transit of people across border areas. It is important to highlight that many of the pendular migrants came to Colombia to access to health services. By 2022, 4.98 million Border Mobility Cards were issued by the Colombian Government.

Three migration phases have been identified (Moreno and Pelacani, 2021; Acosta et al., 2019; Beyers and Nicholls, 2020). The first migration phase is characterized by a diaspora of Venezuelans who are well-educated professionals, business owners or investors, with an above average socioeconomic level. This group fled Venezuela between the years 2000 and 2012 mainly to the USA and Europe “seeking better opportunities”. The second phase (2012-2015), labeled as a diaspora of “growing hopelessness” (Acosta et al., 2019; Beyers and Nicholls, 2020), is characterized by low-income migrants motivated by the political, social and economic collapse (e.g., political repression, insecurity, food and medicine shortages) which had a severe impact on their living conditions. In this phase, displaced Venezuelans fled mostly to countries in Latin America. Finally, the third phase (2015 onwards), labeled as the “migration of desperation”, involves the lion’s share of the historical Venezuelan

diaspora, and includes the most vulnerable migrant population that left Venezuela after the breakdown of basic utility infrastructure (energy and sanitation) and social and health services.

Box 2: The pendular migration phenomenon

Pendular migration is defined as frequent and short-term population movements across an international border. The Regional Response Plan for Venezuelan Refugees and Migrants (*Plan Regional de Respuesta para Refugiados y Migrantes de Venezuela - RMRP*), has estimated that, by 2020, Colombia received approximately 2.09 million pendular migrants (Interagency Group of Mixed Migratory Flows (*Grupo Interagencial sobre Flujos Migratorios Mixtos - GIFMM*, 2021). Pendular migration, as with other migratory phenomena, can be either regular or irregular. Venezuelan migrants and refugees with “regular status” entered the country through regular border crossings with government checkpoints and remain in the country with an official permit. On the contrary, migrants and refugees who enter the host country through irregular crossings and without an unexpired official permit have an “irregular status”. Regular pendular migration between Colombia and Venezuela is regulated by the Colombian Ministry of Foreign Affairs through the Border Mobility Card (*Tarjeta de Movilidad Fronteriza - TMF*), a document that allows Venezuelan citizens to enter, transit and stay temporarily in border regions in Colombia for a maximum period of 30 days. A TMF does not allow Venezuelans to live, work or study in Colombia, affiliate to the Colombian health insurance system or travel to other regions of the country.

According to the Colombian Ministry of Foreign Affairs, by 2019 approximately 4,315,103 Border Mobility Cards had been issued and, as of March 2020, nearly 36,000 Venezuelans entered Colombia every day through this modality. There is no official estimate of the number of irregular Venezuelans that cross the border back and forth almost daily. Pendular migration, regular and irregular, has become a subsistence mechanism for both Colombian and Venezuelan citizens living in Venezuela (Mojica et al., 2020). A recent needs assessment of the pendular migrant population during the COVID-19 pandemic surveyed Colombian and Venezuelan persons in the departments of Arauca, La Guajira, and Norte de Santander, during the months of June and July 2021 (GIFMM, 2021). This study provides the following key insights that characterize pendular migration:

- Labour inclusion and income generation: Nearly 20 percent said they did not have a source of income; 33 percent stated that they

had some type of work in Venezuela, while 24 percent said they carried out some economic activity in Colombia.

- Frequency, duration, and intention to stay: About 30 percent of the population crosses the border daily, 17 percent once a week and 12 percent every two weeks; 48 percent planned to stay only a couple of hours and 18 percent a maximum of one day; and 41 percent reported an intention to change their residence to Colombia in the next three months.
- Motivation: The most frequently reported motivations to travel to Colombia are accessing food (57 percent), accessing medicines (52 percent), access to medical treatment (44 percent), job opportunities (43 percent), visiting their family in Colombia (13 percent), access to other household goods (10 percent), access to education for children (7 percent), and access to education for children and youth (9 percent).
- Needs: The main needs reported by the interviewed Venezuelan pendular migrants are: food (85 percent), medical attention (55 percent), and employment (45 percent); only 36 percent report having three or more meals each day; only 40 percent of pregnant and 45 percent of lactating women have an adequate Body Mass Index score.

2.3.3. The neighboring nations' reaction to the Venezuelan diaspora

Initially, Colombia chose to respond to the exponential influx of displaced Venezuelans in the last decade by creating a Special Permit of Permanence (*Permisos Especial de Permanencia* - PEP). This short-term mechanism to regularize migratory status of Venezuelans in Colombia grants temporary residence and access to formal employment and the country's health insurance system - beyond emergency care services, which are available to every adult or child in Colombia. There were several PEP emission phases, between July 2017 and December 2018.

Unlike in other countries, the PEP is free, but it requires a valid identification document. Additional requirements to be met are as follows: (i) Being in Colombian territory on the date of publication of the resolution; (ii) Having entered the national territory through an authorized Migratory Control Post with a passport; (iii) Not subject to any judicial record at the national and international levels; and (iv) not being the subject of a deportation process. With the PEP, Venezuelan citizens can stay for a period of 90 days in Colombia, extendable up to a maximum of two years. After the maximum two-year term ends, there is no explicit mechanism to gain a permanent residence permit or visa (Acosta, Boilin & Freiere, 2019).

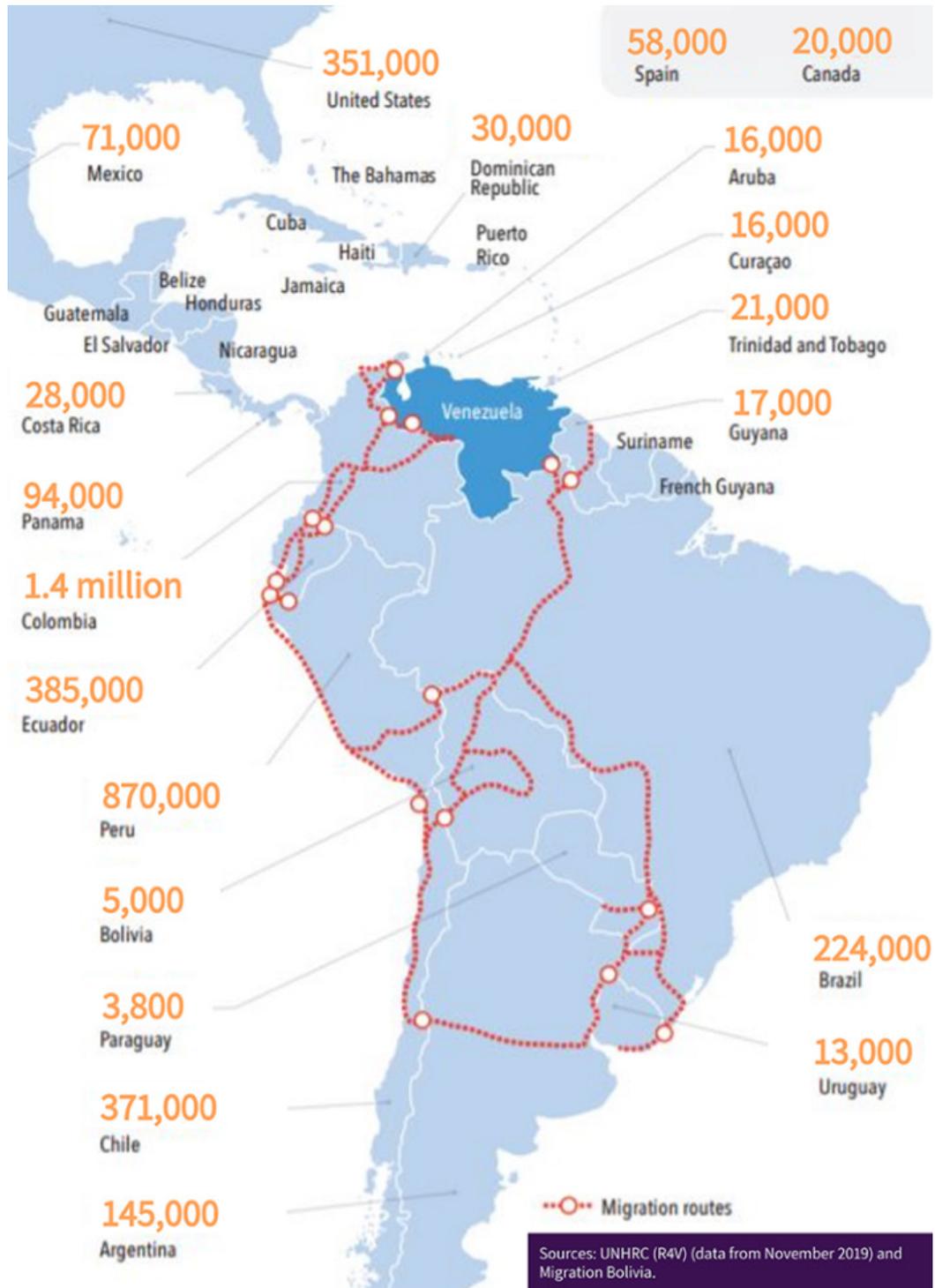
To provide better integration of the displaced Venezuelans and establish a long-term regularization mechanism, the Colombian Government created the Temporary Protection Statute for Venezuelan Migrants (through the Presidential Decree 216 of 2021). The Temporary Protection Statute (TPS) ensures the transit of displaced Venezuelans from the temporary protection regime to an ordinary migratory regime. That is, migrants will have a ten-year period to acquire a resident visa. This statute was directed to displaced Venezuelans who are in Colombia on a regular basis, in other words they have a valid residence permit, and those who are in an irregular situation who can prove they were in the country before January 31, 2021. By being registered with the Colombian authorities and having a permit to stay in the country, displaced Venezuelans can access the institutional offer regarding health, education, work, and care for children and adolescents at the national, departmental, and municipal levels. Also, they can perform any legal activity or occupation in the country, including those developed under an employment relationship or contract.

Other Latin American nations have had diverse responses to the Venezuelan migratory crisis, which has indirectly affected the inflow to Colombia. Argentina, Brazil, and Uruguay have implemented the extension of the Southern Common Market (MERCOSUR) ⁴ Residence Agreement. This international agreement states that citizens from a MERCOSUR-member country can obtain a two-year residence permit (Acosta, Boilin & Freiere, 2019). In addition, these three countries have implemented policies to nationalize displaced Venezuelans. However, since December 2016, when Venezuela was suspended from MERCOSUR, new restrictive procedures and measures regarding residence permits and nationalizations appeared.

Ecuador created the “Law of Human Mobility” in 2018, which harmonized the country’s migration normative and allowed people from any country member of the Union of South American Nations (UNASUR) a two-year residence permit. This meant that, under this legal framework, Venezuelans could enter the country freely with their passport or national ID. However, in recent years, new visa restrictions to displaced Venezuelans (presenting a criminal record, applying for a visa before arrival and presenting a valid passport) have been introduced by Ecuador (Acosta, Boilin & Freiere, 2019).

4 The Southern Common Market (MERCOSUR, for its Spanish initials) is a free-trade area and continuous regional integration process founded by Argentina, Uruguay, Brazil, and Paraguay. Bolivia, Chile, Colombia, Ecuador, Guyana, Peru, and Suriname are associate members. Venezuela was a full member but has been suspended since 2016.

Figure 2.5 - Migration routes and flows



Source: [World Bank \(2019\)](#).

Peru also created a Temporary Permanence Permit (TPP), which allows Venezuelans to legally be in the Country's territory for a one-year period and authorizes them to work. However, the TPP is not an authorization of permanence and, therefore, displaced Venezuelans with this permit are not considered as residents and cannot obtain an immigration card. After the expiration of the TPP, if a Venezuelan citizen has no criminal record and can show proof of legal economic activities during the term of the TPP, they can request a residency permit (Acosta, Boilin & Freiere, 2019). In 2019, Peru restricted the entrance of displaced Venezuelans by imposing a law that stated that a passport was mandatory to enter the country.

Chile has historically had a more restrictive policy than other Latin American countries. To enter the country, Venezuelans have to request a visa at the Chilean consulates in Caracas or Puerto Ordáz. Beneficiaries of the democratic responsibility visa are granted a one-year residence permit, extendable only once, after which they must apply for permanent residence or leave the country (Acosta, Boilin & Freiere, 2019).

CHAPTER 3: DEMOGRAPHIC AND EPIDEMIOLOGIC PROFILE

3.1. Host population

The 2018 census estimates that Colombia has a total 48,258,494 inhabitants, of which 51.2 percent are female and 48.8 percent male (DANE, 2018). Population density in Colombia varies tremendously across its territory, mainly due to the country's range of geographical features. For instance, the Amazon region (390,486 km²), characterized by jungles and savannas with extreme flood and drought seasons, has an average of 2.8 inhabitants per squared kilometer; while the Andean region (282,540 km²), located at the massive Los Andes cordillera, has by far the highest population concentration, with 122 inhabitants per squared kilometer. In 2019, 77 percent of Colombians lived in the urban areas and it is projected that, by 2050, this will increase to 84 percent of the population (Ministry of Health, 2018). Most of this urban population is concentrated in the largest cities: 10.8 million in Bogota (the capital), 4 million in Medellin, 2.8 million in Cali, 2.3 million in Barranquilla, 1.3 million in Bucaramanga and 1.1 million in Cartagena.

Fertility

Colombia's population is aging, as a result of steady declines in fertility, mortality and population growth rates. Fertility has followed a continuous negative trend, as a result mainly of increased education and better access to sexual and reproductive health services. In 1960, the fertility rate was 6.74 (births per woman), decreasing to 1.81 in 2018. The current fertility rate barely surpasses the replacement level. Again, there is an important variation across regions: for the 2015-2020 period, the average number of children for women in the Amazon (3.38) is approximately 1.8 times larger than in Bogotá (1.90) (DANE, 2020). Likewise, this variation is closely correlated with structural inequalities across the country. For instance, in the Amazon-Orinoquia region approximately one third (30 percent) of the population lives in poverty, according to the Multidimensional Poverty Index constructed by DANE, using the 2018 census data. In Bogotá, only 4.4 percent of the population are classified as "multi-dimensionally" poor.

Mortality

Currently, average life expectancy in Colombia is 76.15 years. Although, by sex this indicator tends to be higher for women, this gap has decreased (Ministry of Health, 2018). Between 2005 and 2017, the death rate has fluctuated between 369 to 645 deaths per 100,000 people. The main cause of death was circulatory system diseases (Ministry of Health, 2018). In 2017, circulatory system diseases produced 150.3 deaths per 100,000 inhabitants per year, which represents 30.5 percent of the total deaths in the country. In the same year, non-transmissible diseases were the second largest cause of death (25.3 percent). The most prevalent non-transmissible diseases were diabetes mellitus, nutritional deficiencies and nutritional anemias, chronic diseases of the lower respiratory tract, cirrhosis and certain other chronic liver diseases. The third most common cause of death was neoplasms (20.2 percent), and the fourth was external causes (15.5 percent). Transmissible diseases constituted only 6.9 percent of the total deaths in 2017 (Ministry of Health, 2018).

Morbidity

According to the data collected from the RIPS between 2009 and 2019, approximately 57.5 million people received services from the healthcare system in Colombia. On average, there were 95.9 million services provided annually. Of those services, 65.6 percent were provided to people who consulted for non-transmissible diseases; 13.1 percent were provided for people who suffered from transmissible diseases and malnutrition; 14 percent were given for people who had nonspecific clinical manifestations; 5.4 percent were for injuries; and 1.9 percent were to attend for maternal and perinatal conditions (Ministry of Health, 2020).

3.2. IDP

According to the official registry of victims, since 1985, 6.5 million people were forcefully displaced in Colombia (National Victim Unit, 2020). The internal armed conflict has affected men and women almost proportionally: in the registry there are 3,301,848 women and 3,130,014 men (NCHM, 2015). Additionally, about a third of the registered victims are under 18 years old: 503,323 in early childhood (0 to 5 years old), 977,660 children (6 to 12 years old) and 798,593 teenagers (13 to 17 years old). The majority of internally displaced people (53 percent) are adults between the ages of 18 and 60 (3,441,664 people). Of this population, 1,211,286 were young adults aged between 18 and 26 years old, and 2,230,378 were adults aged between 27 and 60 years old (NCHM, 2015). Forced displacement continues to be a reality in Colombia: in a recent bulletin, the Ombudsman Office of Colombia reported that, in January 2022, 4,408 people from

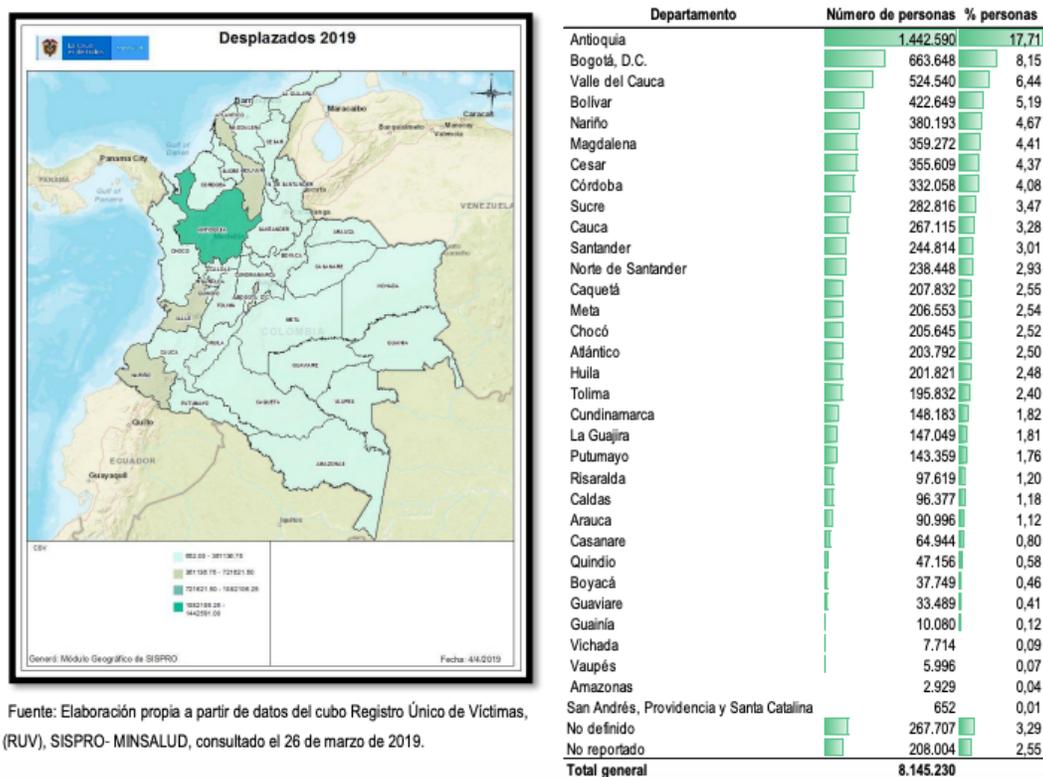
1,358 families were directly victimized by 17 events of mass displacement resulting from confrontations between illegal armed groups. Importantly, the most affected region was the northeastern corridor of the country, bordering Venezuela: Arauca, Casanare, Vichada and Norte de Santander (Defensor del Pueblo, 2022).

Ethnic communities in Colombia have been disproportionately victimized by forced displacement. According to the registry, 869,863 displaced persons belonged to an ethnic group, which means that this form of violence affected 14 percent of the Colombian ethnic population in 2005. UNHCR reports that, of the total IDP, 21.2 percent recognize themselves as Afro-descendants and 6.2 percent are indigenous. The regions in Colombia that have the largest number of reported IDP are Antioquia (17.7 percent), Bogotá (8.2 percent), Valle del Cauca (6.4 percent), Bolívar (5.2 percent) and Nariño (4.7 percent) (see 3.1).

A study published in 2007, which was the first academic effort to collect rigorous and representative data from the displaced population in Colombia, shows that 95 percent of IDPs were under the poverty line, 75 percent were below the extreme poverty line and 50 percent were unemployed (Ibáñez and Moya, 2007). In addition, this study shows that forceful displacement causes an average consumption and income decrease of 28 percent and 50 percent, respectively. Finally, the data suggests there was a higher incidence of domestic and community violence among IDPs.

According to the International Organization for Migration (IOM), displaced individuals that are affiliated to the Sistema General de Seguridad Social en Salud (General Social Security System - - SGSSS) have the same opportunity and access to healthcare services as any Colombian (IOM, 2002). However, evidence shows that, at least at the beginning of this century, the affiliation rate to the SGSSS for displaced households is almost 20 percent lower compared to urban households living in extreme poverty (Ibáñez and Moya, 2007). Also, only 48 percent of displaced households were affiliated to the national poverty alleviation network and 14 percent of them had a health insurance plan.

Figure 3.1 – Number and geographical distribution of Internally Displaced Population



Reference: Ministerio de Salud y Protección Social. (2019). Análisis de Situación de Salud (ASIS) Colombia, 2018- Dirección de Epidemiología y Demografía. Retrieved from: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/PSP/asis-colombia-2018.pdf>

Morbidity

A 2003 study identified three types of health problems caused by internal forced displacement. First, mental health issues, caused by the extreme stress resulting from drastic and sudden life changes. Second, the lack of proper nutrition caused by scarcity of economic resources. Third, gastrointestinal and respiratory problems due to inappropriate living conditions. Most of the health problems that IDPs face, even years after they have been displaced, are directly related to structural barriers to satisfy basic needs – such as human capital mismatch and the subsequent inability to enter the labor market (Mogollón, Vázquez, García, 2003).

A study funded by the IOM and UNHCR indicates that around 80 percent of displaced households reported a family member being sick during the previous three months. The most common diseases were acute respiratory infection and acute diarrheal disease. Again, this high prevalence reflects precarious living conditions. The seminal study of Ibañez and Moya (2007) shows a similar picture: 50 percent of the surveyed households informed that one or two members were sick, and 20 percent reported that three or four members of their family were sick. Of all the sick family members, 40 percent had to go to a hospital to be treated.

3.3. Displaced Venezuelans

Demographic information is available only for the almost half-million (442,462) Venezuelans that have been registered in the Official Venezuelan Migrant Registry (*Registro Administrativo de Migrantes Venezolanos* - RAMV). Of those registered in the RAMV, 49.7 percent are women (219,799), 18 percent are children between the ages of 0 and 9, 52 percent are between 20 and 39 years old, and adults over 50 do not reach 6 percent of the total (DNP, 2018). Within all age groups the gender distribution is similar.

In the last five years, migration from Venezuela has concentrated mainly in the eastern border areas of Colombia (Norte de Santander, Arauca and Guajira), Bogotá and the Atlantic Coast (see Figure 3.2). About 80 percent of the migrant population is concentrated in seven of the 32 *Departamentos* (Departments, the largest decentralized government subdivision), and in 60 of the 1,122 *Municipios* (Municipalities, the smallest subdivision within departments) in the country (*Departamento Nacional de Planeación* (National Planning Department - DNP), 2018). Bogotá is the city with the highest number of migrants (278,511), which represents 22 percent of the total number of people from Venezuela - yet only 2.5 percent of the total population in the capital city. Although the highest number of immigrants are in Bogotá, the border areas are the most traumatized by Venezuelan migration flow because of its volume in high relative terms (i.e. the number of migrants as a percentage of the total population of the department). The greatest proportion is in the department La Guajira which represents 4.5 percent of the total population of this department, followed by Norte de Santander (4.3 percent), Atlántico (3.1 percent), Sucre (2.6 percent), César (2.3 percent) and Magdalena (2.2 percent).

Information collected by the National Epidemiological Surveillance System (SIVIGILA), a system that focuses on monitoring public health events, shows that the number of Venezuelans that received healthcare services in Colombia has grown almost exponentially. While in 2017 there were 72,677 cases of foreign patients (combining emergency care, hospitalization, external consultation and procedures), in 2018 this number almost multiplied by 4.5, reaching 325,335 cases (see Table 3.1). In the 2017-2019 period, the most prevalent health events monitored in the SIVIGILA regarding Venezuelan migrants in Colombia were: malaria (57 percent, 40 percent and 27 percent of total events reported in 2017, 2018 and 2019, respectively), domestic violence (11 percent, 14 percent and 8 percent), gestational syphilis (1 percent, 3 percent and 9 percent), acute malnutrition in children under five years old (2 percent, 4 percent and 8 percent), and tuberculosis (4 percent).

TTable 3.1 – Healthcare provided to the Venezuelan migrant population

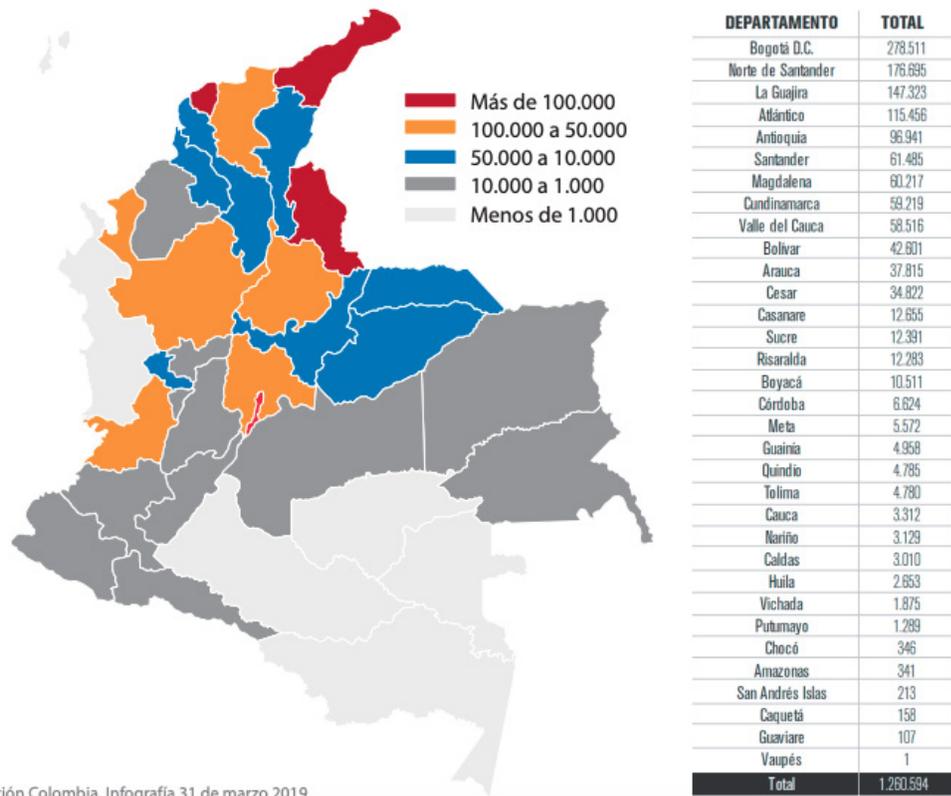
Heath care provided	2017	2018	Variation %
Emergency care	8,926	130,708	183.4%
Hospitalization	4,562	16,900	270.5%
External consultation	48,589	130,708	196.0%
Procedures	10,600	47,019	343.6%
Total	72,677	325,335	202.6%

Reference: DNP. (2018). Documento Conpes 3950 Retrieved from: <https://colaboracion.dnp.gov.co/CDT/Conpes/Econ%C3%B3micos/3950.pdf>

The complete list of most frequent health events reported is presented in Table 3.2. In particular, in 2019 deaths caused by Human immunodeficiency virus (HIV) represented 6.6 percent of the events registered by SIVIGILA. In addition, during this year 8,209 pregnant women and 7,496 women breastfeeding were registered in this monitoring system, and most of them did not receive proper prenatal controls or have access to the Colombian social protection network. In addition, self-reported data suggests that the most frequent chronic pathologies are: arterial hypertension, diabetes, lung disease and heart disease (Ministry of Health, 2018). Also of note is that a significant number of the Venezuelan migrant population has some type of disability (11,648 people).

In 2020, the Colombian non-governmental organization (NGO) *Profamilia* conducted a study focusing on the six cities with the highest migratory flow from Venezuela to identify the most urgent needs in maternal, child and adolescent health, communicable and non-communicable diseases, violence against women and mental health. By triangulating diverse official data sources (see Profamilia 2020), this study finds that the most urgent needs are: access to primary care services, diagnostic tests for the main public health events, prenatal check-ups and postpartum check-ups, and access to information on the supply of health services (where to find what is needed within the humanitarian response). It also found that the health services most frequently used by displaced Venezuelans related to sexual and reproductive health were consultations for pregnancy confirmation, counseling on contraceptive methods, and assistance in the use of these contraceptive methods. Those related to maternal and child health were Extreme Maternal Morbidity (EMM), prenatal care and delivery care, Acute Respiratory Infections (ARI) and Acute Diarrheal Diseases (ADI). Finally, the study shows that the most frequently used services related to communicable diseases were consultations regarding diagnosed HIV and Hepatitis; and to non-communicable diseases, related to the circulatory system and diabetes.

Figure 3.2- Number and geographical distribution of Venezuelan Migrants



Fuente: Migración Colombia, Infografía 31 de marzo 2019

Reference: Ministerio de Salud y Protección Social. (2019). Infografía Fenómeno Migratorio. Retrieved from: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/infografia-migrantes-25junio2019.pdf>

Table 3.2 – Main health events regarding Venezuelan Migrants in Colombia monitored in the SIVIGILA - Epidemiological period 4 (16th week), 2017-2019

Events	2017	2018	2019
Malaria	56.80%	40.03%	27.34%
Gestational syphilis	1.22%	2.76%	8.91%
Domestic violence	11.16%	14.35%	7.95%
Acute malnutrition in children less than 5 years old	1.83%	4.28%	7.59%
Deaths caused by HIV	2.84%	4.02%	6.60%
Extreme maternal morbidity	2.23%	3.23%	6.52%
Dengue	1.01%	1.45%	6.20%
Low birth weight	1.62%	2.83%	5.81%
Late perinatal and neonatal mortality	1.01%	3.03%	3.28%
Tuberculosis	2.43%	3.49%	2.67%
Rabies	2.23%	0.72%	2.53%
Congenital syphilis	1.01%	0.92%	2.46%
Other	14.60%	18.89%	12.12%

Reference: Ministerio de Salud y Protección Social. (2019). Infografía Fenómeno Migratorio. Retrieved from: <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/infografia-migrantes-25junio2019.pdf>

The regions in Colombia that have the largest number of reported Venezuelan patients are: Norte de Santander (30.1 percent), Guainía (17.2 percent), La Guajira (12.8 percent), Arauca (4.9 percent) and Vichada (4.3 percent) (Ministry of Health, 2018). Of the 129,336 foreigners affiliated to the SGSSS, only 21 percent correspond to Venezuelans who obtained the PPEP. This means that only a small portion of the Venezuelan diaspora have a regularized immigration status and are registered in the National Health Insurance System. The number of Venezuelans treated in 2017 and 2018, by type of healthcare provided is presented in Table 3.1.

CHAPTER 4: COLOMBIA'S HEALTH SYSTEM

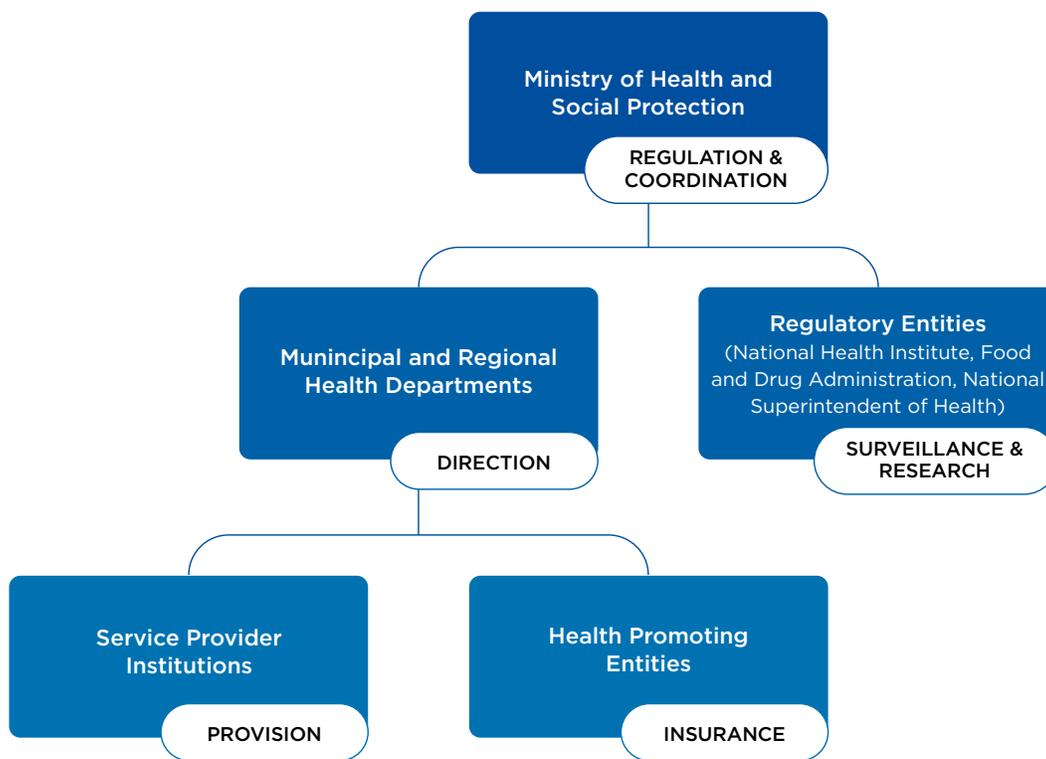
4.1. Health System structure

The SGSSS is a branch of the SGSS in Colombia and is directed and coordinated by the Ministry of Health and Social Protection (MoH). The system is organized as a network of private and public entities. In particular, the MoH coordinates and regulates four different groups of organizations in the health sector: (i) Health Promoting Entities (*Entidades Promotoras de Salud* - EPS), (ii) Service Provider Institutions (*Instituciones Prestadoras de Servicios* - IPS), (iii) Departmental and Municipal Health Secretariats (*Secretarías de Salud*) as representatives of local government, and (iv) other regulatory entities, such as the National Health Institute (*Instituto Nacional de Salud* - INS), the Food and Drug Administration (*Instituto Nacional de Vigilancia de Medicamentos y Alimentos* - INVIMA), the Institute for the Evaluation of Health Technologies (*Instituto de Evaluación de Tecnologías de Salud* - IETS), and the National Superintendence of Health (*Superintendencia Nacional de Salud* - SNS). In addition, this social insurance system combines different affiliation regimes, in a “managed competition” and “consumer choice” scheme. The main structure of the Colombian health system is described below in Figure 4.1.

The EPS are private, public, or mixed insurance companies that offer a regulated health service package, and contract health service provision with the IPS. These companies compete by offering differential insurance plans in terms of the service network strength, quality, and access to complementary services (such as broader health insurance plans). The EPS affiliate people, and make payments to the IPS when insured patients make a claim. The EPS receive an average risk-adjusted lump sum per insured individual: the payment per capitation unit (*Unidad de Pago por Capitación* - UPC). Thus, to be successful, these companies must properly manage both financial risk (cost efficiency) and health risk (prevention, early diagnosis, and quality). Recently, EPS and Health Secretariats have been bundled under the label “Benefic Plan Management Entities” (*Entidades Administradoras de Planes de Beneficios* - EAPB), given that many local governments managed public insurance companies.

The IPS are hospitals, clinics or health centers – both public or private – categorized according to the complexity of the services they provide, ranging from level I to IV, where levels III and IV correspond to complex or “high cost” diseases. The EAPB and IPS are present in all territories, and they are supervised by the SNS. An IPS requests payment from the EAPB that manages the health insurance of the patient. To get any service, patients request authorization from the EAPB for all procedures and, if in the contributory regime, pay co-payments. When a patient is uninsured (approximately 6 percent of the total population and 64.6 percent of the displaced Venezuelans in Colombia), an IPS requests payment from the local government.

Figure 4.1 - Colombian Health System



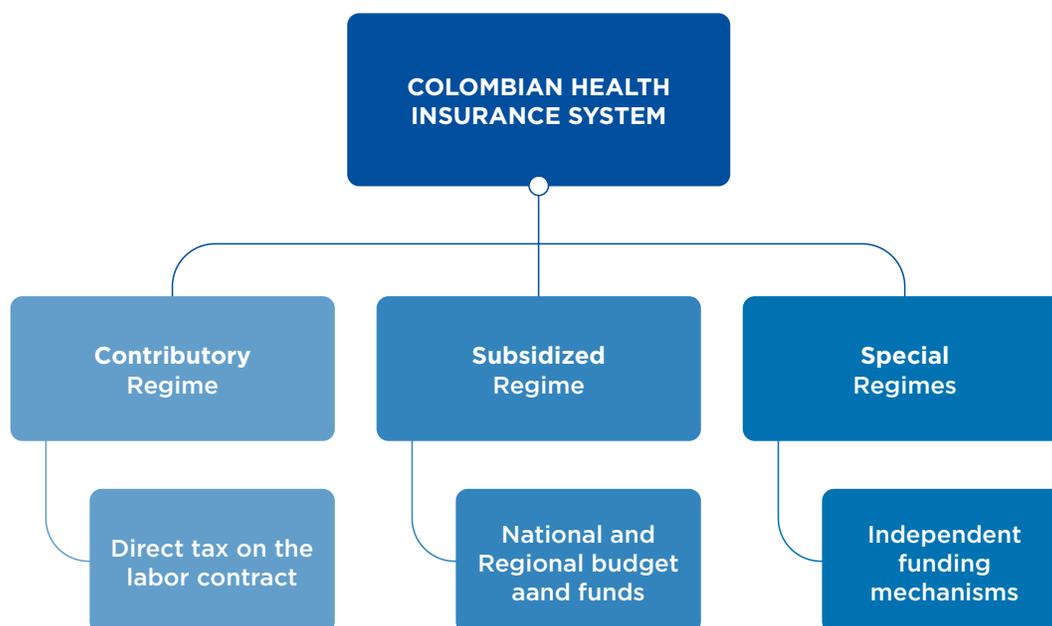
The Colombian Health Insurance System is composed of three coexisting affiliation regimes or sub-systems: (1) the contributory regime, (2) the subsidized regime, and (3) special regimes. The three regimes offer regulated health plans, with broad access to medicines, surgical procedures, medical, and dental services. The difference between the first two regimes is the financial source that covers the lump sum per insured individual (UPC). In the contributory regime, the UPC is funded through a direct tax on the labor contract of the insured person, charging 12.5 percent tax on 40 percent of their salary. Hence, affiliation to the contributory regime happens when a person has a formal labor contract. The cost of this insurance contract is shared between employer and the

employee: employers cover approximately two thirds (8.5 percent) and employees one third (4 percent) of the total burden (12.5 percent).

In the subsidized regime, the UPC is financed entirely by the national government's budget. Health insurance affiliation within this sub-system is conducted by EPS which receive lists of beneficiaries from all state programs – provided in the national social protection network – or lists of individuals who are eligible through population-based focalization mechanisms. All registered IDPs and regularized Venezuelan migrant refugees are automatically affiliated through the subsidized regime. According to the guidelines of the MoH, all Venezuelans living in Colombia should be enrolled in a health insurance plan. To subscribe to an EPS and access the full benefits of the SGSSS, a foreigner must have one of the following documents: (i) immigration card, diplomatic card or residence permit, as appropriate, (ii) passport of the United Nations organization for those who have the quality of refugees or asylees; (iii) passport for children under seven years; (iv) special permission permit (PEP) (Ministry of Health, 2017). In June 2018, there were a total of 28,069 Venezuelans affiliated to the SGSSS (having a PEP in active condition), of which 93 percent belong to the contributive regime and 7 percent to the subsidized regime. As of August 2020, 260,721 Venezuelans were enrolled to the SGSSS, which represents an increase of 829 percent (MoH, 2020).

The third sub-system gathers several coexisting “special regimes” that serve particular groups of society, such as: military forces, national police, public school teachers and public universities. Each group has a separate financing mechanism, with differentiated health benefit plans and sometimes even an independent healthcare provision network. The operation of the Colombian insurance system is summarized in the following diagram.

Figure 4.2 – Colombian Insurance System structure and funding



The population that is not affiliated to any of the three regimes, and thus are not insured, can access the health system through emergency service units or special health prevention services, such as vaccination campaigns. The cost-of-service provision for this “non-affiliated” population is covered by the state, which transfers resources retrospectively to the IPS that provided the healthcare. In practical terms this means that frequently healthcare providers must bear the financial risk of temporary delays in state transfers. The costs of non-affiliates, both residents and displaced persons from Venezuela, reveal the importance and centrality of affiliation in guaranteeing and calculating the healthcare budget and avoiding financial risks for healthcare providers.

The OECD Reviews of Health Systems diagnosis of the Colombian health system can be summarized in three points (OECD, 2016). First, the country’s health system has shown rapid progress toward universal coverage. In 1993, the overall rate of affiliation was 23.5 percent; 4.3 percent for the population in the first quintile of the income distribution (the poorest households), and 6.6 percent in rural areas. In 2013, these indicators were: 96.6 percent, 89.3 percent, and 92.6 percent. Second, the system provides financial protection by minimizing out-of-pocket spending. In 1993, health services represented 52 percent of national expenditure, while, in 2006, it only represented 15 percent, and today remains one of the lowest in the region. Third, access to services has improved substantially. For the households in the poorest quintile, reported unmet health needs fell from 33.2 percent (in 1993) to 2 percent in 2013. Also, preventive healthcare consultations (12 months prior to survey) rose from 30.1 percent (in 1993)

to 62.8 percent in 2013. Yet, evidence suggests that competition among insurers has not resulted in health risk management, but mostly in financial risk management.

4.2. Health policy and normative response to the migration crisis

Under the Colombian constitution, all residents of Colombia are entitled to basic medical care under the country's national health system. Nevertheless, migrants' health needs often exceed the capacity of the existing health and social support systems (OFDA-USAID, 2020). All health insurance plans must cover "obligatory services" described in an official benefit plan and exclusions list⁵, which encompass most essential care and prevention services, and are the same across all social insurance regimes (WHO, 2017). Whereas some countries globally have been unwelcoming by not allowing refugees the right to access human services, such as government- or insurance-funded healthcare and legal employment, Colombia has been relatively hospitable to displaced Venezuelans. From the beginning of the most recent migratory crisis through to January 2021, almost half of displaced Venezuelans already had the opportunity to register, work legally, and receive benefits of temporary residency. Analysts trace this line of policy to the 1990s, when Colombia's internal armed conflict and illicit drug violence forced millions of Colombians to emigrate — many to Venezuela (Janetsky, 2019).

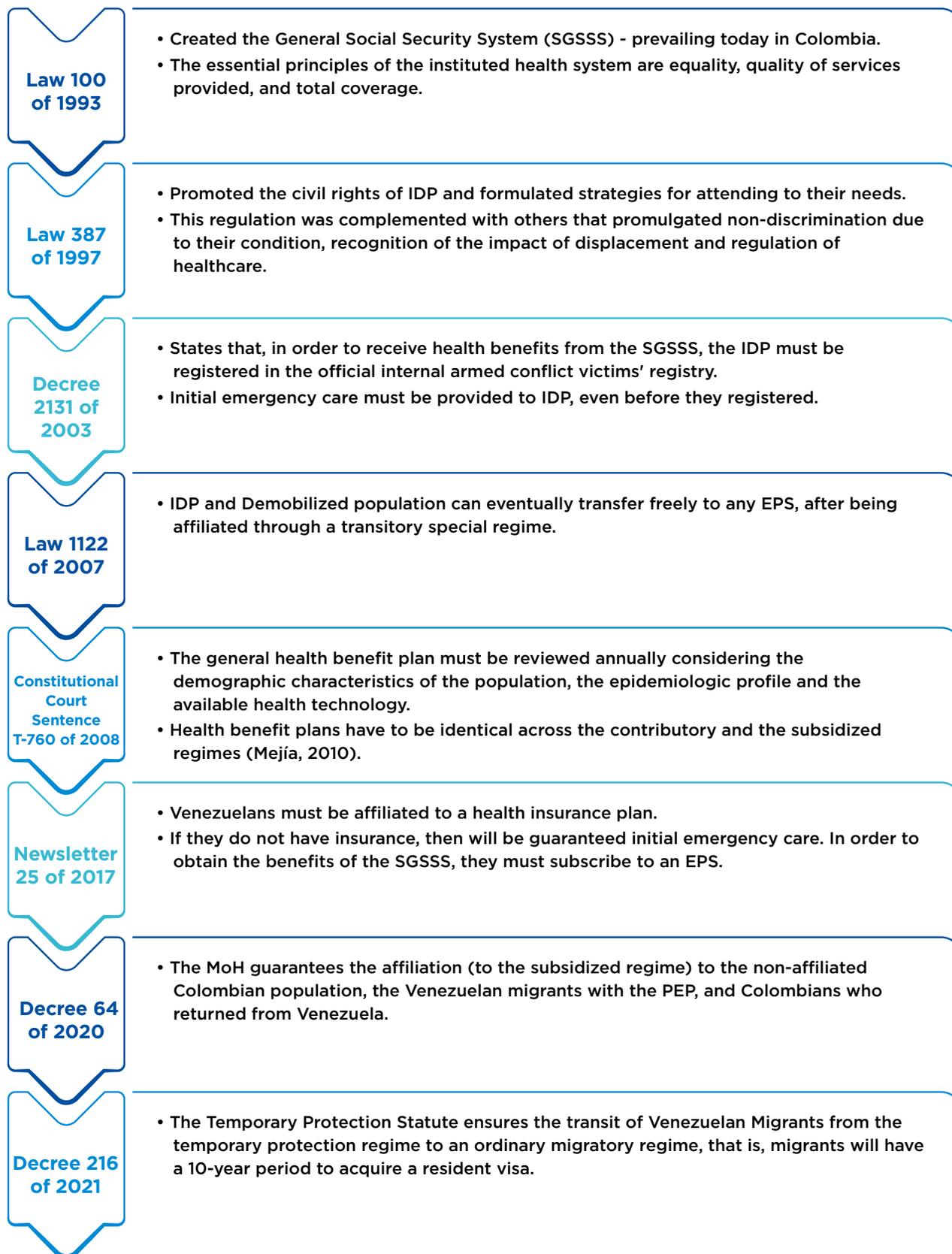
Figure 4.3 presents the timeline that summarizes the response made by the Colombian health system to both forced displacement crises: internally displaced population by the Colombian armed conflict and displaced Venezuelans. Law 100 of 1993 created the SGSSS prevailing today in Colombia. The essential principles of the instituted health system are equality, quality of services provided, and total coverage. Law 387 of 1997 promoted the civil rights of the internally displaced population and formulated various strategies to attend to their needs, including access to health services. It promoted the affiliation of internally displaced persons to the SGSSS. Later, this regulation was complemented with others that promulgated non-discrimination due to their condition, recognition of the impact of displacement and regulation of healthcare (Congreso de la Republica, 1997). Decree 2131 of 2003 stated that, in order to receive health benefits from the SGSSS, the IDP must be registered in the official internal armed conflict victims' registry. Initial emergency care must be

5 The benefits plan and exclusion list is available here: <https://www.minsalud.gov.co/salud/POS/Paginas/resultados-pos.aspx>

provided to IDP, even before they registered. Thanks to Law 1122 of 2007, IDP and the demobilized population could transfer freely to any EPS, after being affiliated through a transitory special regime (Congreso de la Republica, 2007). In accordance with the Constitutional Court Sentence T-760 of 2008, the general health benefit plan must be reviewed annually, comprehensively, and has to be updated with the same periodicity considering the demographic characteristics of the population, the profile epidemiology and available technology. Health benefit plans have to be identical across the contributory and the subsidized regimes (Mejía, 2010).

In 2017, the MoH — through “Newsletter 25 for Health System Actors in Colombia” — decreed that Venezuelans must be affiliated to a health insurance plan. However, if they do not have insurance, then will be guaranteed initial emergency care. Also, in 2020, the Colombian government guaranteed affiliation (to the subsidized regime) to the non-affiliated Colombian population, displaced Venezuelans with the PEP, and Colombians who returned from Venezuela, though Decree 64. Finally, in 2021 the Temporary Protection Statute (TPS) ensured the transit of displaced Venezuelans from the temporary protection regime to an ordinary migratory regime, that is, migrants will have a 10-year period to acquire a resident visa (Presidential Decree 216 of 2021).

Figure 4.3 - Health policy response timeline



CHAPTER 5: HEALTH INFORMATION AND REPORTING SYSTEMS

5.1. History and structure

In 1993, Colombia established a unified social protection information system to support the management and monitoring of the SGSS, which comprises the Pension System, the General System of Social Security in Health, General System of Labor Risks and Complementary Social Services (Law 100 of 1993). Between 2002 and 2012, the Ministry of Health and the Ministry of Labor were integrated into one entity, called the Ministry of Social Protection, and the information system had at least two important limitations. First, it focused mainly on social and labor rights monitoring and protection, setting aside key information needs that are fundamental for health systems, such as epidemiological surveillance data. Second, the system included only administrative records leveraged in paper and manually, so data quality and opportunity were substandard.

In 2012, the Ministry of Social Protection was again excised into two government agencies: the Ministry of Health and Social Protection (MoH) and the Ministry of Labor. In addition to the management of the SGSS, under this new structure the new governing body for the health sector had to lead a broader public policy portfolio that included: creating guidelines and promoting the implementation of collective health interventions and interventions on health risk factors; monitoring health outcomes and health needs; fostering health promotion; coordinating intersectoral actions to improve health outcomes; monitor and respond to user perceptions; leading human talent development policies; guaranteeing public health surveillance; collecting relevant environmental information; and providing non-financial resources — such as technical assistance — to municipal health secretariats. Even if the extension of the roles in the charge of the MoH was initially promoted by Law 1122 of 2007, it is clear that separating the ministries did bolster the work the MoH did in the abovementioned public policy portfolio.

In 2007, Colombia's *Social Protection Information System* (SISPRO) was legally constituted (through Law 1122 of 2007). Yet, some years before this milestone, technicians at the MoH had already created the cornerstones for this potent information system. From the start, there was an explicit effort to avoid creating parallel information systems, and to strengthen SISPRO as the unique system for the management, consolidation, processing, and availability of all the information for the entire social protection sector. The main purpose of SISPRO was to provide complete, standardized, timely and high-quality information to monitor, regulate, and inform decision-making and policy design. Under the new administrative structure, SISPRO evolved after 2011 to address new health information needs. In addition, Law 1715 of 2015 defined that the reach of the Colombian health system goes far beyond the SGSS, hence SISPRO should integrate data from all relevant sectors. The main challenges in this initial process were: insufficient standardization and consistency of the reports on health conditions (e.g., diagnoses and health procedures codes); fragmentation and lack of alignment of the communication channels; underreporting; insufficient coordination between the government agencies (e.g., between the National Statistics Administrative Department and the MoH).

Currently, SISPRO receives and processes data produced by all the government agencies involved in the Social Protection System in a single electronic warehouse designed to manage large volumes of data, accessing and analyzing information efficiently. The system uses a custom-made technological platform (PISIS) to collect the information produced from the ledgers of all the transactions related to the health, pensions, professional risks, labor, employment and social assistance for the more than fifty million users of the Social Protection System. SISPRO has four main components: (i) Health, (ii) Pensions, (iii) Occupational Risks and (iv) Social Promotion (labor, employment and social assistance). The health component consolidates information from 38 databases, 35 population studies, and 39 observatories. The most important databases are: the RIPS (Individual Service Provision Registry), SIVIGILA (National Epidemiological Surveillance System), the Births and Deaths database, the Early Detection and Specific Protection database (which includes provision ledgers of preventive dental health, family planning, birth and neonatal services), the Amplified Immunizations Schedule (PAI) database (a ledger of the implementation of the birth to 18 immunizations schedule), and the Unique Affiliated Individuals Database (a ledger of all persons enrolled to the health insurance and occupational risk insurance schemes).

Specifically, the RIPS are a set of standardized characteristics of the services provided in the health system. All healthcare service providers (IPS) are mandated by law (see Resolution 3374 of 2000) to report the RIPS of all care provided as a legal support to generate electronic sales

invoices to process payments coming from health risk management agencies (EPS). Each service can be, by definition, either a consultation or a procedure, and can be provided in one of three settings: outpatient, inpatient, and emergency. Additionally, each registry includes the patient's unique identification number, the external cause for the consultation or procedure, a diagnosis, and any resulting interventions, conducts or costs generated.

The constant evolution of SISPRO has allowed it to surpass its initial scope. Currently, the system incorporates dimensions beyond the components of the SGSS which has set this technological platform as the cornerstone for the future implementation of e-health strategies in Colombia, for example: mobile health, e-learning, digital repositories, unified electronic health records, and data portability. In addition, SISPRO has strengthened the integration of the country's information systems, promoting the articulation with sectors that use health information (and vice versa), such as education, justice, transportation, agriculture, environment, among others. For instance, the MoH plays a leading role in the national gender-based violence prevention system and participates in the coordination of the National Statistical System (led by DANE).

In addition to SISPRO and SIVIGILA, the Colombian health system has databases that are used for very specific tasks. For instance, the High-Cost Account (*Cuenta de Alto Costo*) collects information on the use and prices of services provided to patients of high-cost diseases, such as chronic kidney disease, HIV/AIDS, diabetes, cancer, hemophilia and rheumatoid arthritis. This data system, managed by the Colombian High-Cost Diseases Fund — an independent technical body created by Decree 2699 of 2007 — mandates all EAPB to report high quality information that is used to promote the creation and adoption of technical referents, reduce the trend of new high-cost cases and ensure that the management of existing evidence is data driven. In addition to the collection and use of this data, the Fund is designed to contribute towards the stabilization of the health system by discouraging adverse selection and discrimination through a risk adjustment of the basic premium based on high-cost cases.

Another important example of a specialized dataset (parallel to SISPRO and SIVIGILA), is the Sufficiency database (*Base de Datos de Suficiencia*). This dataset is created from an audited sample of the RIPS and is used by the MoH to estimate the payment per capitation unit (UPC). The objective of this exercise is to have higher quality data to estimate actual costs of service provision. Unfortunately, access to this information is very limited.

5.2. Response to the migratory crisis and current challenges

Today Colombia has a very potent health information system that can actively provide evidence to design and implement public policies targeted to migrant and forcefully displaced populations in the country. As mentioned before, SISPRO generates data on emergency care utilization, all procedures and consultations, diagnosis, hospitalizations, patient characteristics and costs; that can be discriminated at the local level, by IPS and by very specific populations (such as IDP or Venezuelan migrant population). As an answer to recurrent concerns that the RIPS were not accurately capturing information on the care provided to migrants in Colombia, in 2017, the MoH issued “Newsletter 029” (Circular 029), a specific technical guideline that mandates IPS and health secretariats to report an additional individual registry for foreign persons. This data has proven to be strategic to monitor the demand for and utilization of health services by Venezuelan migrants throughout Colombia.

For instance, the strategic health plans developed by all local governments – both at the municipality and department levels, called Integral Plan in Health (*Plan Integral en Salud*) – to be implemented in the 2020-2023 period (as part of the more comprehensive Territorial Development Plan - *Plan de Desarrollo Territorial*), used as an input a specific report on migrant health service utilization (morbidity, mortality, enrollment and use) constructed from the “Newsletter 029” data.⁶ Another important example of use to be highlighted is the creation of the National Observatory of Migration and Health (*Observatorio Nacional de Migración y Salud*). This e-platform presents dashboards of basic frequency indicators for enrolment to health insurance, service utilization, health needs (infant health and malnutrition, maternal health, sexually transmitted diseases (STDs), family planning consultations, high cost and chronic diseases and COVID-19 active cases) and mortality causes. Moreover, these reports can be disaggregated by year, age group, gender, Department and Municipality.

Yet, there is still room for improvement to further increase the use and impact of this health information system. Morbidity and mobility reports for the migrant populations dispersed throughout the Colombian territory could guide public policy design and align health necessities with funding mechanisms. Yet, available reports present frequency indicators, such as the number of foreign patients served or the distribution of these patients

6 More information available here: <https://www.minsalud.gov.co/salud/publica/epidemiologia/Paginas/planes-territoriales-de-salud.aspx>

across groups (by age, territories, or gender), and do not include indicators that measure prevalence (the rate of individuals who have a condition at or during a particular period) and incidence (the rate of new individuals who develop a condition during a particular period). Also, there is no evaluation on the quality and biases of this administrative data, especially for regions of Colombia where service provision and overall institutions are weaker.

There are important data gaps (demographic and epidemiological) to be filled to plan a more effective health response to forced displacement in future. Specifically, there is a complete disarticulation between SISPRO and the data systems managed by the 75 members in the Interagency Group on Mixed Migratory Flows (*Grupo Interagencial sobre Flujos Migratorios Mixtos* - GIFMM), a coordination platform for the response to the refugee and migrant crisis in Colombia. This group, created in 2016, is co-led by IOM and UNHCR, and includes U.N. agencies, international and local NGOs and the Red Cross Movement. For instance, there are at least two great gains by linking SISPRO to the independent information systems of the GIFMM members that provide humanitarian aid. First, by generating real-time person-level reports of the benefits and overall assistance received, the Social Protection System could avoid duplicating efforts or service provision. Second, person-level information that includes the GIFMM assistance would help in the design and targeting of social protection services by providing a complete picture of health service utilization and health needs. Third, person-level information could feed strategies to induce the demand for health insurance and health prevention activities.

The interviews with key actors also support the idea of the imperative need to integrate the Colombian Social Protection System's information with other platforms that capture information on migrant populations. This integration not only includes GIFMM, but different community-based organizations, universities, and other institutions devoted to the study of migration in the country. However, the challenge is to overcome the barriers to share and integrate information.

“There were restrictions of a much more micro institutional nature, even of information frictions, where perhaps the least well distributed good in these migratory processes, in my opinion and with my experience, after having been in this for some years, is the access to information”. - KIMH Bogotá.

“There is a potential coordination problem there that is not let's say, in the GIFMM what we have

is an excellent capacity for articulation between the agencies at the planning level and I think they have been working on that a lot. But no, I have not seen that we share information, that we make a single registry of patients, that does not happen”. - KIUA Bogotá

For instance, some of the challenges in accessing health information have to do with the regional reality and their capacity. In some regions, the attention of specialist physicians is outsourced to the private sector, and there is not necessarily a report of all the patients' information to the public system, meaning that there could be some data loss.

“In La Guajira, there was no second level of care for an issue and so they subcontracted a hospital and then they billed. But then you are only looking at, let's say what is the primary public network, they are not capturing all the information of what the care is. Because they outsource services, because they don't have them, they don't have that level of complexity. So, they outsource them to a private or another one, or is provided by cooperation.” - KIMH Bogotá

Another issue that can impact accessing or integrating health information is data protection policies. Although the information recovered by different cooperation agencies could be helpful to validate the public health information, and vice versa, the policies of data and identity protection prevent a proper articulation. When asked about examples of effective cooperation between national and local-level government agencies and cooperation agencies, a key informant mentioned:

“With international cooperation. And, through the GIFMM. The GIFMM has been one of the entities that have supported us, since all the cooperating institutions are registered in it.

We have seen that each cooperating institution has a barrier for the protection of information to users and we analyzed that there is a same population that benefits from many cooperating institutions. In other words, the same person receives multiple benefits.

We have tried to articulate with all of them, but it is difficult for them to provide the database they have to another cooperant to cross-check information because they do not allow it. This goes against some of the rules they have stipulated to protect the identification of their user and all those things”. - KIHS Maicao

Regarding the access to information and the audiences that consult it, in the key informant interviews, the need for an *organization and services mapping* was clear to better orient displaced Venezuelans about the health services and institutions they can visit.

“We know who we all are, but we don’t know who is doing what, where and how. I mean, everybody knows, this is cooperation. This is from the public sector; this is from the private sector. But nobody knows for sure where to refer what type of cases. There is no national mapping of services by cluster, for example in health. These are the 10, 15, 20 or 30 organizations. Perhaps the GIFMM in-house staff does know this, but here I keep coming back and saying the same thing. They are very hermetic institutions”. - KIAC Barranquilla

Articulation between the government agencies that manage and fund the Colombian health system with the institutions that provide the health services is another aspect to strengthen to assure a better experience to the health system enrollees.

“The ADRES7 and the SAT8 do not have an intercommunication, they are not inter-operative. So what happens is that I can affiliate a person today and the resolution 1128 tells me that the person has access to their services immediately they are affiliated, but the reality tells me that they

7 ADRES is the Health Resources Administration Agency, which is part of the Ministry of Health and Social Protection.

8 SAT is the platform that hosts the database of the enrollees in the Colombian health system.

arrive at the IPS and the IPS says, I am sorry but you do not appear in the ADRES and if you do not appear in the ADRES nobody is going to pay me, I cannot attend to you. The end.” - KIAS Bogotá

Colombia’s information health system is still perceived as fragmented despite these efforts. Pending discussions on the ownership and use of the information are yet to occur, as stated in the testimonies.

“So we would have to look at how to solve it. But the fact is that in information systems, one of the problems is that they are very fragmented and there is no technological solution at the moment”.
- KIUA, Bogotá

“Well, that is the problem based on a mistaken concept — that is that health information belongs to the providers — but health information should belong to the individual. You should be the owner of your information, go and look for the information, you have to beg for the results to be given to you. So, there we have a mess, let’s say a structural mess that has to be solved”. - KIUA, Bogotá

CHAPTER 6: DISPLACED POPULATION'S EXPERIENCE IN COLOMBIA'S HEALTH SYSTEM

6.1. Availability of services and health facility capacity

The primary evidence collected suggests that health facilities visited in this study are relatively well prepared to provide the necessary services to all populations. As explained before, the health facility assessment details the existing capacity to meet the health needs of both displaced populations, displaced Venezuelans, IDP and host communities. This analysis uses data collected in a total sample of 20 health facilities distributed across 13 different municipalities in Colombia. This assessment determined the availability and quality of health services at supported facilities, with the purpose of understanding the health system response to the immediate and longer-term needs of displaced populations and host communities.

Regarding readiness in terms of the basic amenities, we find that all health facilities scored above 60 percent in this domain (Table 6.1 and Figure 6.1). On basic equipment and supplies, most health facilities had all the basic equipment to treat patients. The score of standard precautions for infection prevention sub-index for all the 20 health facilities is above 92 percent, meaning that all institutions have a protocol and equipment to manage infections. With respect to diagnostic capacity, many facilities did not have the equipment to treat and diagnose malaria, measles, tuberculosis, and diabetes.

Figure 6.1 – General Readiness Index

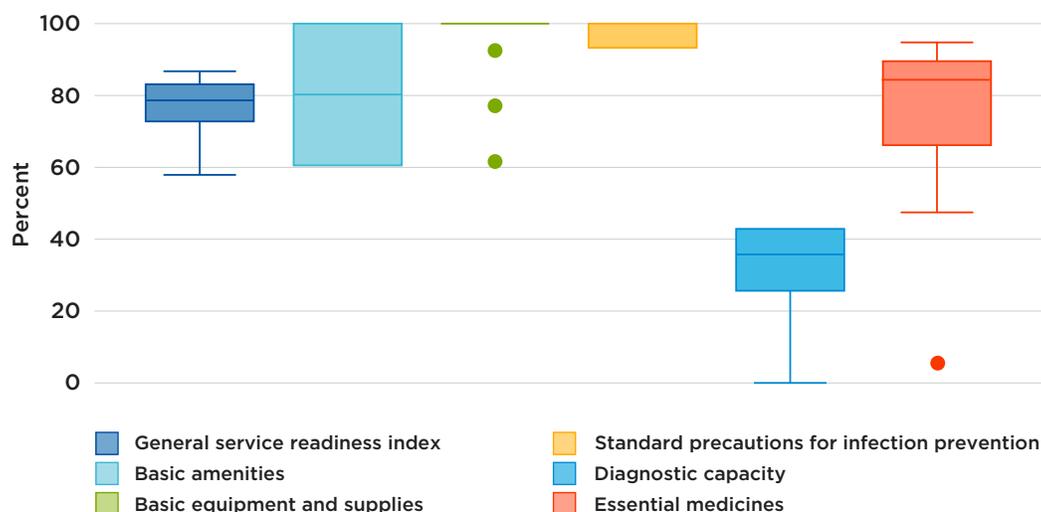


Table 6.1 – Descriptive statistics of the General Readiness Index and its five sub-domains

Index	N	Median	SD	P25	P75	Min	Max
General readiness	20	78.41	8.81	72.20	83.27	57.62	86.47
Basic amenities	20	80.00	17.74	60.00	100.00	60.00	100.00
Basic equipment and supplies	20	100.00	9.82	100.00	100.00	61.54	100.00
Standard precautions for infections	20	100.00	3.59	92.86	100.00	92.86	100.00
Diagnostic capacity	20	35.71	12.50	25.00	42.86	0.00	42.86
Essential medicines	20	84.21	21.63	65.79	89.47	5.26	94.74

This is explained by the way in which the health provision network is organized in Colombia: to optimize infrastructure and resources, complexity levels vary across health facilities. It is important to mention that this sub-domain is responsible for most of the variation in the General Readiness Index. The last readiness sub-domain explores the availability of essential medicines. In this dimension most health facilities scored above 80 percent, but the dispersion between facilities is high.

In addition, almost all the health facilities in the sample reported evidenced full capacity to provide general services (in the last three months). Estimates of the general service index show that 75 percent of the facilities reported had a full score of 100 percent (see Figure 6.2 and Table 6.2). Only one health facility obtained a surprisingly low score (of 9.1 percent), which could be explained by the fact that most of the complexity level 3 facilities would be expected to have low scores regarding the provision

of general services given that these services are provided by level 1 and 2 facilities. Only patients that need complex and specific procedures attend high complexity services. The services that are included in this index are: curative care services for children under age five, HIV and adolescent treatment, diagnosis and management of non-communicable diseases, minor surgical services (such as incision and drainage of abscesses and suturing of lacerations that do not require the use of a theater) and COVID-19 testing and treatment.

Figure 6.2 - General Service Index

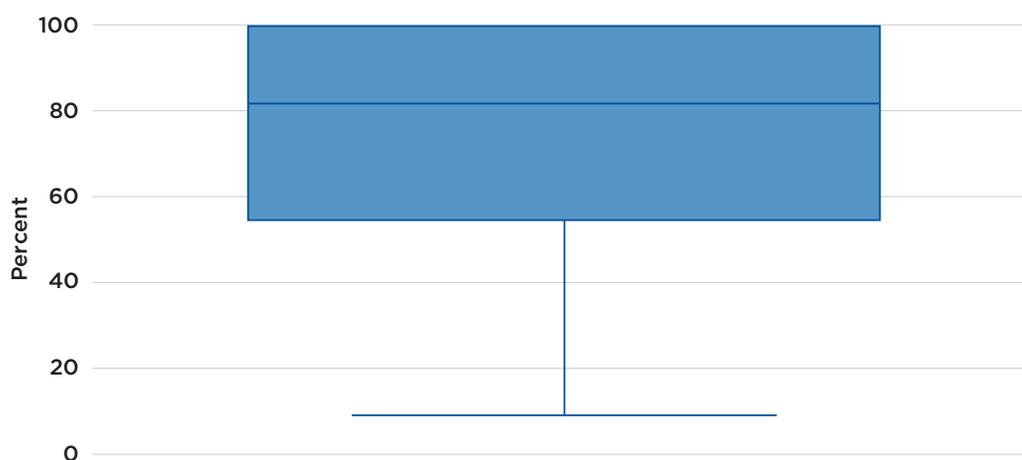


Table 6.2 - Descriptive statistics General Service Index

Index	Obs	Median	SD	P25	P75	Min	Max
General services	20	81.82	27.50	54.55	100.00	9.09	100.00

Regarding the availability of mental health services, there are only 14 observations in the sample because six health facilities currently do not provide psychosocial support or mental health services (see Figure 6.3 and Table 6.3). For those that did provide these services, the data shows that the readiness to provide them was limited. The maximum score in availability of services index was 63.6 percent and the lowest was 18.2 percent. Moreover, 75 percent of the facilities had a score below 54.6 percent. Regarding the availability of drugs to treat mental health problems, three quarters of the facilities scored 62 percent or higher. Only one facility reported that they did not have essential psychotropics available.

The abovementioned results are especially worrying given the ample evidence on the widespread need for mental health services for displaced populations in Colombia. Data from the National Mental Health Survey

suggests that the lifetime prevalence of diagnosable psychiatric disorders in displaced adults is 15.9 percent (Tamayo Martínez et al., 2016) which is more than approximately 50 percent higher than that observed for non-displaced individuals (10.1 percent, see Gómez-Restrepo et al, 2016b). Using data from a survey applied to 1,309 households in Meta, Colombia (a region ridden by violence), León-Garrido et al. (2021) show that 15.5 percent of the population presents symptoms of mental health disorders, and that forced displacement accounts for 31 percent of the measured mental health inequalities. Similarly, using data collected from Venezuelans migrating from Ecuador to Perú, Carroll et al. (2020) find evidence that suggests a link between mental health outcomes and migration vulnerability factors, such as stress associated with migration itself, loss of status, travelling with children or while pregnant, culture shocks, alienation and the discrepancy in aspirations and achievements.

Figure 6.3 - Psychosocial and mental health service availability indexes

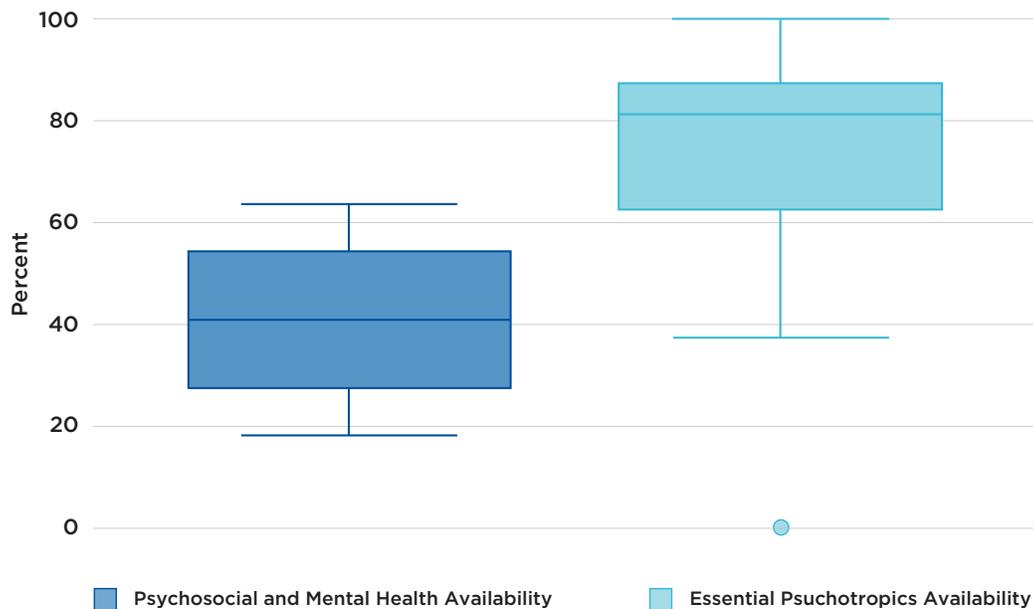
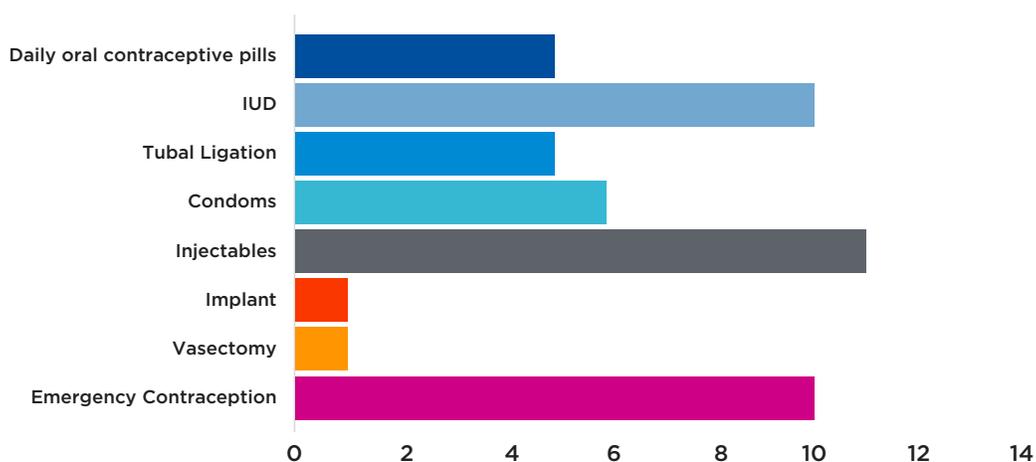


Table 6.3 – Psychosocial and mental health service availability indexes

Index	N	Median	SD	P25	P75	Min	Max
Psychosocial and Mental Health	14	40.91	16.23	27.27	54.55	18.18	63.64
Essential Psychotropics	14	81.25	28.24	62.50	87.50	0.00	100.

Similarly, the availability of family planning services was relatively low in this sample of health facilities. For instance, as shown in Figure 6.4, just half of the health facilities report providing emergency contraception methods, injectables and preformed tubal ligation; and only one health facility provided condoms and did vasectomy procedures. These results suggest that very frequently the health facilities do not provide many options for family planning in Colombia. However, this result may partially be explained by the specialization of health facilities, given the complexity level they have.

Figure 6.4 – Number of interviewed health facilities reporting provision of family planning services

6.2. Access to healthcare

6.2.1. Barriers to access when uninsured

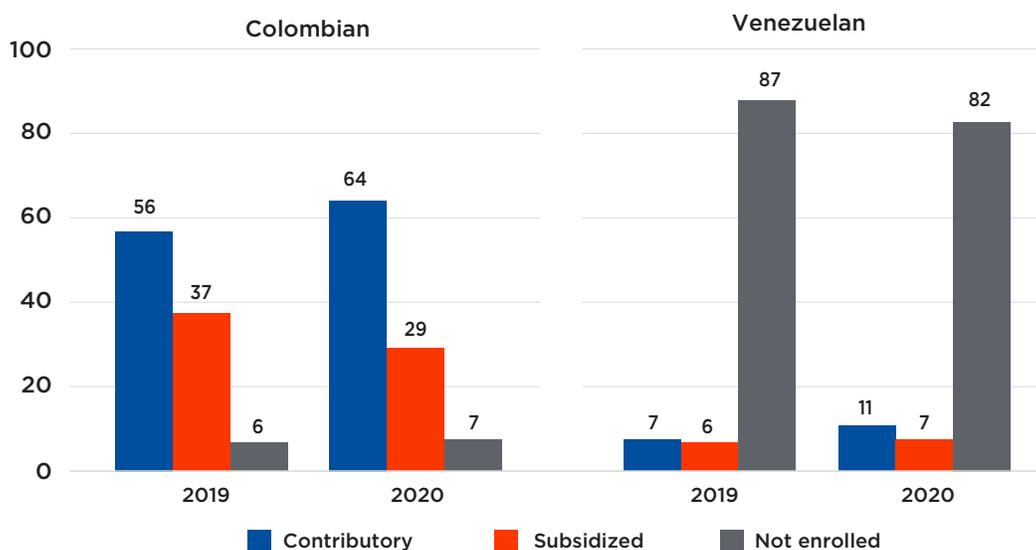
The optimal access to health services in the Colombian health system is through insurance enrollment. According to the Health and Migration Observatory of the MoH, currently, approximately 653,126 Venezuelans are affiliated to the Colombian health insurance system (which represents almost 35.4 percent of the total Venezuelan migrants and refugees in Colombia), 53.7 percent to the contributive

regime, 41.2 percent having a PEP permit and 39.4 percent having a permit through the Statute of Temporary Protection (MoH, 2022).

Unenrolled persons can only access healthcare through emergency care units and complementary collective interventions. Given that access through emergency units is inefficient and has more barriers, and complementary collective interventions have a limited scope - focusing on public health prevention strategies- effective healthcare provision for the more than one million displaced Venezuelans without insurance is limited. Therefore, it is important to understand on a deeper level the reasons that prevent displaced Venezuelans from obtaining their legal status and further enrolling in the Colombian health system. First, we will describe formal processes defined in Colombia's regulatory framework, which define a set of legal barriers to health. Afterwards, we discuss other barriers, such as operational and procedural barriers, which are identified in the evidence collected by the present study.

More than 80 percent of the services provided to Venezuelans in Colombia are provided to individuals that are not enrolled to the public insurance system (Figure 6.5). This is problematic because this service utilization implies an inefficient allocation of resources. On the one hand, given that services are provided to unaffiliated individuals through emergency care units, the complexity and cost of most of these cases may have been reduced through preventive or early detection efforts available only to insured individuals (for instance, through primary care consultations). According to the National Planning Department (DNP), healthcare costs are significantly lower through the public insurance system, in contrast to services accessed through the emergency care units (DNP, 2018). On the other hand, the costs of the services provided to unenrolled individuals must be initially covered by the IPS, and then reimbursed by the state. This itself generates an important financial burden for the healthcare providers; but also, since these costs may sometimes be unbearable for the IPS, they may generate incentives to avoid treating migrants, even when the law mandates it. Consequently, this could at least partially explain the observed disparities in the access to and quality of the services provided to migrants in Colombia.

Figure 6.5- Share of health services utilization per type of affiliation



Source: Sheppard et al. (2021). Data from SISPRO-RIPS Ministry of Health and Social Protection.

Not surprisingly, one of the main findings of this study is that the experience with the health system for Venezuelans in Colombia depends entirely on them having their migratory status regularized and being enrolled to any of the regimes in the health insurance system. In fact, access to healthcare for any person enrolled in the public insurance system is identical, regardless of their nationality. However, even if the Colombian health system in theory should provide healthcare to all individuals in the country's territory (insured or uninsured), effective access for unenrolled individuals is substantially limited.

“When you go to the health service, you have to wait three, four to five hours for them to come out and they tell you: ‘we can’t attend you because you don’t have a PEP, you don’t have a record’”. - Venezuelan Migrant living in Maicao, Colombia.

“I don’t go to the hospital unless it’s an emergency. So, ‘have you had good attention?’ No, not at the hospital, they almost never want to receive me, because it is not an emergency” - Venezuelan Migrant living in Bogotá, Colombia.

To give birth, is it the same? For emergencies in the hospital. To obtain medications and

treatments for chronic diseases? No ma'am, they are provided by the EPS. And when you have a mental health problem? Thank God I don't. I mean, do they go to hospitals, clinics, community health workers, informal providers, pharmacists, drugstores, traditional healers, private providers? To the hospital."- Venezuelan Migrant living in Bogotá, Colombia

As mentioned, displaced Venezuelans who are not enrolled in the health insurance system can only access healthcare through ER units or public health prevention programs. To access emergency services, any patient (with or without health insurance) must go through a triage evaluation to determine if their physical or mental integrity, caused either by trauma or sickness, requires immediate and adequate medical attention to prevent disability or death. Technically, emergencies comprise any patient's medical condition representing a vital risk: heart attacks, respiratory infections, heart insufficiency, severe injuries in the head, neck, or spine, severe burns, intoxications, heavy bleeding, allergic reactions, extreme pain, risk of losing a limb or organ, to mention a few.

The MoH has explicitly aimed at strengthening the public health actions to answer the Venezuelan migration crisis by mandating that all IPS must "guarantee emergency care to the migrant population", following the technical guidelines to classify patients in the emergency services and insists that "under no circumstances may the triage be used as a mechanism for denying emergency care" (MoH, Circular 25 of 2017). This resolution also argues that the verification of the users will be after the triage process; meaning that the institutions that provide the health service will identify the coverage and payment responsible after the patient has gone through the emergency service classification.

These regulatory mechanisms should, in theory, guarantee access to emergency medical attention to all Venezuelans in Colombia. However, displaced Venezuelans face barriers to access emergency services. Frequently, migrants report that services at emergency units are denied given that in triage their case is not classified as an emergency. It is important to note that triage was redesigned precisely to control the excess consultations that do not correspond to emergency needs. It has been documented how patients (Colombian and Venezuelan) systematically were using emergency units to get quicker access to the health system (MoH, Resolution 5596 of 2015). Thus, to respond to the increased demand derived from this practice and the collapsed capacity of the emergency services, new triage guidelines were implemented.

“I do not receive medical attention because it is not an emergency. If you are walking, they told you: “no, you are fine”. And it is not like that, because if you go to a place like that, it is because, damn it! It’s because there’s nothing else to do, you know”. - Venezuelan migrant, Cúcuta Colombia.

“Unless you have a serious accident or a high-risk illness, they attend to you here in the emergency unit, but otherwise, if you have a consultation or care from a gynecologist, care from a dentist, you pay for it”. - Venezuelan migrant, Tumaco Colombia.

All persons in Colombia benefit from the health promotion and prevention efforts through Complementary Collective Interventions (PIC), which provide basic medical services such as vaccinations, birth control orientation, and pregnancy controls. Again, in theory, the prioritization and availability of these prevention strategies should partially answer the health needs of Venezuelan migrants. The MoH regulations state that all territorial entities — Governors, Mayors, District and Municipal authorities, and administrators of health benefit plans — must analyze the situation of migrants in their territories and define action plans for vulnerable or unprotected populations (women, pregnant women, children and adolescents, elderly and people with disabilities). The interventions, however, depend on the priorities of each local authority.

“The immunization plan covers them. That is, everything that has to do with vaccination is covered, everything that has to do with the offer of the PIC of the collective interventions plan is also covered. But this responds to a territorial reality, because remember that health is decentralized, so it is what the territorial entity has also prioritized in terms of resources or in terms of focusing public health priorities and so on”. - KII Bogotá

Specifically, in Colombia, complementary collective interventions must be implemented and must impact the social determinants of health positively and directly (MoH, Carta 25 of 2017). The services are meant to be free and aimed at the whole population, regardless of their affiliation status. The MoH has established the following prioritized topics and populations:

- i. Promotion of integral care and child development.
- ii. Promotion of information on vaccination schemes.
- iii. Promotion of sexual and reproductive rights such as preventing unwanted pregnancies, gender violence, sexually transmitted diseases, including HIV/AIDS.
- iv. Promotion of institutional actions to detect warning signs in pregnant women.
- v. Promotion of spaces for counseling and care in mental health crises or the consumption of psychoactive substances.
- vi. Promotion of campaigns on endemic diseases.
- vii. Promotion of actions for diagnosing and managing diseases with epidemic potential.
- viii. Programs for the prevention of acute respiratory diseases.
- ix. Promotion of healthy lifestyles.

All the complementary collective interventions must be extended to displaced Venezuelans. However, the access to treatment for chronic diseases is still a barrier for unregularized migrants.

“Here in Colombia the ones that are not possible are internal medicine, at least diabetes, hypertension, psychiatry, psychology, here in Colombia there is a barrier to access that. Here they say that you have to have the PEP, that you have to have the SISBEN and it is logical that if you do not have the special permit of permanence (PEP), you are not going to have SISBEN, so if you automatically go to a healthcare center as a Venezuelan and you do not have PEP, you do not have SISBEN they will tell you that when you have SISBEN you come and we will make the appointment for you”. Venezuelan Migrant Cúcuta.

If the emergency and complementary interventions are limited for the unenrolled populations, what are the barriers for displaced Venezuelans to register? The conversations with key informants provided some explanations.

6.2.1.1. Documentation

One of the main problems identified was the difficulty carrying proper documentation, whether because the entry to Colombia was illegal or due to the absence of efficient institutions in Venezuela that can ship

or provide accurate and legal documentation. This last reality leaves migrants with inadequate quality documents or forms that Colombian public officers will not accept to move forward the registration process.

“For migrants the biggest barrier is that they did not enter the country legally. People who enter the country legally find it relatively easy to obtain their special permit. But there are many who entered illegally, so they do not have their passport stamped, some do not even have a passport, which is what happened with some patients, they do not have their identity document, so that is the biggest barrier for them to be enrolled”. - KIRSO Bogotá

“The lack of institutionalism and all the processes that were broken in Venezuela, because it does not allow them to have the documentation, the documentation up to date, nor the apostilles, nor anything that is required in the procedures established in the country so that they can be in a regular way. That is to say, the procedures really, although one understands that they are within the norm, they do not respond to the reality of migration, especially for people coming from Venezuela”. - KIOL Bogotá

“They require a valid [identification] document. [An official would say:] but you know, that this photocopy [of the official document] that you brought me does not look good today or does not look good, bring me another photocopy and the migrant does not have an additional 200 pesos for the photocopy. So it is an operational administrative barrier”. - KIOL Bogotá

Also, the KIIs mentioned the registration difficulties faced by migrants who are Venezuelan citizens but experience the territory in a bi-national logic, like the Wayuú Population. The complexity of the migrants and indigenous population raises questions about the articulation with their political authorities and their role and efficiency in registering their communities in the health system.

“We have a Colombian-Venezuelan population that is also part of the Wayuu population, where they identify themselves as Colombians, but remain in Venezuelan territory. They are not identified, because we, as a Colombian republic, do not have them identified, but they are part of an authority. They do not have passports, they do not have [residence] permits, they do not have safe-conduct”. - KIHS Maicao

6.2.1.2. Knowledge and skills to navigate the Colombian health system

Another barrier identified in the KIIs is the lack of understanding among displaced Venezuelans of how the Colombian health system works. Inadequacies in the educational strategies led by the Colombian Government and the complexity of the health system’s technical and operative procedures are highlighted as some of the limitations to displaced Venezuelans accessing healthcare.

“We cannot deny that migrants have additional or exacerbated barriers, coming to a system where in the middle [of all processes] there is an insurer, [a system] where I will not be cared for everywhere and where there are [complex] service routes. [This] generates a chasm with what they have [formerly] interiorized [...] Of course, we are talking about a complex, fragmented health system, where knowing the routes can be difficult”
- KIAC Bogotá

“Let’s say a Venezuelan regularizes his status and has different options to become an affiliate [of the health system]. He can enter [the online portal] “My Social Security” and fill it in on his own. You can also approach any territorial entity and be given the assistance and support you need in an integration center. But not all people could do so, either because of their age, their knowledge, or how they manage these web portals. That is why it is very important that there is support so that people can fill in their information in a correct way”. - KIAC Bogotá

“There is a lack of knowledge on the part of the migrant refugee and returnee population about the regularization route”. - KIOL Bogotá

Additionally, migrants do not have access to official information through traditional media. Most of them do not have access to television or radio, nor the internet. Their information is partial or biased and based on what they are told by relatives and other migrants. In this sense, there is a need to reassess the communication strategies to promote regularization and the enrolment in the healthcare System and the procedures to achieve it.

“They come from Venezuela without having much access to Internet, in many cases, without even having a television signal. They enter through trails, through unauthorized places, so they do not receive information either. They come with information from relatives who have gone through the process and the information is confusing. So, I believe that one of the barriers to regularization is the lack of information”. - KIOL Bogotá

“A barrier that we have found is that the migrant population is located in economic terms in the communities where no one reaches, where not even the hand of God reaches, that is, there is no internet signal there, there is no radio communication”. - KIOL Bogotá

“I believe that it is still necessary to reach the most vulnerable who do not have access to information as we commonly know it as digital media. For us it may be something normal to find out through the newspaper, the internet, the telephone, but when these options are not specific to a refugee, a migrant who arrives in the country or who does not have access to these inputs, access to information is still restricted. This is with respect to regularization”. -KIAN2 Bogotá

The testimonies of the KIIs also show that another of the barriers to entering the health system is this population’s lack of knowledge of their health rights.

“But many of the problems of effective access to health services are common to those of the non-affiliated population. This must do, of course, with the fact that the unaffiliated population is the population that has less experience, knowledge, and appropriation of their rights, of the care routes, they are also less advocacy of their own rights” - KIMH Bogotá

6.2.1.3. Cultural behaviors

As mentioned before, Venezuelan migration to Colombia has been diverse. As stated by different key informants, migrants are used to a comprehensive welfare system which operates mainly through supply-side policies (such as direct service provision and no insurance markets), which is very different from the Colombian healthcare system. Consequently, the Venezuelan health system has shaped social norms and sociocultural behaviors that could be interfering in the experience of migrants in Colombia and can help explain additional cultural barriers to registration and affiliation to the health system in a foreign territory. Illegal entry to Colombia enforces these cultural barriers that negatively impact proper enrolment and access to the health system.

Many Venezuelan migrants are initially reluctant to access local health services for fear of being deported, especially if their arrival was by irregular means. So, they avoid enrollment.

“People have a fear of searching, of looking for health authorities if it is not necessary, for me there is an element that people don’t, they don’t want to get to hospitals or clinics because they always keep in mind that they can also be deported or that they need an ID. So, there is, also in my opinion, but I have not done any scientific study, there is an obstacle to reach the health service for lack of knowledge, out of fear, out of not having documentation” - KIAC Bogotá

Key informants also pointed out the difficulties migrants have in learning the intricacies of the Colombian health system. Some believed the significant differences between the Venezuelan and the Colombian health systems and the fact that displaced Venezuelans have existing habits based on their relationship with the state, characterized mainly by welfare provision, was a key barrier.

“Maybe the habits that they have, the habits of working, many are not given to work, many are inclined to expect from the government to give them everything. Maybe they come with other habits from where they are migrating, that they were given everything for free. Here in Colombia things are a little more difficult. So here they have had to do many activities to be able to benefit”. - KIH5 Maicao.

“One problem is that for Venezuelans this is all “Greek” to them, this social insurance and social security and affiliation. That does not exist in Venezuela. Venezuela is a national health system where you are there and you go to the public service and they attend you with your Venezuelan identification, there is no health insurance, no insurance as such. So, understand that logic. Besides, they had access to many things for free, they were provided by the government in their public services and medicines, etc. So this logic that it is something with insurance and you have to pay or you have to pay co-payments, etcetera. Well, it is not within the logic of what they knew and then, whether there is a problem of demand or not, there is not much demand. They do not see the urgency to affiliate because that is not the way they used to access health services”. - KIUA Bogotá.

“I think there is a very strong information problem, to what processes they have access once they are regularized, people are regularized to get a job, a place in school and they keep going to the emergency room and they do not know that they can be affiliated, or what an EPS is. It must be taken into account that they come from another health system, a public system where this figure does not exist, so there is no need to make sure that on the demand side, the affiliation, there is an issue of information”. - KIMH2 Bogotá.

Moreover, the key informant testimonies suggest that for some migrants, enrolling in the Colombian health system is not perceived as an advantage,

at least in the short term, when they can access better and agile health services through international cooperation.

“When the cooperation, by its mandate, is called to attend to all the population regardless of their migratory status, and, accessing some benefit from the cooperation is much more agile than doing it in the regular way well, many of the population will hide their migratory status” - KIOB Bogotá

“They do not do it basically because they have seen that they have much faster access to assistance services through international cooperation or services that are supported by different national or international NGOs, which make them attend them faster, without any paperwork and without any type of payment, so they decide to continue under the assistance modality and not to affiliate. We are beginning to see this in some areas in a small proportion, but it is something we are very afraid of”. - KIAC2, Bogotá

The key informants mention other cultural aspects associated to the resistance of displaced Venezuelans to follow (once enrolled) the regulatory framework. It is important to highlight that this adherence to the regulations includes a mandatory follow-up every four months to certify that their current permanent residence is the municipality where they are reporting to. This follow-up can be perceived as discriminatory for displaced Venezuelans.

“There are others that have to do with the sociocultural aspects of the returned migrant and refugee population and there is a resistance to assuming our processes and regulations. Although it is not implemented in all territories, the regulatory framework requires migrants to make a reporting process every four months, in the territorial entity. What is the purpose of this? Well, the population is a migrant from their own country and within our own territory. So they are probably insured in Riohacha, but a family member

did well in Bucaramanga, so they migrated to Bucaramanga. So this report every four months allows the territorial entity to have a minimum count of how many people it is responsible for assisting, how many migrants. Many migrants say that this is a discriminatory act because Colombians are not made to report. iOf course, because we Colombians do not migrate with the same speed!”. - KIOL Bogotá

Finding strategies to promote and motivate affiliation through the health management organizations (EPS) must be considered since, for these institutions, migrants, are a risky population considering their pendular reality and the financial effort involved in assisting them.

“The EPS does not help anyone who does not meet their UPC. That is to say, they only affiliate if they have already decided who is going to pay. So, for them it is a big problem. Now, for them it has not been a great motivation either, let’s say, they have not made affiliation days for the Venezuelan population because it is a population that in general is a passing population. But let’s say, it has been thought of more as a migrant population that moves, that is not necessarily going to stay here or that is going to return or that is going to go somewhere else, so it is not a very interesting population to seek to affiliate, because they come with a lot of problems of everything they have suffered, so you affiliate them and you have to solve it” - KIUA Bogotá

Some concerns rose about migrants arriving in the country after January 31, 2021, the reference date to access the benefits of the TPS. The question of how to adapt and make a more flexible legal framework in response to Venezuelan dynamics migration has currently not been addressed.

“Well, first of all, the most obvious one, is about the date, it is oriented to the people who were here before that date and the migration flows did not stop after that day, no? So, I do not know the figures, maybe someone is following them

up, but the field work that we do with the Health Foundation issues, most of the people who are in trouble are those who arrived after that date, they keep arriving and there are some surveys out there, I think it is the Inter-American Development Bank or for example Venezuela migration, which indicate that many of these people want to bring their family. So, I do not know how the Statute is going to be sensitive to that” - KIHM2, Bogotá

Finally, another barrier identified to enroll displaced Venezuelans in the health system is the difficulty of locating and contacting them. Migrants cannot be reached easily because they constantly change their residency and contact number as part of their migratory reality.

“I remember, the secretariat of Buga saying, “ok, I want to look for migrants, where are they, who tells me where they are? Migracion Colombia, no, Migracion Colombia gives me a statistic, because nobody gives me the telephone numbers of the people, nobody tells me more or less where they are [...] Then we discovered that many of those telephones were from the Internet cafes where the people close to them were. Well, because they change a lot, but at least there you get something, eh, and that has been solved, but it is still a challenge to locate this population”. - KIUA, Bogotá

SWIHSS Case Study: Promoting full integration and health access with emergency units as an entry point

The *SubRed Integrada de Servicios de Salud Sur Occidente* (South-West Integrated Health Service Sub-Network - SWIHSS) is an integrated public health service providers network that operates in the southwestern region of Bogotá, Colombia’s capital city. This network of public hospitals provides services such as emergency care, hospitalization and outpatient services. The model of care of the SWIHSS is known for its focus on prioritizing patient-centered care based on scientific research and medical training.

After the last wave of social and economic displacement from Venezuela, the SWIHSS made substantial progress in providing access and care, and promoting the enrolment to the Colombian health insurance system of Venezuelan pregnant women in Bogotá. As part of a pilot project, this network provided pregnant Venezuelan women with all the prenatal check-ups and medicines required, regardless of their legal migratory status. This innovative approach aimed at ensuring safe pregnancies and childbirths in response to the health challenges with which many pregnant migrants arrived in Colombia.

“At the beginning, we identified that the patients came with many pathologies. Syphilis, we identified a lot of HIV, babies who came with heart disease, so we ensured them everything: vitamins, treatments, while they are pregnant, they go to the emergency room every month for their check-ups”. (KII - Bogotá).

According to the testimonies collected, the SWIHSS has provided service to more than 500,000 displaced Venezuelans with an irregular migratory status and no health insurance. The network has developed an internal protocol to identify Venezuelans who have a vocation of permanent residence in Colombia and support them in the process of formalizing their migratory status and enrolling in health insurance.

“A social worker intervenes [and] helps orienting them through the regularization of their migratory situation.” (KII - Bogotá)

Bogotá has a special Health Financing Fund to collect and manage all health resources. In the case of emergency care and hospitalization services, the SWIHSS receives the reimbursement of services provided to uninsured individuals directly from this Fund. The fact that the Fund and the SWIHSS are part of the local government facilitates the payment of services and resources for the care of migrants.

6.2.2. Barriers to access when insured

In-depth interviews revealed a phenomenon that limits access to healthcare for displaced Venezuelans as a family unit. It is not uncommon that family members migrate separately and at different times. In these cases, frequently one family member could have regularized their migratory status and enrolled to the health insurance system. Also, it may happen that even if the whole family migrated together, not all of them go through the regularization process. In either of these cases, the existing mechanisms to regularize migratory status (PEP and the TPS

for Venezuelan migrants) are unipersonal or individual and do not cover family members. Hence, only the individuals with a regularized status can effectively start the enrollment to the public insurance system in Colombia.

“When I was already here in Colombia, it was difficult for me to go to the doctor, to go to have some tests done, some exams, I couldn’t do it because I didn’t have IPS, but nowadays I do, I really feel good because I go to my IPS and they take care of me in the best way possible, I have no complaints about that IPS, and they give me my medications and everything I need, the exams that I need, they give them to me, and that is why I feel good about that part; Well, my concern is that my son doesn’t have an IPS and my mother doesn’t have insurance”. - Venezuelan Migrant living in Cucuta, Colombia.

“Well, for us it’s mainly the lack of medical attention because I have my mom and she doesn’t have insurance, she doesn’t have IPS or anything... I mean it’s hard because they won’t treat her anywhere”. - Venezuelan Migrant living in Bogota, Colombia

Another important and frequent normative barrier to access when insured are the restrictions and processes associated with enrolling with a different EPS when a person or family migrates to another municipality. In general, four requirements must be met to switch EPS. First, to have been affiliated to the same EPS for one year. The year of affiliation is counted from the date of enrollment of the member head of household. Second, not to be hospitalized in an institution providing health services. This applies to all members of the family nucleus (in the case of having more beneficiaries under the insurance). Third, to register the transfer request for all the members of the family nucleus. Fourth, the EPS to which the migrant wishes to transfer must be authorized to operate within the municipality where he or she resides. The transfer can be made across the different regimes, can be done online or in person and no documents are required (just the virtual or physical form). By regulation, if the request is made within the first five days of the month, the switch must be fulfilled by the first calendar day of the month following the request. However, when a family migrates to a municipality where their EPS is not present, they are compelled to join an EPS that has coverage there. If a person has

been affiliated for less than one year, then the process is delayed given that they do not fulfill the requirement to change EPS.

6.3. Who provides healthcare to unregularized and uninsured migrants?

Institutions such as the Red Cross and AmeriCaras Foundation have played a key role in the Venezuelan migration crisis in Colombia by providing medical assistance to uninsured individuals through Health Attention Units (HAUs) located in municipalities on the migratory route (see Figure 2.5). They provide free primary healthcare services and free medications for migrants and returnees affected by the Venezuelan crisis. Without a doubt, all humanitarian emergency response programs in Colombia have played a fundamental role by alleviating the limited access of unregularized and uninsured displaced Venezuelans.

The testimonies collected through IDIs suggested that, especially in the municipalities close to the Venezuelan border, migrants constantly rely on these healthcare providers. Moreover, they mention receiving good treatment and medicines, as well as timely care and consider these providers as the only institutions that deliver complete health services for migrants.

“We go to these foundations because they are the ones that take us into account. First, because we are a migrant population. Second, because they always give you support, they assist you, they do not leave you waiting, unlike going to the public hospital or going to an EPS, you have to wait for a social worker to come to see if your case deserves attention or not and if it is not very urgent, then they tell you that you have to go to the San José hospital for triage and that is a bit of a long process”. - Venezuelan Migrant living in Maicao, Colombia.

“I go to the Red Cross for medical services, in Villa del Rosario before COVID-19, it was the only place we could receive healthcare, and in Boconó. It always had to be there because in other places they did not receive us”. - Venezuelan Migrant living in Cucuta, Colombia.

According to the interviews, these non-governmental organizations supply medicines to treat chronic diseases at fixed times or deliver them to their addresses.

“To get medications and treatments for chronic illnesses we go to the Américas Foundation, to the Red Cross, and if we cannot get it in these places, we go to pharmacies or drugstores”. - Venezuelan Migrant living in Maicao, Colombia.

“Américas, you would go there and pick up your medications or they would deliver them to you. They had an established schedule every Friday from 7:00 a.m. to 10:00 a.m. to deliver the medications”. - Venezuelan Migrant living in Maicao, Colombia.

Finally, the qualitative evidence collected through the IDIs reveals that the COVID-19 sanitary crisis also affected access to the health services provided by these humanitarian institutions. Migrants report limited access and delays in healthcare provision through these humanitarian crisis response programs, explained mainly by the strict biosecurity protocols implemented and the restrictions on health supply.

“It has worsened, because previously, at least here, there are foundations such as Américas, Save the Children Colombia and the Red Cross that provided us with assistance. But nowadays, since you have to comply with biosecurity measures, it is a little more difficult to access the service, since they give you a number that you have to dial many times to get an appointment, to then access the health service”. - Venezuelan Migrant Maicao, Colombia

Another key finding of the IDIs was that public hospitals are absorbing most – if not all – of the burden of providing health services to displaced Venezuelans. Public health providers have been financially affected by this situation, in addition to congestion due to the excess demand for services. In particular, services highly demanded by the Venezuelan

migrant population — such as emergency obstetric and newborn care (EmONC) — have created important financial and operational tensions in the Colombian health system that cause additional barriers to healthcare. The following testimony suggests this:

“Well, I’m going to tell you something, when I arrived here in Colombia when my child was hospitalized at the San José hospital, they asked me for an amount of almost US\$1,800,000 for the days that my child was hospitalized. Because of the hospitalization? Then I told the girl that I didn’t have money to pay for that, that I was Venezuelan, that I didn’t have that, that it was sad and unfortunate, but that they could put me to sweep, to mop, to do whatever because I didn’t have money to pay.

Then she told me to go to the social worker and there I talked to her, and I explained that I didn’t have anything. It was hard because I had been here four or five days since I arrived from Maracaibo and my father died there in Maracaibo and I couldn’t even travel because my child was in bad shape here, so I told her that I didn’t have anything to pay for it, that they should see what they were going to do with me because I didn’t know that I had to pay for it.

Then she sat me down and told me “no, don’t worry, I’m going to do the process with you, so you pay US\$80,000”, and I told her “but I don’t have that money” because I don’t have it, I’m not working here; and my son’s father, what he sold here when we were new here, was water and it was barely enough to eat and pay for the little room where we lived, and to half eat, because he even went to the hospital every other day because he didn’t have enough money to go to the hospital every day. Because it was US\$4,000 that was needed to go back and forth, and we didn’t have it. So, she told me -Well, I’m going to ask you the questions, so that you don’t pay anything, so I left, and I didn’t pay a penny”. - Venezuelan Migrant living in Maicao, Colombia.

The interviews with key actors indicate the work with humanitarian agencies through intersectoral clusters have succeeded in building a model to address the humanitarian crisis triggered by the Venezuelan migration. However, the next step to take is to move from a crisis approach to an institutional response to the Venezuelan migration.

“I believe that it has been a successful model of cooperation through the creation of the inter-agency roundtables led by IOM and UNHCR, and the articulation in the sectoral roundtables, what are these roundtables called? In the clusters. This seems to me to be a successful model. Of course, when you begin to get to know it closely, you detect opportunities for improvement, but I think the problem is that definitely, since this phenomenon cannot be understood only as a humanitarian crisis, but as a long-term phenomenon, it does not mean that a humanitarian crisis cannot last, it cannot be timed, but what I mean is that this is more than a humanitarian crisis. It cannot be treated as an earthquake, nor as a drought, nor as a displacement due to an armed conflict. It is a long-term phenomenon and to that extent we have to move from a response based on a humanitarian crisis approach to an institutional response where the state absorbs the capacity to integrate migrants to their social rights”. - KIMH Bogotá

Colombian local governments and actors recognize that working with the international humanitarian aid organizations is crucial in reaching and assisting migrants' health needs. The Colombian health system would not have been able to provide services fully because the humanitarian emergency exceeded their assistance and financial capacity.

“Fortunately, for more than two years we have had support from international cooperation, which has been vital for us. In itself, health resources for the territory were not enough for Colombians. Now, with the migrant population, much less.

If we see that the services are saturated. Even more migrants are coming than the Colombian population itself. Through some cooperating

partners, such as Save the Children, we are handling the care of the child population, the population of pregnant women who are victims of violence.

Well, we also have Americares, they provide healthcare services to this same population group, because there are a lot of them. There are other cooperating partners that are also part of the process, such as Action Against Hunger, there are many, because here in the territory we have more than 37 cooperating partners that between all of them are articulated to provide attention to this population". - KIHS Maicao

However, to move toward an efficient institutional response to the migrants' health needs, it is mandatory to involve other actors, such as the insurance companies and the Registry Office.

"I believe that in this process progress was made at a time when we are still in an emergency, welfarist situation on the part of the health system. Now we are in a moment of transition in which many of these people are going to move from a welfare context to a context of insurance and inclusion in the health system. And I believe that this is an opportunity to improve by involving new actors that are fundamental and that we should have included before. For example, the work with insurers, the work with health insurers has been very null in terms of response to refugees and migrants". - KIBI, Bogotá

"A major aspect is coordination with other actors outside the health system, but on which the health system depends. That is, the Registry Office, for example. The Registry Office is a fundamental institution in all aspects of access to health services and we have many challenges with the Registry Office". - KIAC2, Bogotá

6.4. Perceptions of healthcare appropriateness and quality

The evidence collected in the IDIs suggests that the perception of the quality and appropriateness of healthcare services depends substantially on being affiliated to the health insurance system and thus of having a legal status. Displaced Venezuelans without insurance describe the attitudes of healthcare workers as discriminatory, as well as the protocol and regulations asked to get proper medical attention. Not receiving equal healthcare, favoring legal status over health needs, and receiving partial solutions to chronic diseases or pain, are the main claims reported in the IDIs as examples of discrimination.

“The truth is that most Venezuelans, we migrants are afraid to go to a hospital because we are not treated like any other person. But if it is a health system, we all should be the same, equal. There are some protocols that have to be followed, but suddenly if you arrive at least with a pain and that, and you do not present a legal document, they do not attend you and then that is what I do not think is right”. - Venezuelan Migrant, Barranquilla, Colombia.

“Well, that’s where the attitudes of the workers are an issue! There are some people who call themselves doctors and their profession is to save lives, not to say: ‘I’m not going to treat him because he has no way to pay’”. - Venezuelan Migrant, Maicao, Colombia.

“The hardest experience I had was with the baby girl with a toothache, and I took her to the PASO Simón Bolívar. And the dentist attended her, but when she asked me if I had SISBEN, EPS and other things, and I said ‘no’, she told me that unfortunately she had to prescribe her something to reduce the inflammation of the tooth, but that she couldn’t attend me because I didn’t have medical insurance. And I had to go with the baby, and so I bought what she [prescribed] me and, so far, when the tooth hurts, I give her the medicine that she took that time and it calms the pain. So we have been going on like that.” - Venezuelan migrant, Barranquilla, Colombia.

Some of the displaced Venezuelans interviewed alleged that medical personnel had an implicit discriminatory conduct when attending them, precisely because of their foreign origin. Testimonies also indicate frustration in unregularized migrants when denied medical services, explicitly for their nationality. This experience impacts the perception of the quality of medical care for this population. Being rejected by the system gives them a negative perception of health services in general. The experiences described in the interviews, especially the claims about the medical personnel having discriminatory practices, raises the need to design and implement strategies to end this conduct.

“I don’t know, because they think that we don’t deserve attention because of that, because we are foreigners and they are nationals, so it is difficult because there are traits of discrimination and some have traits of xenophobia, they don’t say it expressly but with their attitudes and their way of looking at people, you can see it, when they say that they are Venezuelan or foreigners, they change the attitude of the person towards them” - Venezuelan Migrant, Tumaco, Colombia.

“Without lying to you, I went to several places, I went to the health post, to the hospital and several points walking. And I was very disappointed when they told me that they could not attend to me because I was Venezuelan. Wow! That is something... you feel ugly, you feel bad, because you are going for health and health shouldn’t be denied to anyone”. -Venezuelan Migrant, Cucuta, Colombia.

“So, there is always the fact that if you are Venezuelan and you don’t have an ID card, that you are not affiliated, you meet people there who are not trained or don’t have that orientation with the foreigner”. - Venezuelan Migrant, Tumaco, Colombia.

It is important to highlight that, in addition to the structural limitations of the health system that affect the general population, González-Uribe et al. (2022) highlight the importance of stigmatization, discrimination, and revictimization when accessing mental health services.

Testimonies of uninsured migrants without resident permits contrast with those of migrants with a regularized migratory status and access to health services (given that they are enrolled to the SGSSS). The evidence collected suggests the latter receive proper healthcare and quality health services. They refer to being attended to, having access to appointments, medicines, and well-prepared medical professionals.

“Very good, very good, they tell me, such and such a day you have an appointment, be on the phone, you must see the doctor, for example. I have had no complaints from Nueva EPS for me, if I have to go for tests, they tell me the day I have to go, the time I have to be there and that’s it”. - Venezuelan Migrant, Bogotá, Colombia.

“I really feel good because I go to my IPS and they take care of me in the best way possible, I have no complaints about that IPS, and they give me my medications and everything I need, the exams that I need, they give them to me, and that is why I feel good about that part”. - Venezuelan Migrant, Maicao Colombia.

For internally displaced and host populations, their perception of healthcare quality is based on waiting times for appointments and procedures and the time given by the physicians during the medical assessment. Although there are positive and negative experiences reported, unlike displaced Venezuelans without legal status and insurance, the experience of the quality of healthcare services in the host population (including internally displaced people) depends on the capacity and quality of the local health service provision network, of the EPS providing the insurance, and of the IPS providing the health service.

“And there are even doctors who reject the patients, and they have to tell them: ‘take this and take that’. But when rushed, so sometimes when they give it — as I have seen — so rushed [because] they had a patient who got complicated”. - Internally Displaced Person living in Barranquilla, Colombia.

“Well, in my case, when I have an emergency, here in Tumaco, there is the Divino Niño and the

Puente del Medio. I prefer to go to the Puente del Medio because the attention is much better than at the Divino Niño, they attend to you faster. And, for example, in terms of quality, how is the attention at Divino Niño and how is the attention at Puente del Medio?

Well, at Divino Niño you get an appointment, they give you a card and you must wait or sometimes it takes two hours, three hours, sometimes you are attended the next day... imagine, if you go in case of an emergency, well, you die there". - Colombian living in Tumaco, Colombia.

"The treatment has always been excellent and in their responsiveness, always, always, in the EPS, in the clinic and in the hospital, but the procedures are always quite delayed". - Internally Displaced Person living in Maicao, Colombia.

6.5. Human capital: availability and integration of Venezuelan professionals

Special integration and employment mechanisms for foreign medical professionals have been implemented in other countries. Peru, Colombia's neighboring country, implemented a decree to utilize migrants with medical training to work with infected COVID patients. In the emergency decree "N 037-202," President Martín Cornejo detailed in Article 4 that the country would create a Special COVID Service group which allowed foreign health professionals to participate. The permit to work and to treat patients would last for thirty calendar days and was designed to specifically help Peru alleviate the burden of care for health facilities (El Peruano, 2020). The decree was explicit in its wording that foreign workers would be hired temporarily to specifically assist in the nation's response to COVID.

Similarly, several OECD countries have assisted in providing work authorizations to foreign health professionals in medical or support staff roles. For instance, in the Canadian province of Ontario, the government declared that international medical graduates who have passed their exams to practice in Canada or have graduated from school in the past two years can apply for a supervised thirty-day medical license to treat patients during COVID-19. In Chile, the national health service can hire foreign health

professionals even if their qualifications aren't formally recognized in the country. In France, non-licensed foreign health professionals can work as support staff in non-medical roles. Additionally, multiple OECD countries such as Belgium, Germany, Ireland, and Luxembourg have expedited applications for the recognition of foreign qualifications. Countries have also facilitated procedures to receive qualifications sooner, such as fee waivers and reduced language tests. Colombia's participation in the OECD presents a great opportunity for the country to gain foreign guidance and resources to create emergency policies utilizing the medical skills of displaced Venezuelans already in the country to treat COVID patients (OECD, 2020).

According to the testimonies collected in the key informant interviews, integrating the migrant or refugee workforce is not the norm in Colombia. Although in some cities like Barranquilla, migrant health professionals joined the local workforce and were crucial to dealing with COVID-19, this is not true for the rest of the country. Moreover, official figures, documentation and statements regarding their participation are scarce and weak.

“What I can say is that we have professional university specialists, technicians who, fulfilling their requirements and in a state of legal permanence, are working in health institutions here in the city, with good results, without any type of prevention in the medical unions or scientific associations of the city. There are radiologists, rheumatologists, internists, physicians and I would believe that they have been part of the solution to the pandemic, because in the pandemic we require a lot of human talent and I believe that they have been part of the solution”. - KIHS Barranquilla

There are several limitations in integrating the Venezuelan workforce into the health system. First, the Colombian medical community has historically had an adverse and unfortunate reaction to incorporating Venezuelan professionals even during the most critical stages of the COVID-19 pandemic, as reported in the testimonies of key actors.

“It was going to be said and it was leaked that as part of the emergency measures being taken for Covid, they were going to resort to some of the doctors for an express homologation. And

there was holy anger from the medical sector threatening with a strike and we had to change and say no! That was when there were no more doctors, no more nurses, all the others have died” -
KIUA, Bogotá

Another important barrier in Colombia is the homologation process of professional titles. The difficulty in obtaining the legalization and authentication of the migrants’ professional training from Venezuela is a fact; there is no willingness from that country to facilitate the apostille, according to the key actors interviewed.

“There is a frustration...not having been able to advance more with the process of homologation of degrees. The homologation had three issues, one first substantial and evident. And that is that an apostille is needed and you did not have a counterpart with whom to do it” - KIUA, Bogotá

The interviews with key actors suggest some alternative solutions to overcome the administrative and cultural limitations to the integration of the Venezuelan workforce in Colombia.

In the interviews with key informants some reflections were made on the need to generate evidence about the lack of quality and opportunity in the care migrants receive (in comparison to the host populations). Also, interviewees mention the necessity of developing and implementing training programs for medical personnel to provide them with the necessary tools and capabilities to guarantee the effective integration of displaced Venezuelans.

“And I understand, also today the health personnel are super fatigued, so give them another course, you kill them. We have to do something innovative, because I think it is something that happens, I do believe that the migrant population is left last in line, not all of them obviously, but there is a feeling of... you hear things like ‘the resources of the ward are scarce because I have to spend them on a person who is not from our country, when here we have people who are in a worse condition and cannot be affiliated’”. - KIBI, Bogotá

“My vision is that the first thing to do is to generate evidence that this is happening. When you approach it as ‘no, no, they treat you like they treat everybody else’. Some USA studies with the African American community come to my mind where they show that they give them less doses of pain control or that they make women suffer more during childbirth, and that is very well evidenced. I think there is information here to do that. I would make something as a way to call attention”. - KIBI, Bogotá

“Well, very little. Profamilia has done focus groups to understand at least how it is looking at the health problems of migrants and especially migrant women. But otherwise I do not see the ministry and I do not know of any international cooperation that is working on more pedagogical aspects with health personnel and explaining simple issues such as the traditions that exist in Venezuela, culturally what to do with a child with diarrhea, for example”. - KIUA, Bogotá

CHAPTER 7: HEALTHCARE UTILIZATION, COSTS, AND SPENDING

7.1. Healthcare utilization

Residents of Colombia can access healthcare in one of three ways. In order of decreasing frequency for Colombians, the first is through enrollment as a contributory member of an EPS, a health management organization. This contributory regime applies to workers in the formal sector and their families, who fund insurance premiums with their employers through a payroll tax. The second route is enrolling under the subsidized regime, where premiums are covered by the nation. Both schemes are available to officially registered Colombians and Venezuelans. While subsidized members by law have access to the same scope of services as contributory members (given that since 2012 the benefit plan is the same), their health needs tended to be greater while their *de facto* access (e.g. filling of prescriptions) was more limited (Díaz Grajales et al., 2015; Hilarión-Gaitán et al., 2015). Finally, any person in Colombia (citizen or migrant), can have access to health services as an unenrolled resident. However, this group is entitled only to emergency care and mass public health services.

The regularization status for displaced Venezuelans improved when in February 2021 the Colombian government created the Statute of Temporary Protection for Venezuelan Migrants (Frydenlund et al., 2021; Tresman, 2021). The objective of the temporary protection status is to allow displaced Venezuelans living in Colombia to transition from a regime of temporary protection to an ordinary migratory regime. For instance, Venezuelan migrants will have ten years to reside in Colombia, enroll in all social protection services, work legally and eventually transit to a permanent resident visa. This measure seeks to protect the migrant population that is currently in irregular conditions and reduce current and future irregular migration.

Since the COVID-19 pandemic began in March 2020, all residents of Colombia (both citizens and displaced Venezuelans) have been subject to a range of evolving national and local restrictions, which have resulted in varying health, economic, and social impacts for all those living in

Colombia. While previous literature has examined responses to COVID-19 across humanitarian settings, small numbers of settings, few indicators, purely cross-sectional designs, and variability in data sources and methods generally limit their analytical power.

Managing the COVID-19 pandemic has challenged health systems in every country. This is especially true for low- and middle-income countries (LMICs), which were already struggling to provide quality health care for their population (Langlois et al., 2020).

According to a survey across 106 Global Fund countries (which include Colombia), the COVID-19 pandemic interrupted the treatment and diagnosis of all three of the epidemic diseases it addresses: malaria, tuberculosis, and HIV. With increased service demands due to COVID-19, LMICs reported shortages of medical supplies, qualified workers, and disruptions in service delivery, limiting the capacity of their systems to respond to other problems (Global Fund, 2020).

These challenges were compounded in countries with concentrations of forcibly displaced people, adding to the existing difficulties of providing adequate access to healthcare services. Of the 82.4 million forcibly displaced persons worldwide, 39 percent live in just five countries. They are distributed across the World Bank's income categories: Germany (high), Colombia and Turkey (upper-middle), Pakistan (lower-middle), and Uganda (low) (UNHCR, 2021). All these countries face the dual demands of tending to both local and displaced populations.

Even before the COVID-19 pandemic, displaced populations confronted barriers to accessing healthcare due to discrimination, lack of information, high costs, and fear of deportation. The pandemic magnified these problems: according to the Mixed Migration Center, less than half of the migrants with COVID-19 symptoms could access testing or treatment (IFRC, 2020). Additionally, refugees and migrants face special risks causing high rates of mental health disorders, and several communicable and non-communicable diseases (WHO, 2018).

Colombia hosts approximately two million displaced Venezuelans, which is the second-largest number of migrants in any host country globally (Migración Colombia 2022; UNHCR, 2021; R4V-GIFMM, 2020).

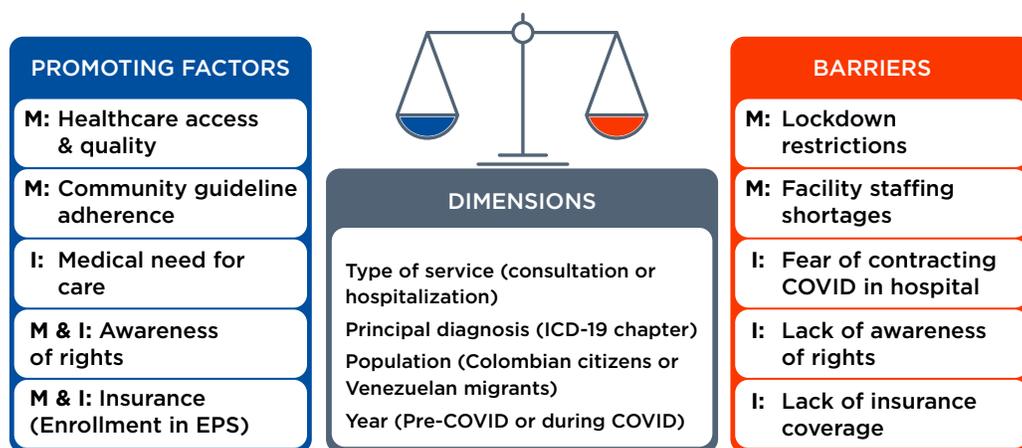
Most migrants, who began arriving in 2015, have located in large cities such as Bogotá, Barranquilla, Cucuta, and Medellín, searching for work opportunities (Guataquí et al., 2017).

7.1.1. Conceptual framework, data source and empirical approach

To understand rates of health services utilization across individuals, nationalities, locations, and time, we endeavored to develop a theoretical framework. We conceptualized each resident's decision concerning health services utilization as a balance of opposing factors, as shown

in Figure 7.1. These factors can operate at the level of the municipality (M), the individual (I), or both (M & I). Factors that promote utilization include access and quality of services, insurance coverage, medical need, patients’ awareness of their rights, and patients’ insurance coverage. If a patient was not previously enrolled in an EPS, the hospital may assist the patient to register to help ensure that it receives payment. Factors that act as barriers to services include lockdown restrictions and facility staffing shortages. Factors that operate at the municipal level were expected to remain consistent across a municipality. Individual-level factors may differ between Venezuelans and Colombians, as well as among persons within each group.

Figure 7.1 - Conceptual framework - Utilization of medical services in Colombia: a balance



Notes: “M” denotes municipality; “I” denotes individual; “ICD” denotes International Classification of Diseases; COVID denotes corona virus disease.

The COVID-19 pandemic places additional barriers on accessing services in several ways. First, the general lockdowns that began in March 2020 made it more difficult to move about. While consultations with physicians were allowed, transport was less accessible, and patients may have feared infection while visiting or traveling to and from a health facility.

Given the concern about minimizing risks to medical personnel, the health system explicitly focused on emergency care and reduced the supply of non-emergency services. For example, some hospital staff shifted to remote and part-time work (often three of the five working days). Also, protective measures in healthcare facilities reduced the number of services that could be delivered in a working day. Thus, patients experienced more difficulty in obtaining in-person appointments.

This section focuses on the “dimensions” factors (e.g. types of services, populations and year). As depicted by the balance scale, these dimensions

reflect the relative weight of the combined promoting factors compared to the combined barriers. We derived rates of COVID-19 cases, deaths, hospitalizations, and consultations by dividing them by the corresponding populations and expressing them as rates per 100,000 population. To accommodate potential wide ranges of rates among different indicators, we expressed all values on common logarithmic (base 10) scales. We chose base-10, rather than natural logarithms, to facilitate interpretation. As about half the municipalities had no Venezuelan deaths, we could not perform the logarithmic transformation with the original data. Instead, for deaths we used a “shifted” log scale in which the constant 1 (i.e., 1 death) was added to the count of Colombian and Venezuelan deaths in each municipality before taking the logarithm.

For overall COVID-19 cases, where data was tallied by epidemiologic weeks, the study period was March 1 through November 28, 2020. As the breakdown of COVID-19 deaths by nationality began only on April 26, 2020, the breakdown of that indicator was April 26, 2020, through November 28, 2020. Our interpretation of the findings was informed by other components of our multi-faceted study of COVID-19 in Colombia across 60 municipalities. These other components included a telephone survey of 8,130 displaced Venezuelans and Colombian nationals, key informant interviews, a review of policy documents, and mobility data from cell phones (ELRHA, 2021).

7.1.2. Findings on comparative utilization

7.1.2.1. COVID-19 case rates

Figure 7.2 shows the Venezuelan versus Colombian COVID-19 case rates, with each municipality represented by a dot. The horizontal (x) axis shows each municipality’s rate for Colombians while the vertical (y) axis shows the same municipality’s rate for Venezuelans. The dashed 45-degree line here and in subsequent figures shows the line of equality that would apply if a municipality had identical x and y values. On average, Colombians have substantially higher reported COVID-19 rates than Venezuelans, by an average factor of 10.64. Venezuelans reported COVID-19 rate in each municipality was highly correlated with that of the municipality’s Colombian residents ($r=0.52$, $p<0.0001$). Thus, the pattern was consistent across municipalities. When the 2020 study period was subdivided into two equal time segments to examine the stability of this relationship, the Colombian rate proved consistently higher in both periods.

Findings from the telephone survey and other components of the larger study suggest some possible explanations. Displaced Venezuelans were statistically significantly less likely to report use of COVID-19 testing compared to their Colombian counterparts. Venezuelans were also less likely to report flu-like symptoms related to COVID-19 than Colombians (ELRHA, 2021). With lower membership in contributory health plans,

Venezuelans faced less access to non-urgent healthcare. As weekend mobility (when patrons might visit bars and clubs) appeared to be a greater contributor to COVID-19 transmission than weekday mobility, Venezuelans may have been less mobile due to lower disposable income, and thus less exposed.

Description of the data sources used in the utilization analyses

Health services utilization. Our main data source for the quantities of healthcare services received by Venezuelan migrant refugees and Colombian citizens by municipality of residence and month of service was the RIPS. It records all healthcare system transactions in Colombia. The transactions were transmitted from the institution that provides the service, the IPS, such as a hospital or clinic, through the member's EPS to the central registry (RIPS). This data on service utilization serves as the numerator for rates of hospitalizations and consultations. Although RIPS also reports numbers of procedures, we did not count them to avoid overlap with our main measures. Since the system is used to pay facilities, the usual reporting lag was only one to two months.

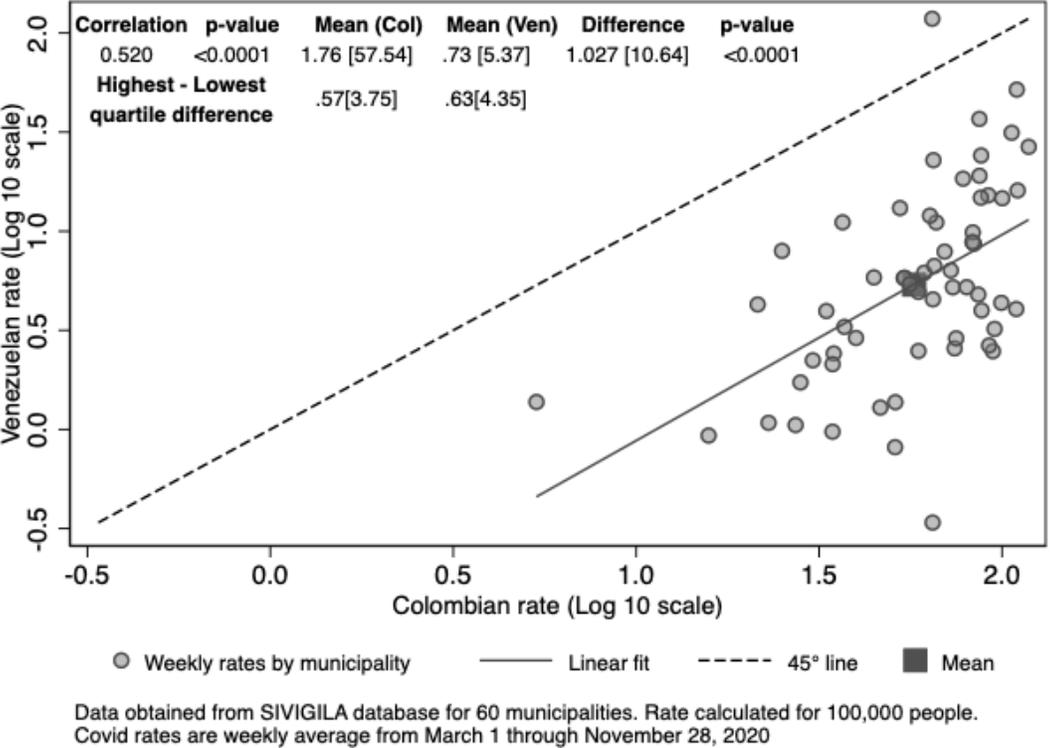
Breakdowns by diagnosis. The RIPS also classified each health service by principal diagnosis. These diagnoses are grouped into the main 22 chapters of the International Classification of Diseases Tenth Revision (ICD-10) diagnosis classification system (WHO, 2016). To handle COVID-19, the ICD-10 system added a code for COVID-19 in the chapter "codes for special purposes." The data available for this report on hospitalizations and consultations cover March 1 through July 31 for 2019 and 2020. This data represents all health services (consultations, hospitalizations, emergency room services, and interventions) delivered by licensed facilities or providers in Colombia.

COVID-19 cases and deaths. Colombia's epidemiological surveillance system (SIVIGILA), operated by the National Health Institute and the Ministry of Health and Social Protection, reports officially confirmed COVID-19 cases and fatalities by municipality and week. Our analysis is based on unofficial data.

Denominators. The denominators are the number of persons in the country and each study municipality by nationality and age. These denominators came from the Colombian census for Colombian citizens (DANE, 2018) and from the border control agency for Venezuelan migrant refugees (Ministry of Foreign Affairs, 2021 and 2019). The proxy measure of enrollment in contributory insurance in each municipality was derived from RIPS. The contributory regime

share is the proportion of health services delivered through the contributory regime. It was calculated as the municipality's sum of services (ambulatory, inpatient, and procedures) provided to contributory EPS enrollees divided by the municipality's grand total of all services. To clarify the importance of small numeric differences near the extremes of a proportion (i.e., 0 and 1), proportions were graphed on the logit scale. The logit scale is defined as the natural logarithm of $p/(1-p)$, where p is the contributory regime proportion of services for the specified municipality for a given nationality.

Figure 7.2 - Venezuelan versus Colombian COVID-19 case rates per 100,000 population in 2020 by municipality

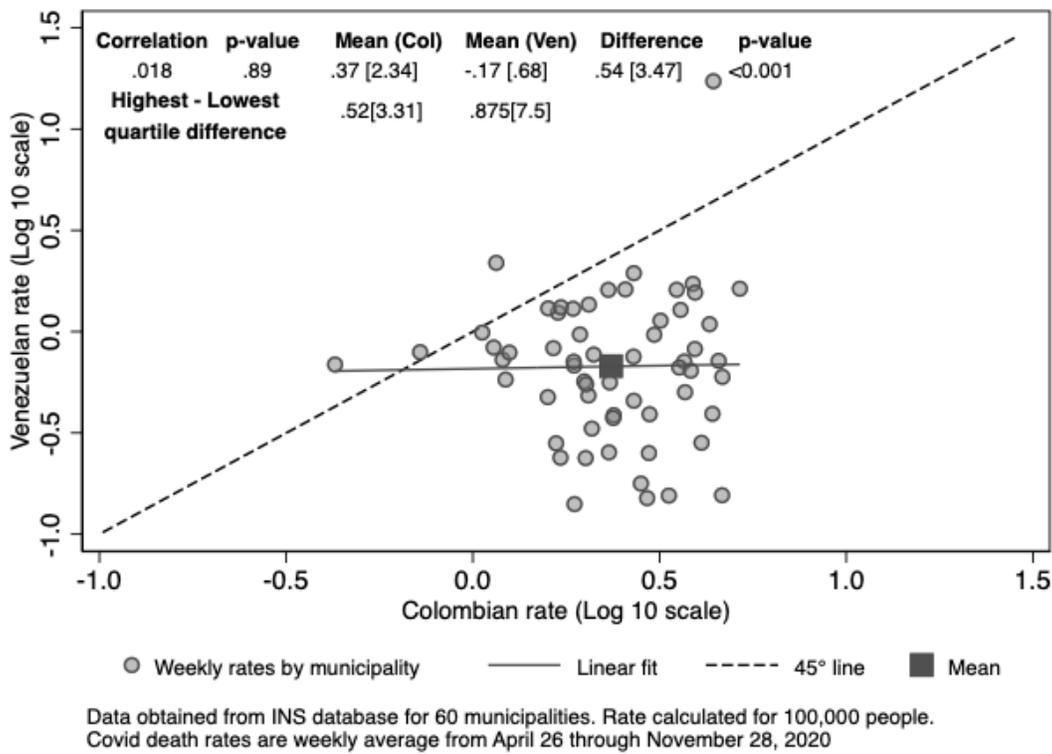


In addition, policies and practices around COVID-19 risk (e.g., masking and social distancing), as well as access to testing, vary substantially among municipalities, which would explain the inter-municipality variation in COVID-19 rates. When COVID-19 rates were separated by quartile for Colombians, the ratios of the highest quartile to the lowest quartile were similar for Colombians (3.75) and for Venezuelans (4.35), indicating that both nationalities have substantial variation across municipalities.

7.1.3. COVID-19 death rates

Figure 7.3 shows the relationship between Colombian and Venezuelan COVID-19 weekly death rates by municipality. The actual (not transformed) COVID-19 population-weighted average weekly death rates of Colombians and Venezuelans across these municipalities were 2.57 and 0.56 per 100,000 population, respectively. Similar to the pattern for COVID-19 case rates, the death rates of Colombians were significantly higher than those of Venezuelans. However, the relative rate of Colombians compared to Venezuelans for death rates (4.57) was substantially smaller than that for case rates (10.67).

Figure 7.3 - Venezuelan versus Colombian COVID-19 death rates per 100,000 population in 2020 by municipality



The differential age structure of the Venezuelan and Colombian populations may be an additional explanatory factor for higher rates of COVID-19 cases and deaths in Colombians than in Venezuelans. In 2020, 92.6 percent of Venezuelans were aged 0-49 years compared to 75.7 percent of Colombians. On the other hand, only 6.7 percent of Venezuelans were aged 50-69 compared to 18.3 percent of Colombians, and only 0.8 percent of Venezuelans were aged 70 and above compared to 6.0 percent of Colombians. Thus, Venezuelan migrants tended to be younger than Colombians.

Dividing each population's COVID-19 death rate by its case rate approximates its case-fatality rate. These were 3.63 percent for Colombians versus 8.29 percent for Venezuelans. The case-fatality rate of Colombians was only 0.44 times that of Venezuelans. As Colombians are older, on average, than Venezuelans, their case-fatality rate was expected to have been higher than that of Venezuelans if they had had the same access to care.

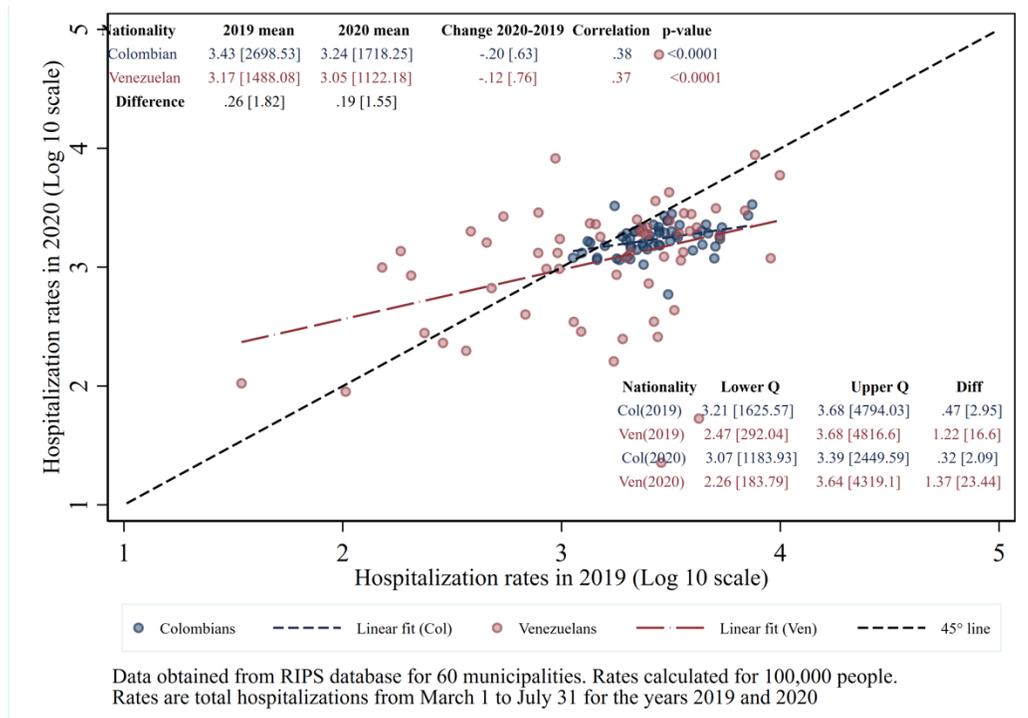
Unlike the significant positive correlation for COVID-19 case rates between Colombians and Venezuelans, there was zero correlation between the death rates of the two populations ($r=0.00$, $p=1.00$). This negative result indicates that the places that have a higher death rate by COVID-19 for Colombians are not necessarily the places with higher death rates for Venezuelans. The researchers' main explanation for the absence of correlation is chance variation in Venezuelan deaths at the municipal level due to small numbers. The median municipality had only 6,462 Venezuelan residents and only one Venezuelan COVID-19 death over the 32-week period. and, as noted, almost half of the municipalities had zero reported COVID-19 deaths. If the death rates in many municipalities reflect substantial chance variation, they would not be expected to correlate with another variable, such as the death rate in Colombian residents.

7.1.3.1. Overall hospitalization rates

Figure 7.4 shows overall (all-cause) hospitalization rates by municipality in 2020 versus 2019. Hospitalization rates fell modestly for both nationalities (by 37 percent for Colombians, calculated as $1.00-0.63$, and 24 percent for Venezuelans, calculated as $1.00-0.76$), presumably from lockdowns and fear of visiting a hospital. Unexpectedly, the gap between the nationalities in hospitalization rates per 100,000 population narrowed from 2019 to 2020. In 2019, Venezuelans were 45 percent below Colombians (calculated as $1-1/1.82$). By 2020, the gap fell to 35 percent (calculated as $1-1/1.55$). Despite Venezuelans' lower overall hospitalization rates, relative rates tended to be stable between the two years.

The higher age of Colombians, noted above, had been hypothesized as a contributing explanation for their higher rates of hospitalizations compared to Venezuelans. However, further analysis of a subset of the hospitalization data found evidence to the contrary. Using RIPS for March through May 2020, we used age distribution of Colombians to compute the Venezuelans' age-standardized hospitalization rate. Unexpectedly, it was 4.3 percent lower than the Venezuelans' crude rate. While this age-standardized rate had been expected to be higher than their crude rate, it turned out to be 4.3 percent lower. The reason could be that Venezuelans aged 50-69 had a lower age-specific hospitalization rate than their younger peers, perhaps because they were even more fearful of visiting a hospital.

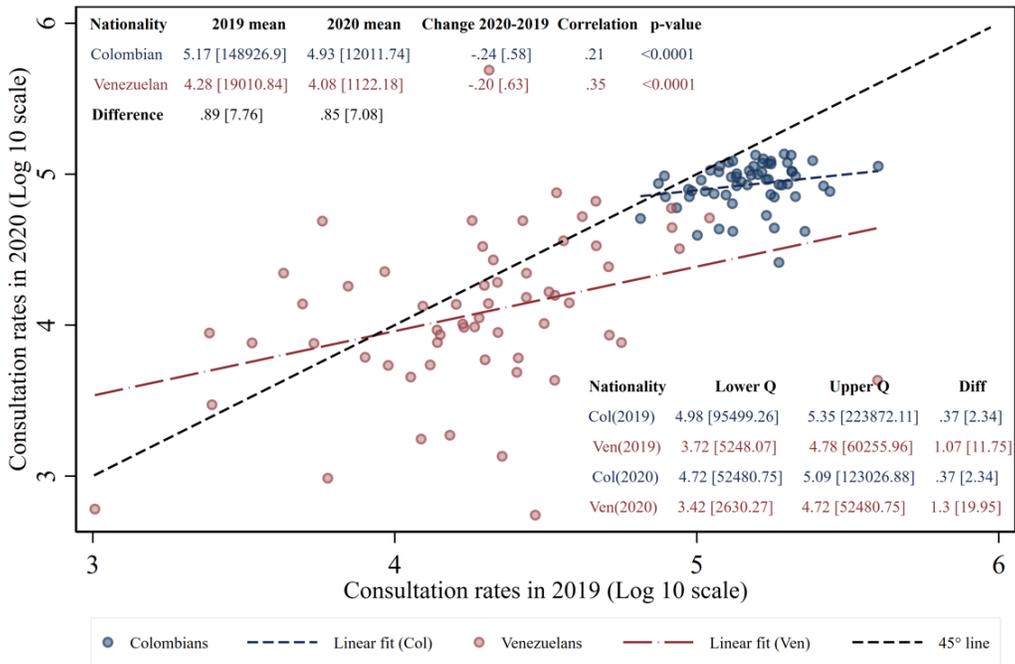
Figure 7.4 - All-cause hospitalization rates of Colombians and Venezuelans: 2020 versus 2019



7.1.3.2. Overall consultation rates

Figure 7.5 shows consultation rates by municipality in 2020 versus 2019. Consultation rates fell by slightly more than hospitalizations for both nationalities (by 42 percent for Colombians, calculated as 1.00-0.58, and 37 percent for Venezuelans, calculated as 1.00-0.63), again presumably from lockdowns and fear of visiting a health facility. Colombians have substantially higher rates of consultation compared to Venezuelans in both 2019 (factor of 7.76) and 2020 (factor of 7.08). Stated differently, Venezuelans' consultation rates were 87 percent below those of Colombians in 2019. In 2020, the gap was trimmed slightly to 86 percent below Colombians. However, each municipality's rate of consultations relative to the grand mean of all municipalities was generally stable for both Colombians and Venezuelans between the two years, as shown by the highly significant positive inter-year correlations (0.21 for Colombians and 0.35 for Venezuelans). Rates varied across municipalities much more widely for Venezuelans (interquartile ranges 12-20-fold) compared to Colombians (interquartile range of 2-fold).

Fig 7.5. All-cause consultation rates of Colombians and Venezuelans by municipality: 2020 versus 2019



Data obtained from RIPS database for 60 municipalities. Rates calculated for 100,000 people. Rates are total consultations from March 1 to July 31 for the years 2019 and 2020

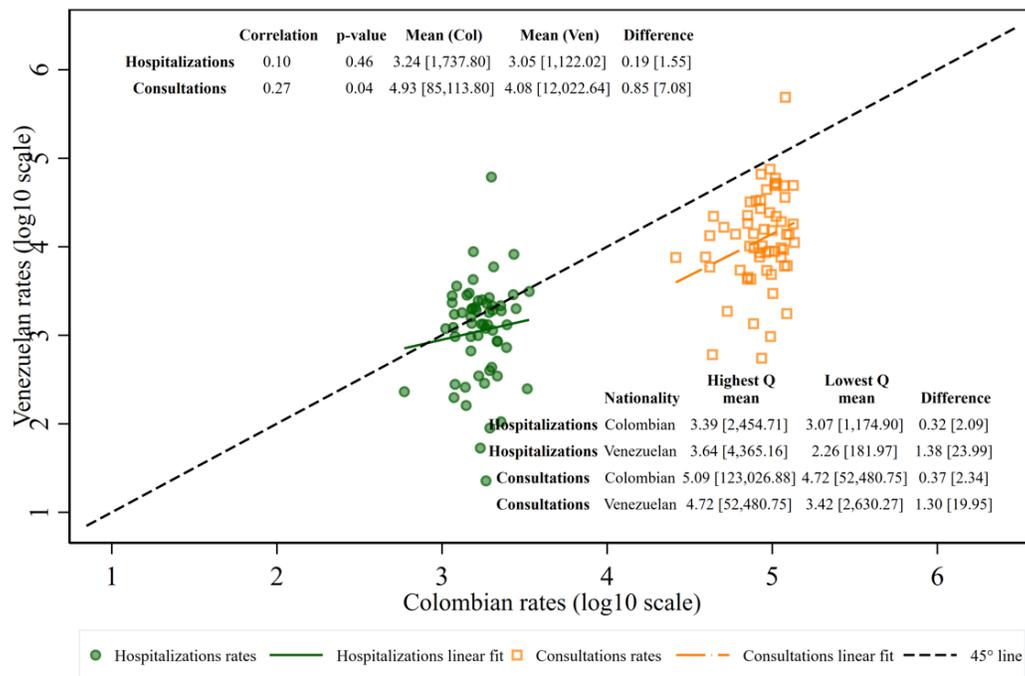
As with hospitalizations, the higher age of Colombians, noted above, had been expected to have been an additional explanatory factor for their higher rates of consultations compared to Venezuelans. However, further analysis of a subset of the consultation data found evidence to the contrary. Tabulations of RIPS for March through May 2020 gave age-specific consultation rates for Venezuelans. These were weighted according to age distribution of Colombians to give an age-standardized consultation rate for Venezuelans. While this age standardized rate had been expected to be higher than their crude rate, it turned out to be 0.8 percent lower. The reason could be that Venezuelans aged 50-69 had a lower age-specific consultation rate than their younger peers, similar to the pattern for hospitalizations, perhaps because they were even more fearful of visiting a healthcare facility.

7.1.3.3. Relationship between hospitalization and consultation rates

Figure 7.6 compares Venezuelan migrants and Colombians on both hospitalization and consultation rates in 2020. There was a significant positive correlation in consultation rates between Colombians and Venezuelans in 2020 (0.27, p-value <0.05). As expected, Colombians have substantially higher rates of consultations (ratio of 7.08), and less variability across municipalities (interquartile ratio 2.29) compared to Venezuelans (interquartile ratio 20.42). The consultation rates of Venezuelans were positively correlated with those of Colombians in the

same municipality ($r=0.27$, $p=0.04$). On the other hand, the correlation of hospitalization between the two nationalities was small (0.10) and not statistically significant ($p=0.46$). The observations straddle the line of equality (represented by the dashed 45-degree line in Fig 7.6) and the ratio of 1.55 is relatively close to 1.00. However, beneath this similarity on average for Venezuelans, their rates vary substantially across municipalities (interquartile ratio = 23.44).

Figure 7.6 - Hospitalization and consultation rates in 2020: Colombians versus Venezuelans



Data obtained from RIPS database for 60 municipalities. Rate calculated for 100,000 people. Hospitalization and consultation rates are total rates from March 1 through July 31, 2020

7.2. Comparative costs of healthcare

Migration to Colombia from Venezuela has increased the demand for health services, education, and other public services. Refugees from Venezuela require medical treatment, as many seek care in Colombia due to the lack of adequate medical treatment in Venezuela. Those with health concerns, particularly pregnant women, children, the elderly, and persons with HIV/AIDS propose an additional challenge for the Colombian health system because their health often worsens during the journey across the border (R4V, 2020, p. 09).

According to statistics released from the national government in the years 2017, 2018, and 2019, the costs of providing health services to

displaced Venezuelans accumulated to 616 billion Colombian pesos (US\$169 million). The government also provided educational services to Venezuelans, costing 460 billion Colombian pesos (US\$126 million). As a percentage of the country’s total GDP, the total cost for health services, educational costs, and infant care for displaced Venezuelans represented only 0.12 percent of the national GDP over the three-year period. In this same period, providing health services to Venezuelans represented 0.06 percent of the Colombian GDP. Specifically, 83.3 percent of the health expenditure was covered directly by public health service providers and 16.7 percent by the subsidized regime (Melo-Becerra et al., 2020, p. 4).

7.2.1. Empirical approach

The first step to obtain the average cost of healthcare for Colombians and Venezuelans was to obtain the average expenditure per person per year from Knoema, a web site that aggregates data from the World Health Organization (WHO) and other sources. For 2018, this was US\$513 per person. Based on the share for the social security system in Colombia (64.03 percent), we estimated the share for personal health services as US\$328.47 per year. Next, we assessed the average annual utilization per person in Colombia as 2.31 consultations and 0.0787 hospitalizations. From other data, we estimated the average length of stay as seven days. Next, we converted the consultations into “bed day equivalents.” Each consultation used resources equal to those of 0.32 hospital bed days based on a synthesis of hospital costing studies in low- and middle-income countries (Shepard et al., 2000). Pooling this information together, we obtained the unit costs in Table 7.1.

Table 7.1 - Unit cost and average national utilization rates

Type of health service	Unit cost	Annual rate per person	
		Colombians	Venezuelans
Hospitalizations	US\$ 1,782.39	0.0800	0.0527
Consultations	US\$ 66.83	2.3775	0.5332

Based on relative utilization and population sizes between Colombians and Venezuelans, we obtained the average annual rates of services by nationality shown in Table 7.1. We then obtained the average cost of services per person per year by nationality and the gap per person between Colombians and Venezuelans.

7.2.2. Gap in costs between nationalities

Figure 7.7 shows cost of personal health services per person per year by nationality and the gap of US\$171.77 per person between Colombians and Venezuelans. The bulk of this gap lies in ambulatory care, which Colombians had used substantially more than Venezuelans. Figure 7.8 shows the aggregate gap in US\$ millions. If Colombia wanted to bring Venezuelans up to the same level as their own residents, the annual cost would be US\$307.19 million, of which the large majority (US\$220.41 million) would be for ambulatory services. In theory, annual donor support of this magnitude (US\$307.19 million) would allow Venezuelans to achieve the same level of healthcare services as their hosts.

As Venezuelans manage to make use of the permissions they received in February 2021, they will likely seek more services. As many will be in the subsidized regime, at least initially, their costs will largely fall on the Colombian government. Financial support and management expertise should allow the health system to cope with this increase in demand. Table 7.2 summarizes the resulting funding gap.

Figure 7.7 - Cost of personal health services per person by nationality, 2020

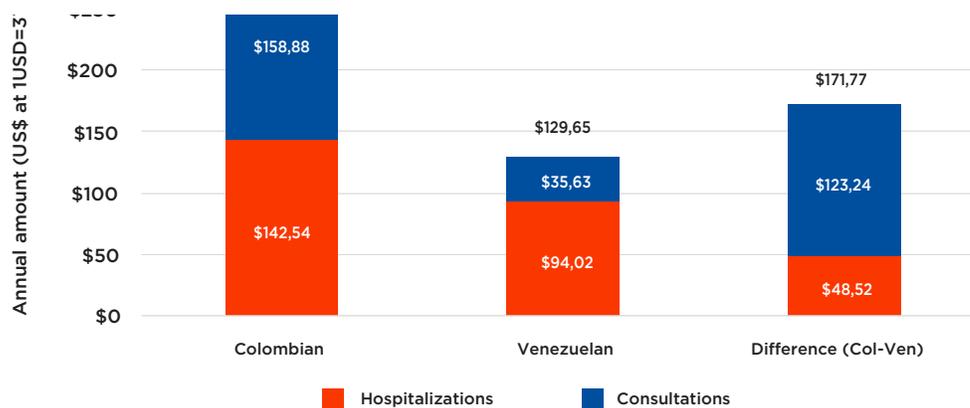


Figure 7.8 - Aggregate cost of 1.79 million Venezuelans' personal health services by nationality, 2020

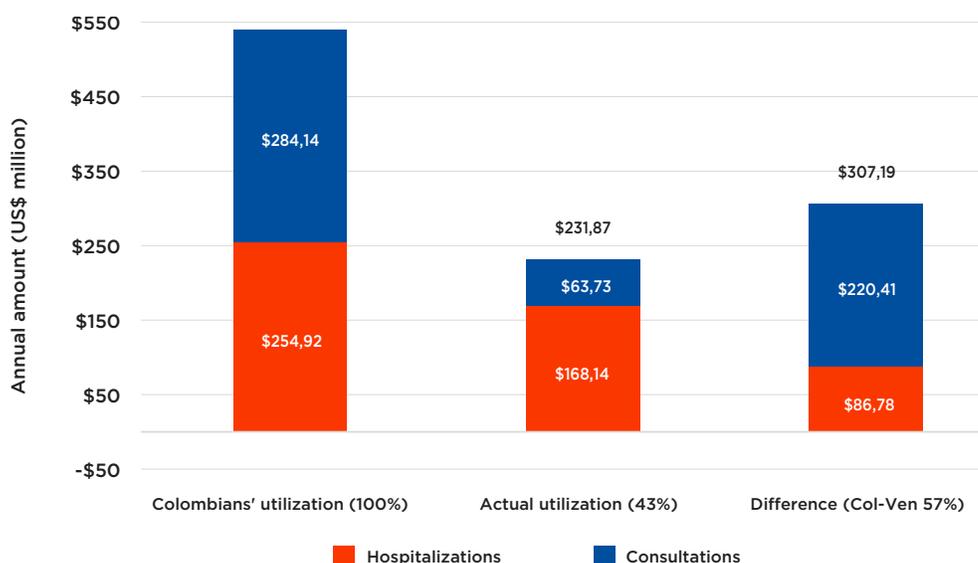


Table 7.2 - Annual funding gap to bring Venezuelans on par with Colombians (US\$ million)

Item	Rate	Amount
Gap in personal health expenditures	90%	\$307
Collective share for collective expenditures*		\$278
Total gap		\$585

*Derivation of collective share

Total health expenditure per person	\$513
UPC amount per person (personal health care)	\$269
Difference (collective expenditures)	\$244
Difference as % of UPC	90%

7.3. Interpretation of findings on utilization and costs

7.3.1. Narrowed gap in hospitalization rates

Displaced refugee populations have difficulty accessing health services in most parts of the world. Under the Colombian constitution, however, all residents of Colombia are entitled to basic medical care under the country's national health system. Impressively, from March through July

2020 of the COVID-19 pandemic, Venezuelans were not too far below Colombians in hospitalization rates per 100,000 population. The gap had narrowed from 45 percent for the comparable months in 2019 to 35 percent in 2020. Thus, for healthcare needs sufficiently serious to require hospitalization, Colombian healthcare institutions had done a reasonably good job of meeting legal and medical requirements. For consultations, however, the gap was wide and narrowed only slightly. Venezuelans' consultation rate per 100,000 population was 87 percent below that of Colombians in 2019 and 86 percent below in 2020. Moreover, differences in access to testing appear to be a major factor explaining this gap between the two nationalities. Data from the related telephone survey also showed that displaced Venezuelans were statistically significantly less likely to report use of COVID-19 testing compared to their Colombian counterparts (ELRHA, 2021).

7.3.2. High illness threshold for Venezuelans

Our findings on reported COVID-19 case rates suggest that Venezuelans accessed care for COVID-19 only when they were seriously ill. While the reported Colombian COVID-19 cases likely span the spectrum of severity, the Venezuelan reported COVID-19 cases are only the most severe, explaining both the higher Colombian numbers and the Colombians' lower case-fatality rates.

The Venezuelans' younger age distribution is likely explained by the presumption that Venezuelans migrate to and remain in Colombia only if they feel well enough to work. Comprehensive reporting from the U.S. prior to widespread vaccination document that hospitalization and death rates per 100,000 population for COVID-19 increase dramatically with age (CDC, 2019). Therefore, the older ages of Colombians may be a contributing reason behind higher COVID-19 rates for Colombians compared to Venezuelans.

As previously noted, half of the municipalities had no reported COVID-19 deaths, so there was little observed variation. Furthermore, the shift in the logarithmic transformation meant that the calculated death rates were higher in communities with fewer Venezuelan residents. These data limitations mitigated against finding associations of other variables with calculated death rates of Venezuelan residents.

7.3.3. Changes underway

Colombia's system of Universal Health Insurance and its databases for tallying service utilization, COVID-19 cases and deaths provide policymakers with powerful tools for comparing Colombians and Venezuelans. For most ambulatory services, Venezuelans' use of services has been far lower than those of Colombians. As consultations are generally not emergency

care, they require enrollment in Colombia's health insurance system. On February 9, 2021, the Colombian government announced a policy of regularizing all Venezuelan migrants then in Colombia (Tresman, 2021). The Colombian decree should gradually allow Venezuelans to enroll in Colombia's health insurance system and promote more equal access to all types of health services. This policy makes Colombia similar to Portugal, Jordan, Qatar, and Ecuador in including displaced populations in its COVID-19 response and providing access to public services for displaced populations (Columbia University, 2021). Initially, as migratory regularization and insurance enrollment processes are coordinated, this policy should substantially increase Venezuelans' enrollment in the subsidized insurance regime. Over time, as Venezuelans are hired into formal sector employment, enrollment in contributory schemes should rise.

However, given that enrolling is a complex process, public policymakers should anticipate challenges in implementation. First, an undocumented Venezuelan must obtain a permit. This process may have considerable bottlenecks, such as providing legal evidence of residing in the country before January 31, 2021 or having valid identification documents. Then the migrant can proceed to enroll in an EPS through local government agencies or the national migration agency (*Migración Colombia*).

CHAPTER 8:

HEALTH FINANCING SYSTEM RESPONSE FOR THE DISPLACED POPULATION

Colombia is spending eight percent of its GDP on healthcare expenditure (see Table 8.1). The healthcare system in Colombia is financed from two main sources: domestic general government health expenditure and private spending. As of 2019, the government was responsible for 72 percent of total healthcare expenditure. The private sector contributed 28 percent of total health expenditure. As a portion of private expenditure, out-of-pocket expenditure on health comprised about 15 percent of total health expenditure. This is below the recommended level from the WHO: <20 percent of total health expenditure should be financed out-of-pocket (McIntyre, Di and Filip Meheus, 2014).

Table 8.1 - Key Healthcare Financing Indicators for Colombia, 2000-2019

Indicator	2000	2005	2010	2015	2019
Total Health Expenditure (%GDP)	6	6	7	8	8
Domestic General Government Health Expenditure (% THE)	75	72	71	72	72
Private Health Expenditure (% THE)	25	27	28	29	28
Out-of-pocket expenditure (%THE)	14	16	17	15	15
External Sources on health (%THE)	0	1	--	--	--
GGHE (% General Government Expenditure)	15	17	17	17	17
OOP per capita (US\$)	18	34	76	72	74
THE per capita (US\$)	133	207	488	465	495

Source: World Health Organization, Global Health Expenditure Database

Despite the relatively stable financing figures shown in Table 8.1 above, Colombia's health system faces complex financial challenges, and its sustainability has been a recurring concern. A study conducted by the National Superintendence of Health in 2014 presents evidence that suggests this. In recent years, 29 EPS have shut down and 45 percent of public hospitals were at high risk of financial breakdown. In March 2022, the national government publicly announced that it will transfer COL\$

7,300,000 million (equivalent to approximately US\$2 billion), in addition to the already budgeted resources assigned to the health system, to pay for the services that could not be financed through the UPC in the contributive insurance regime. The national government has already contributed to local governments' debts for services not financed through the UPC in the subsidized regime: out of the total COL\$1,600,000 million of debt, COL\$1,300,000 million have been paid, of which US\$858,516 million by the nation and US\$441,659 by local government resources (MoH - News Bulletin, 2022).⁹

The system's financial fragility is more evident when it is acknowledged that 72 percent of health expenditure in the country is funded with public resources. This public financing covers the subsidized regime spending. In addition to problems in the transparency of the administration of "too big to fail" EPS and IPS, there are two concrete factors that contribute to this fragility. First, the fact that the main point of entry to the system is still emergency service units, and not primary care units. Second, that for many years there was an over-growing benefit plan, with disproportional adjustment on financing mechanisms.

8.1. Health financing through insurance

As mentioned in Chapter 5, much of the financing for the Colombian health system flows through the Colombian Health Insurance System which is composed of three coexisting affiliation regimes - contributory, subsidized and special regimes. The three regimes offer regulated health plans, with broad access to medicines, surgical procedures, medical and dental services. The difference across the first two regimes is the financial source that covers the lump sum per insured individual (UPC).

As explained before, in the contributory regime, the UPC is funded through a direct tax on the labor contract of the insured person, charging 12.5 percent tax on 40 percent of their salary. Hence, affiliation to the contributory regime happens when a person has a formal labor contract, is self-employed or pensioned. The cost of this insurance contract is shared between employer and employee: employers cover approximately two thirds (8.5 percent) and employees one third (4 percent) of the total burden (12.5 percent). In the subsidized regime, the UPC is financed entirely by the national government's budget. Health insurance affiliation within this sub-system is conducted by EPS which receive lists of beneficiaries from all

⁹ <https://www.minsalud.gov.co/Paginas/Gobierno-Nacional-cumplio-con-Acuerdo-de-Punto-Final.aspx>

state programs — provided in the national social protection network — or lists of individuals who are eligible through population-based focalization mechanisms. The third sub-system gathers several coexisting “special regimes” that serve particular groups of society, such as: military forces, national police, public school teachers and public universities. Each group has a separate financing mechanism, with differentiated health benefit plans and sometimes even an independent health care provision network.

According to official data sources (MoH – SISPRO), almost 48 percent of the affiliates to insurance system were part of the contributory regime in 2022. When the health system was structurally reformed in 1994 (through Law 100), policymakers expected that 75 percent of the affiliations were in the contributory regime. This gap — which is itself explained by labor informality, tax evasion and inefficiency in the use of resources — is one of the main structural sustainability problems of the insurance system.

8.2. Health financing for uninsured population

The population that is not affiliated to any of the three health insurance regimes has limited access to healthcare services through emergency service units or special health prevention services (such as vaccination campaigns). In this case, the state covers the cost-of-service provision, transferring resources retrospectively to the IPS, which means that the healthcare providers have to bear the financial risk.

Financing of health services for Venezuelan migrants, depends upon how they access the Colombian healthcare system and if they are affiliated with any of the specific regimes outlined above. Venezuelan migrants can affiliate into either the contributory or subsidized regimes through the PEP process. The costing section has estimated the cost for providing services to the Venezuelan population through these regimes. In June 2018, there were a total of 28,069 Venezuelans affiliated to the SGSSS (having a PEP in active condition), of which 93 percent belong to the contributive regime and 7 percent to the subsidized regime. As of August 2020, 260,721 Venezuelans were enrolled to the SGSSS, which represents an increase of 829 percent (MoH, 2020). Additional research conducted by Brandeis University and Universidad de los Andes researchers in August 2019, examining the impact on access to healthcare services for Venezuelan migrants during the COVID-19 pandemic, showed slightly different figures. Using a telephone survey that incorporated 5,159 Venezuelan migrants, the results showed that 74 percent were non-affiliated to any regime, 19 percent were affiliated with the subsidized regime and 6 percent were affiliated with the contributory regime. Of those Venezuelan migrants enrolled in either the contributory or subsidized regimes (1,314), 75 percent

were enrolled in the subsidized regime and 25 percent were enrolled in the contributory regime (see Table 8.2, taken from Bowser et al., 2022).

Table 8.2 - Percentage distribution of insurance coverage of Colombians and Venezuelans

Regime	Colombians	Venezuelans
Contributory	28	6
Subsidized	67	19
Not-affiliated	3	74
Other, missing	2	1
Total	100	100

Source: Bowser et al. ELRHA telephone survey, 2020

8.3. Donor funding

As the number of displaced populations grows globally, it is important to compare the magnitude of the Venezuelan migrant crisis to other situations of refugee displacement, both in terms of displaced populations and global financing. As demonstrated through a recent publication by the Brookings Institute, the number of Venezuelans that have fled Venezuela over the four-year period from 2016-2019 is 4.6 million; very similar in size to the 4.8 million Syrians who have fled Syria since 2015. Despite the similar size of the number of displaced individuals, the global support for the Syrian refugee response has been US\$7.4 billion in comparison to US\$580 million for the Venezuelan crisis. This equates to US\$1500 per Syrian refugee and US\$125 per Venezuelan refugee. Please note that these figures for the Venezuelan crisis refer to the global support for Venezuelans across many countries, not just Colombia (Bahar and Dooley, 2019).

To estimate further the donor financing flowing into Colombia that specifically focuses on the efforts to assist with providing services to Venezuelan migrants, we accessed project titles and total funding from aid projects reported through the Creditor Reporting System from the OECD Development Assistance Committee members. We searched the database using the terms “Venezuela” or “VENEZUELA”. We identified 250 projects in total over the period 2007 - 2020. The total amount of dollars disbursed through these projects is US\$159 (2019 USD, millions).

Using 1.8 million as the number of migrants in Colombia, this equates to US\$88.5 (2019 USD, millions) (OECD, 2022). Doing this same calculation on the aid projects that focus just on basic health or general health, the disbursements are US\$0.4773 per migrant (2019 USD, millions) and commitments are US\$0.6464 (2019 USD, millions). These numbers reinforce the findings from the Brookings Institution that donor funding support has been minimal, especially compared to other crises such as Syria. Support to local governments for emergency services would be very valuable.

Comparison with a separate database suggests that health may comprise only a small share of this total funding. A database of OECD project funding to Colombia that specifically mentions Venezuelans and health gave the results shown in Table 8.3. While the OECD database does not include important multilateral and United Nations donors, such as UNHCR and the World Bank, the amounts in Table 8.3 are 100 times lower than the estimate from the Brookings Institution.

Table 8.3 - Funding for health to Colombia from OECD countries 2009-19*

	Commitments	Disbursements
Total (US\$ million, 2009-19)	\$1.16	\$0.86
Number of Venezuelans (millions)	1.80	1.80
Amount per Venezuelan	\$0.65	\$0.48

Notes: *Official development assistance (ODA) from OECD countries to Colombia to benefit Venezuelan migrants in health (basic healthcare and general health).

CHAPTER 9: CONCLUSIONS AND LESSONS LEARNED

9.1. Assist Venezuelans in becoming official residents

Colombia's experience demonstrates that a middle-income country has been able to provide at least emergency medical services to its refugee population within its national health service. The country's announced plan to allow most displaced Venezuelans to register to remain legally for ten years should increase their integration in the future. As migrants are younger on average than their host counterparts and move between Colombia and Venezuela based on economic conditions, their skills and motivation could help grow the Colombian economy — by building demand and adding to the existing human capital. The Colombian government could expedite this process by training government workers and NGOs to help identify those eligible and to assist their official registration. To do this, the government should promote and facilitate insurance enrollment through induced demand strategies, such as: massive enrollment campaigns, creating incentives for EPS to enroll migrants, creating incentives for NGOs to link emergency aid services to further enrollment processes.

9.2. Adjust metrics for assessing quality of care

A further recommendation relates to the metrics used by Colombian authorities to maintain quality in service provision. According to key informant interviews in a parallel component of this study, health facilities are regularly monitored with many of the key performance indicators based on outcomes (ELRHA, 2021). A hospital serving many migrants will probably show worse outcomes, given their restricted access to preventive services and elevated poverty and malnutrition, than a comparable hospital serving fewer migrants. This perverse incentive could discourage health facilities from serving the migrant community and providing access to non-emergency care. A more sophisticated monitoring system

that adjusts for population differences (e.g. the nationality of its patients) could incentivize outreach to migrant populations.

More insights about this topic are well developed in the study “External Assessment of Quality of Care in the Health Sector in Colombia” developed by the World Bank and International Finance Corporation (2019).¹⁰ To follow are some of the specific calls to action derived from this study: to incentivize quality by improving accountability and implementing innovative contracting mechanisms; to promote continuous quality improvement through training, quality campaigns, and strengthening communities of practice; to support and increase patient choice by creating stronger health service quality information systems for benchmarking of healthcare providers; and to strengthen quality regulation frameworks through certification standards, accreditation of healthcare providers, developing an improved core curriculum for future healthcare professionals; and using including telemedicine to improve quality in dispersed rural areas (World Bank and IFC, 2019).

9.3. Strengthen health promoters

Colombians’ dramatic drop in utilization of ambulatory services during the pandemic speaks to the population’s fear of COVID-19 exposure. However, appropriate safeguards (social distancing, personal protective equipment, and careful training and procedures) and better communication could allow necessary care to proceed. The pandemic demonstrates the need to engage more Colombians and Venezuelans as health promoters, building on a system Colombia has operated for decades (Robertson et al., 1997).

Health promoters played a vital role before the structural reform of the Colombian health system in the nineties (through the 1991 Constitutional Reform and Law 100 of 1994). However, after this reform the idea of health promoters was set aside, and currently only “public health assistants” have the unique role of providing health education. Including interdisciplinary teams — which include health promoters — in the country’s primary healthcare policy could strengthen the coverage and quality of ambulatory health services and extramural care.

¹⁰ Available here: <https://documents1.worldbank.org/curated/en/719321564123515864/pdf/External-Assessment-of-Quality-of-Care-in-the-Health-Sector-in-Colombia.pdf>

9.4. Create responsible units in local government

At the department and municipal levels, governments should create units responsible for registering displaced Venezuelans within their territories and assisting them in obtaining the relevant paperwork, registering for health insurance and seeking employment and other services. The national government should provide training, support, and monitoring to departmental staff who, in turn, do the same for municipal staff. It is important to help local teams build case-management capacity and to provide all health workers with attitudinal training to facilitate migrants' access to social protection services and fully integrate to their new context.

9.5. Ask international donors to accept greater responsibility

Findings highlight the need for international assistance in providing health services to migrants and refugees in Colombia and other countries which integrate migrants and refugees into their national health systems. Under the current system the emergency medical services provided to the unenrolled population are not covered by the insurance system. The direct financial burden is then covered by the health facility (hospital or clinic) providing the services. Therefore, the facility must ask the local government's health secretariat to cover the cost. If the local government lacks sufficient resources, it may ask the national government for assistance. However, the process is inefficient, time consuming and uncertain. In the interim, health facilities operate at a deficit, missing payments to health workers and vendors and risking collapse and sudden shutdowns. In 2018, 42 percent of Colombia's 930 public hospitals were at medium or high levels of financial risk (Amat, 2014). Other countries with substantial numbers of refugees and displaced populations face similar challenges. UNHCR noted that in 2020 "seven in ten people of concern to UNHCR live in urban settings, and the pandemic sharpened the challenge of supporting them" and "the needs remain vast...." (UNHCR, 2020). With international support, Colombia's well-designed national health system could address many of these needs.

9.6. Integrate foreign health workers

To respond to localized humanitarian crisis, Colombia could pilot special mechanisms to validate the professional credentials of foreign doctors and medical professionals. For instance, as a member of the OECD, Colombia could reach out to this organization for guidance in implementing new

policies and learning best practices from other countries on how to utilize foreign medical professionals. It is also important to highlight that, in Colombia, personnel from international organizations are mostly involved in administrative and coordination tasks, with Colombian professionals mainly dedicated to the provision of services.

9.7. Integrating emergency aid and development aid

Emergency aid should always be prioritized. In Colombia, there is ample evidence of the importance of NGOs providing health services to the forcefully displaced population that is not enrolled in the health insurance system. There is a great opportunity to create an integration path between these fundamental rapid response services and the social protection system. One of the first steps to achieve this would be the integration of the existing emergency aid information systems with the social protection systems. Overall, this integration process requires a multi-year or long-term plan.

Also, to avoid humanitarian aid organizations providing services that have already been paid to the EAPBs, a formal coordination mechanism should be created. A suggestion is to have a results-based system that allows aid organizations to request payments to the EAPBs for the provision of services to Venezuelans or Colombians who are affiliated to the health system.

9.8. Innovate, document and scale-up

There are interesting innovations in Colombia regarding case management and healthcare provision to specific populations. For example, the EmONC prevention strategy implemented by the South-West Public IPS Network of Bogotá. In this strategy a local healthcare provider is promoting full integration and health access with emergency units as an entry point. It is important to pilot, evaluate and scale-up strategies to address other health needs of migrants in Colombia (e.g., chronic diseases and mental health).

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