



Migrant women and sexual and gender-based violence at the Colombia-Venezuela border: A qualitative study

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ABSTRACT

Background: Sexual and Gender-Based Violence (SGBV) affects women and girls in multiple ways. During migration and within humanitarian settings, migrant women and girls are exposed to different forms of SGBV and to higher vulnerabilities compared with those men encounter. Survivors of this kind of violence face challenges in accessing healthcare for reasons that not only include legal status, language barriers, discrimination, misinformation on the availability of healthcare services, but also the growing spread of conservative views regarding sexual and reproductive health which pose a considerable threat to human rights. This study was guided by the question of how humanitarian emergency preparedness and response initiatives within four cities at the Colombo-Venezuelan border are addressing SGBV. The goal of this research was threefold: first, to explain the level of implementation of the second goal of the MISp, which is to prevent and respond to the consequences of sexual violence; second, to assess the availability of services for migrants who have experienced some type of sexual violence; and third, to understand the perceptions of migrants regarding sexual and gender-based violence.

Methods and Findings: This study assessed the degree of implementation of the Minimal Initial Service Package (MISP) using a set of tools developed by the Inter-Agency Working Group on Reproductive Health in Crises. This study combined the use of different qualitative methods: i) a literature review; ii) 23 interviews with key informants on sexual and reproductive health; iii) an assessment of 21 health institutions which provide services to migrants; and iv) 24 focus groups with migrants between the ages of 14 to 49 years old (241 participants, of which 121 were women and 120 were men). This research was conducted in four cities at the Colombo-Venezuelan border where there was the highest concentration of migrants. Ethical approval was granted by Profamilia's Advisory Committee on Research Ethics. Although preventing and managing the consequences of sexual violence is the second objective of the MISp, this study found several barriers for the guarantee of comprehensive healthcare for survivors: Venezuelan migrants do not usually consider that healthcare is a need for them after they have survived sexual violence; SGBV during migration is a common occurrence according to key informants; in three out of four cities there were existing organizations working on SGBV, but not all of them could offer comprehensive healthcare services in response to sexual violence.

Conclusions: In this study, we observed that migrants tend to be more exposed to Sexual and Gender-Based Violence due to the normalization of such forms of violence in the Colombian and Venezuelan cultures. Findings suggest that Venezuelan migrants are facing complex SGBV issues during the humanitarian emergency at the Colombia-Venezuela border. Recommendations include local health systems response teams, governments and host communities working together to address early access to prevention, healthcare, and protection services for the survivors of SGBV; eliminating barriers in access to essential and comprehensive equity-oriented healthcare services; developing the skills and capacities of healthcare services professionals around the proper management of SGBV; and countering misinformation, lowering the stigma associated with migrants in host communities, and broadening migrant's perceptions of SGBV, gender roles, and xenophobia.

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Introduction

Migration is one of the key issues at the heart of the Sustainable development goals (SDG) (UN, 2020) and a social determinant of Sexual and Reproductive Health (SRH), in particular that of migrant and refugee women and girls (Zimmerman et al., 2011; Gushulak et al., 2009). Migration has deep effects on people's lives. From an intersectional approach, inequalities in SRH are amplified due to gender roles, disability, race and social class (Crenshaw, 1991; Hill Collins, 2015). Migrant and refugee women and men experience poorer health outcomes as a result of the action of Social Determinants of Health (SDoH). Migration is a social determinant that has a differential impact on health throughout the life of individuals. Migration flows can increase inequalities in the use of health services, as well as expose people to risks of communicable diseases and many forms of violence; women and girls, adolescents, persons with disabilities, LGBTQ people, and indigenous and afro-descendants are particularly at risk (OPS, 2020). Migrant girls and women experience more sexual violence because they can be subjected to trafficking for commercial purposes, forced sex work, and labor abuse and abuse of power that manifests in sexual assault, among others. Their vulnerability is exacerbated by the lack of access to sexual, reproductive and mental health services, care, and justice (Feminicidios Observatorio Colombia, 2018).

Sexual and Gender-Based Violence (SGBV) against migrant and refugee women and girls is the result of multiple intersecting social determinants (Hill Collins, 2015). Within humanitarian emergencies, female migrant and refugees are exposed to many forms of SGBV and also face challenges in the access to essential healthcare for reasons which include legal status, language barriers, discrimination, misinformation on the availability of SRH services, and the growing spread of conservative views on sexual and reproductive health and rights (SRHR) which pose a considerable threat to human rights.

In recent years, Colombia has become the main destination for Venezuelan migrants and refugees, posing several challenges for the health system. Most Venezuelan migrants are crossing the border on foot and usually remain in border cities before moving toward the Colombian Andean region or heading south on their way to Ecuador, Peru, Chile or Argentina. In 2019, there were about 720,000 migrant and refugee women and girls in Colombia. Migrants are mainly arriving to areas that have been largely affected by armed conflict, where there are higher levels or multidimensional poverty (IPPFand Profamilia, 2019), and in which strong social norms and beliefs that normalize gender-based violence and gender stereotypes are fostered. An assessment among migrants and refugees in the Colombia-Venezuela border ranked SGBV care management and prevention as one of the top 10 unmet needs in SRH (PLAFAM and SRI, 2016).

In Colombia, 1421 Venezuelan migrants and refugees were seen by health professionals for cases of SGBV in 2019. Nationally, the number of cases concerning Venezuelan migrants and refugees increased by 45%, from 645 in 2018 to 1421 in 2019 (Profamilia Association and the US Office of Foreign Disaster Assistance Abroad (OFDA-USAID), 2020). However, the different forms of sexual and gender-based violence that migrant and refugee women and girls face do not occur only during migration; such violence takes place in regular social and cultural dynamics across Latin American. In 2010, approximately half of the ever-married women in Venezuela had been abused by their partner in some shape or form, and in 2015, one out of every fifty women had experienced SGBV (Profamilia MSPS, 2017).

Comparatively, Colombia is one of the countries in the region with the highest numbers of SGBV. Around 64.1% ever-married women in Colombia have been psychologically abused by their current partner or an ex-partner; 31.9% reported that their partner or ex-partner had exercised physical violence against them; 31.1% were victims of economic violence; and 7.6% had been subjected to sexual violence by their partners (Keygnaert and Guieu, 2015).

Although even in "normal" conditions Sexual Violence goes underreported, migration poses several additional challenges for data collection and research, and thus aggravates the availability of information. An increasing number of studies have shown that the lack of prevention and response is related to the narrow definition of sexual violence and violence given to victims/survivors, and to gaps in information as seen in underreporting worldwide (Tapales et al., 2018; Robbers and Morgan, 2017; INS, 2018).

Additionally, the number of Venezuelan survivors of SGBV in Colombia seeking healthcare services has increased by 207% from 2017 to 2018 (INS, 2019) and by 37% from 2018 to 2019 (Robbers and Morgan, 2017). However, to our knowledge, few studies have addressed this topic using qualitative research methods, especially within the context of humanitarian emergency preparedness and response at the Colombia-Venezuela border; this research project would be the first attempt to analyze SGBV against migrant and refugee women and girls under this specific setting. Previous work on the subject has focused on sex work of migrant women in Cucuta (Colombia) (Alba-Niño et al., 2018).

Advancing research of key populations and underserved groups affected by SGBV and inequitable access to healthcare in humanitarian settings is crucial to achieve a true Universal Health Coverage (UHC). Attaining the 2030 goals in a short window of time will be all the more taxing for Colombia given the challenges it is facing with the Venezuelan migratory exodus. In order to achieve this goal, it is important to understand the severity and consequences of SGBV as migrants integrate. Advancing research efforts will also shed light on how to respond to SRH needs in humanitarian emergencies.

The Minimal Initial Service Package (MISP) requires a series of actions in order to guarantee reproductive health during humanitarian crises; in addition to the provision of kits and supplies, it calls for crucial actions regarding sexual and reproductive health. This Minimal Package is composed by the following six objectives: i) Selecting an organization to take charge of implementing the package; ii) Preventing sexual violence and responding to the needs of survivors; iii) Preventing transmission and reducing morbidity and mortality due to HIV and other STIs; iv) Preventing excess maternal and newborn morbidity and mortality; v) Preventing unintended pregnancies; and vi) Planning for comprehensive sexual and reproductive healthcare services as part of primary healthcare (IAWG, 2020).

The second goal of the MISP for Reproductive health in humanitarian crises is related to preventing and managing the consequences of sexual violence (IAWG, 2020). Sexual violence is common during humanitarian emergencies and in the case of the Venezuelan migration, it is a phenomenon in which basic and essential care is required. In Colombia, this target aligns with the National Policy for sexuality, sexual and reproductive rights (UNFPA, MSPS, Profamilia, 2014) and the CONPES 3950 (Consejo Nacional de Política Económica y Social (CONPES), 2018) which establishes the general guidelines to respond to the Venezuelan migration and prioritizes safe and effective migration.

The goal of this research was threefold. Firstly, to convey the status of implementation of the MISP in relation to the prevention and management of the consequences of sexual violence. Moreover, to assess the availability of services for migrants and refugees who have suffered some type of sexual violence; and finally, to understand migrants' perceptions of sexual and gender-based violence.

Material and methods

Study design

This was a qualitative study based on the MSIP toolkit's guidelines published by the Inter-Agency Working Group (INS, 2019) on Reproductive Health in Crises. This toolkit was executed using the following qualitative tools: i) a literature review; ii) interviews with key informants on topics such as sexual and reproductive health, gender-based violence and HIV; iii) various assessments of health institutions that provide ser-

vices to Venezuelan migrants and refugees; and iv) focus groups with migrants and refugees. The research project was conducted in Arauca, Cucuta, Riohacha and Valledupar, four cities at the Colombia-Venezuela border with high concentration of migrants and refugees. An interdisciplinary team collected data between the 6th and the 17th of November 2018. The approach followed interpretative research methods grounded in theory and data triangulation to ensure robust results.

Literature review

The review of existing literature involved the identification and revision of international, available national and local data about Venezuelan migration and sexual and reproductive health. According to the MISP guide, the literary review should focus on general information regarding health indicators, stakeholders and the names of organizations responsible for implementing programs, as well as the legal framework for SRH.

Assessment of health facilities

In total, 21 assessments were carried out on topics such as safety, communication, transportation, human resources, prevention of excess maternal and newborn morbimortality, provision of comprehensive services for abortion, prevention and response to SGBV, HIV Prevention, integration of sexual and reproductive healthcare services to primary health care services, and access to contraceptives, STI management and menstrual hygiene. The topics were organized by type as follows: public health ($n = 8$), private health insurance ($n = 4$), NGO ($n = 8$) and public-private health insurance schemes ($n = 1$). In each city, between 4 and 6 facilities were selected based on the availability of services for migrants and refugees, as well as the type of facility and their Registro Especial de Prestadores REPS (the kind registry as healthcare providers) according to the Ministry of Health (MOH). Assessments took around one hour and a half and were commonly performed with the help of the manager or the person in charge.

Interview of key informants

23 key informants were interviewed at NGOs, Inter Agency working groups, Ministry of Health and health facilities. Research participants were selected based on previous experience and by mapping the organizations that have presence in the four cities that had been selected. Face-to-face interviews were performed with three different groups of participants: senior staff responsible for the overall implementation of SRH ($n = 10$), SGBV ($n = 7$) and HIV ($n = 6$). The semi-structured interviews (qualitative) centered around three main topics: (a) knowledge and training of MISP; (b) public health actions during migration; and (c) availability and critical issues in the access to SRH.

Focus groups

The focus groups were conducted by an interviewer and an observer in each city. Both individuals were trained on the MISP toolkit as well as dealing with SRH during humanitarian crises. A total of 24 focus groups, segregated by age (14–17, 18–24, and 25–49 years) and sex (male and female) were conducted, six in each city and two per age group; in total 241 migrants participated, 50% of which were women. Participants were selected through the snowball sampling method in areas at which migrants typically arrive. All focus groups were conducted in Spanish and all participants agreed to being audio-recorded. Observational field notes were taken directly after each discussion. Focus groups asked questions about the provision of healthcare services, pregnancy and delivery, STI, HIV, AIDS, SGBV and mental health.

Analysis

The sociodemographic data collected through the key informant interviews (sex, age and city) and Health Facility Assessments were processed using the Census and Survey Processing System (CSpro) and analyzed using the Statistical Package for the Social Sciences Software (SPSS). The analysis followed the guide of indicators listed in the MISP toolkit. Focus groups sessions were coded using N-Vivo. Some categories were set following the list provided by the toolkit, and others emerged during analysis based on grounded theory. After researchers selected the main categories, one person coded the focus group's information and identified emerging categories. Data triangulation was performed to complement the findings from different sources according to MISP objectives and the toolkit's list of indicators.

Ethical and gender considerations

Ethical approval was granted by the Advisory Committee of Research Ethics at Profamilia on the 1st of November of 2018. The participation in the study was fully confidential and anonymous. In order to avoid potential identification of individuals, no names were used in the analysis. Also, a written informed consent was obtained from each participant. This study provided equal gender opportunity and no individual was excluded due to gender. When and wherever possible, researchers included as many male as female respondents. We paid special attention to any potential power consideration of gender, age or any other that may have affected the way interviewees and participants made decisions.

Results

Results provided insight into three main topics. Firstly, the level of implementation of SGBV preparedness and response; secondly, the availability of services for migrants and refugees who have been affected by sexual violence; and thirdly, the perception of migrants on sexual and gender-based violence.

Level of implementation of SGBV preparedness and response

The problems that impact the level of implementation of the second goal presented in the MISP are related to inter-sectoral coordination and the appropriateness of common objectives to address SGBV.

Appropriateness

Six of the seven key informants on SGBV reported having heard about sexual violence events that had occurred during the current emergency. In three of the four cities (Arauca, Cúcuta and Riohacha), there are organizations that work on SGBV programs for Venezuelan migrants. In Valledupar, one organization offering SGBV programs was found, but none of the programs it offered addressed the needs of migrants and refugees. Assessments showed how high and severe were the number of unmet sexual and reproductive health needs of migrants as they arrive in Colombia. The main unmet SRH needs are: access to contraception services, emergency contraception, safe abortion services and post abortion care, management and treatment of Sexually Transmitted Infections (STIs), prevention of teenage pregnancy, youth friendly services and comprehensive sexual education. In particular, as a result of all the forms of SGBV they are exposed to once they decide to migrate, women and girls often face inequity in access to health care, contraception methods, quality information, or mental health, protection and justice services (7).

Inter-sectoral coordination and common objectives

There are many organizations responding to SGBV during the humanitarian crisis at the Colombia-Venezuela border (12/21). The Pan-American Health Organization, the World Health Organization

(PAHO/WHO) and United Nation High Commissioner for Refugees UNHCR are presently working on SGBV, and their actions in the field are positively recognized. Nevertheless, leadership by the Ministry of Health (MOH) in addressing the humanitarian emergency at the border is lacking, and interagency coordination in response to SGBV was not evident.

The first purpose of the MISP relates to the importance of interagency coordination to address sexual and reproductive health, HIV and SGBV needs during an emergency. However, the low degree of interagency SGBV coordination at the border makes the implementation of the MISP significantly more challenging. For instance: there was no record of interagency coordination in response to SRH, HIV and GBV; there has been a lack of leadership in the SGBV interagency response and coordination throughout the Venezuelan migration as well as a lack of leadership by the government in addressing SGBV prevention and care; and there is a need to strengthen coordination of SRH and HIV response among local technical teams who tend to the migration emergency.

Availability of services for survivors of sexual assault and violence

Access to healthcare services by survivors of sexual assault and violence were evident in two dimensions: the current availability of services and the knowledge about the existence of these services by those who need them.

The people in charge of sexual violence prevention and care programs were not fully equipped for comprehensive care for GBV; only 3 out of the 23 key informants stated having sufficient supplies, funds, data, and information to monitor SGBV disaggregated by migration. In this sense, some main gaps were identified: the first one regarding the shortage of services for the clinical management of sexual violence. Only a little more than half (12/21) of the facilities assessed offered such services, and less than a half (8/21) had disseminated information to the community about the availability of the services.

We found no organization had requested kits for post-abortion care (kit 3), despite kits being available upon request at anytime; and though most were found to offer counseling services (14/21), only 10 out of 21 recognized being able to provide confidential patient history and examination services, forensic evidence collection within 72 h, provision of emergency contraception within 120 h, and provision of treatments to prevent STIs. All the aforementioned actions are required for the care and management of SGBV to be considered all-encompassing.

Most of the facilities do not seem to have enough installed capacity for sexual violence prevention and management. In addition, migrant populations do not recognize the need for this type of services in case of an incident. While most organizations (18/21) claim to cover migrants and refugees and state they have Information, Education and Communication (IEC) mechanisms in place, the widespread ignorance of these programs by the participants in focus group discussions was noticeable. Although training spaces for the clinical management of sexual violence are being created and all organizations have established SGBV referral mechanisms, several informants mentioned after interviews that the health, justice and protection sectors did not fully facilitate these mechanisms in coordination with each other.

Perception of migrants on SGBV

In addition to the failure by many organizations to provide sufficient information to migrant communities about the availability of services, it was evidenced that neither male or female migrants recognize different types SGBV consistently, did not identify SGBV as a medical emergency, and 286 participants were not fully aware of Colombian laws regarding sexual violence:

- ¿If you know of a woman that has experienced sexual violence, where should she go for help?
- She went to file a legal complain, but she was told that she was paid [as a sex worker] [...], and that is why they did not provide me any care.

Participant in a focus group of women between the ages of 19 and 24 years old – Riohacha.

As many other participants expressed, the first thing they usually do as migrants after suffering sexual violence was to seek justice, and that is why during focus group participants often mentioned that survivors of sexual violence should go to the police. This was an idea mentioned by men and women of different ages in all the cities that were assessed, and it represents an important barrier for women and men who need comprehensive healthcare services as survivors of sexual violence, because migrants, especially those with irregular legal status, usually try to avoid interaction with authorities. It should be noted that the lack of timely health care carry important consequences on the lives of migrants such as unwanted pregnancies, sexually transmitted infections, mental health problems, among others.

Additionally, migrants were found to experience SGBV both prior and during migration. Based on the focus group discussion, we found that events are especially common in those cases in which migrants cross the border through unauthorised paths. When they arrive to towns, migrants experience xenophobia and all forms of sexual, psychologic and physical violence. Their vulnerability to SGBV tends to be exacerbated due to the dire circumstances in which they are in and when they are not able to meet their basic needs. Migrants, especially women and girls, are particularly exposed to this kind of violence in their host communities, and often suffer from symbolic violence by which they are seen as prostitutes or sex workers. Furthermore, during focus groups women generally talked about sexual and gender-based violence they were subjected to by their partners and families even before leaving Venezuela:

I was threatened, I left the father of my child because he was hitting me, but I didn't file a claim against him because I was afraid I was going to be left to fend for myself. Then when we came to Arauca, I wanted to report him, but I thought that If I called the police, he was going to be sent to jail and I was going to be left to care for three children by myself " [...]

Participant in a focus group of women between 19 and 24 years old - Arauca

As this woman showed, she experienced violence before migrating, but migration affected her decision to report her aggressor due to its effects on her and her children's lives.

Women also recognized that migration has left them especially vulnerable to sexual and gender-based violence. In this sense, they were not only living under continuous violence in which their families and partners were aggressors, but also being abused by people in the streets they transited, at their jobs, and their living quarters. Women from different age groups mentioned that sexual violence and abuse was one of their main worries, and also mentioned that they had heard about many cases of Venezuelan migrant women having suffered this kind of violence in Colombia.

It was clear that sexual abuse and violence has been a phenomenon that affected both men and women.

Nonetheless, women were perceived as more vulnerable than men, and when men talked about this subject, they always referred to women's vulnerability:

- Please tell us what is sexual violence?
- To have forced sex [...]
- Yes, of course if the woman does not want to, it is rape

Participants in a focus group of men between the ages of 14–17 years old - Valledupar

The notion that women are specially exposed to sexual violence was expressed by men from different ages. In turn, men did not easily identify themselves as possible victims of sexual violence. During field work, it was evident they were concerned about the fact that Venezuelan women that have migrated to Colombia are particularly vulnerable to sexual violence and abuse. In general, migrants and refugee from both

sexes were aware of the problems and risks to which women were exposed as migrants in these humanitarian emergency settings.

However as will be shown, awareness regarding the problem was not necessarily translated into strategies and knowledge regarding how to act and respond to cases of sexual abuse and violence. Even though during focus groups specific questions about the occurrence of this type of violence were not asked, discussion showed this is a problem that migrants are familiar with and revealed the magnitude of the issue.

Most urgent needs in prevention and response to SGBV

- Have you heard about cases of sexual violence?
- Yes, I have seen it because next to my house it is [happening] day and night; day and night, one sees their own family members staying silent, but I am not going to shut up about it.

Participants in a focus group of women between 25 and 49 years old – Cucuta.

In this scenario, actions focused on preventing and responding to these types of violence should be aligned with the most urgent sexual and reproductive health needs. During fieldwork, it was evident that migrant women's needs in this regard are related to how effective and comprehensive healthcare for sexual violence is, the quality of information about the availability of services for survivors, and the placement of measures to protect and prevent sexual exploitation of migrants. These needs are connected with other basic, unmet, and sexual and reproductive health needs specific to migrants, such as access to information and communication about offer and locations for SRH services; access to contraceptive services including emergency methods, safe abortions and post-abortion care; and access to services related to prevention of STIs, including PEP.

Discussion

During migration, forced migration and forced displacement, the risk of suffering some form of SGBV increases, especially for girls and young women (Profamilia Association and the US Office of Foreign Disaster Assistance Abroad (OFDA-USAID), 2020; Profamilia MSPS, 2017; Keygnaert and Guieu, 2015). Liz Kelly's Continuum of Violence (UNFPA, MSPS, Profamilia, 2014) could help explain the scope of gender violence that women experience throughout their lives in different contexts, including migration. This concept underlines how violence is almost permanently experienced by women throughout their lives (UNFPA, MSPS, Profamilia, 2014). Given that migrant women are experiencing a continuum of violence in which gender could be understood as a part of system of oppression, the relationship patterns of Venezuelan migrant women could be traced to events that have taken place even before their migratory journeys began. Migration requires confronting the different forms of violence that women have experienced at home as well as the various types of SGBV that many women face throughout their journey. Their encounters with violence are somehow connected with previous experiences in a continuum. Although the occurrence of sexual violence in humanitarian settings is acknowledged by different responders, our findings demonstrate that SGBV is not receiving sufficient attention, and thus the efforts to prevent and manage the effects of sexual violence are insufficient.

This study revealed how frequently Venezuelan migrant and refugee women in the Colombia-Venezuela border encounter SGBV. Firstly, it is clear that migrants, especially migrant girls and women, are particularly vulnerable to SGBV, and this was evident both in the perceptions of migrants and in the responses given by informants. Secondly, it was noticeable that survivors of SGBV are facing several barriers of access to comprehensive healthcare services. One specific barrier to point out was that migrants did not perceive that seeking SGBV services was a particular need for them. Thirdly, there were evident gaps and limitations when evaluating healthcare services for SGBV, all which seemed to be worsened by misinformation, the way migrants perceive SGBV, and xenophobia and stigma at host communities. Additionally, the study found

that intersectoral actions regarding sexual violence are not reaching the most vulnerable migrant population.

This new evidence is aligned with previous studies on sexual and reproductive health during humanitarian crises (Albaladejo, 2018; Bermúdez et al., 2018; World Bank, 2019; Consejo Nacional de Política Económica y Social (CONPES), 2018), and some previous analysis of sexual and gender-based violence against migrant and refugees (INS, 2015; Kelly, 1987).

Other assessments of the MISP in Nepal (Myers et al., 2018) and Jordan (Krause et al., 2015) have shown great differences in the implementation of the second MISP objective which highlights that even though officials and healthcare providers are well aware of sexual violence in humanitarian settings, comprehensive services to provide clinical care for rape survivors is not sufficiently available; furthermore, it seems that in a variety of contexts, women lack adequate information regarding these services. Thus, this article's findings are consistent with previous evidence, but additionally show that humanitarian actions should consider the fact that migrant women probably have suffered from violence prior to migration.

Recent studies focusing on sexual violence against refugees in Europe (Kelly, 1987; INS, 2015) and the different effects of sexual violence in Latin American migratory contexts (Feminicidios Observatory Colombia, 2018; UNFPA, MSPS, Profamilia, 2014; Bermúdez et al., 2018; INS, 2015) allowed us to understand that both gender-based violence and sexual violence are exacerbated in migratory contexts. Nonetheless, more studies and evidence are required to understand the depth of the effects that SGBV has had on migrants. Also, more actions are necessary to adapt response strategies to SGBV during humanitarian settings. Actions demand full commitment on behalf of stakeholders and humanitarian response officers, including those at territorial and governmental institutions; moreover, it is also important to recognize that migrants could play a major role in the prevention and response to these types of violence via strategies that involve community actions with both migrant and host communities (Zimmerman et al., 2011).

As previously mentioned, one of the main challenges to understand sexual violence and gender violence against migrants is under-reporting, which is one limitation of this study. Additionally, the lack of information on gender violence among Venezuelan migrants and refugee has made it difficult to understand and comprehensively prevent and address this type of violence. In order to address under-reporting, there was a decided attempt to collect qualitative information by taking into consideration both the perspectives of migrant and responses provided by organizations and healthcare facilities. During focus groups, research participants were asked about the number of SGBV cases they were aware of that had taken place in communities close-by; during the assessments of health facilities, staff were asked about the number of SGBV patients they had served. However, in both cases this data was difficult to process, organize and collect and mandatory data collection systems in place at service provider facilities were found to be weak.

Some implications of the major findings regarding how common SGBV is among Venezuelan migrant and refugee women at the Colombia-Venezuela border were mainly connected with the fact that service delivery was limited and the need for improvement in the setting of migration. For instance, there is an urgent need to adopt protocols which have already proven to be successful (such as the Inter-Agency Field Manual, GBV AOR resources, and the IASC GBV guidelines) to guide SGBV response and ensure the availability of service delivery guidelines. Only, MOH protocols and the Regional Office of the Pan-American Health Organization/World Health Organization (PAHO/WHO) were partially implemented at the border.

Moreover, the view that SGBV services are not a specific need for migrants appeared often during focus group discussions. Migrants reported that SGBV is not a clinical issue or a health concern in Venezuela. In order to change this perception so women could access care when needed as they migrate, most organizations must provide service and program information to migrants and put in place information, education and

communication (IEC) mechanisms. Although some efforts in this regard do exist, the widespread lack of awareness about these programs among the migrant population participating in the focus groups was evident. Most organizations stated they are creating spaces for staff to be trained in the clinical management of sexual violence and all of them have established SGBV referral mechanisms, however, several organizations stated that these mechanisms were not fully articulated across the health, justice and protection sectors.

This study was strong in various areas. An important one was that Venezuelan migrant women and girls of an array of migratory statuses and backgrounds enrolled in this research. Also, to our knowledge, this research project would be the first in Latin America to assess SGBV needs in humanitarian emergencies using a rigorous research design such as the MISP toolkit. By assessing the MISP for Reproductive Health, it was possible to understand and identify the barriers and drivers to prevent and manage the consequences of sexual violence, giving special attention to migration as a social determinant of SGBV.

On the other hand, this study presented some challenges and limitations. The main limitation is that conclusions are not representative for all the organizations and healthcare facilities of the four cities at the Colombia-Venezuela border; nevertheless, it is probable that similar situations are being experienced in other hospitals in the regions, as well as across any Colombian city that harbors Venezuelan migrants. One further limitation of this study was that experiences of SGBV were not deeply explored due to established “do no harm” ethical principles that limited talking about sensitive topics in depth. More research is thus required in order to understand the complexity of these scenarios and their nexus with migrants’ vulnerabilities regarding SGBV.

Conclusions

More research is also necessary to identify and develop equity-oriented approaches to bring integrated preventive care and gender-sensitive SRH services to address SGBV within humanitarian emergencies. This means, to provide SRH services in the order to reach the migrant women and girls who are most vulnerable and exposed to any form of SGBV within the complexity of humanitarian settings. In other words: ways to ensure that migrant and refugee women and girls, trans women, adolescent women and those in transit have immediate access to care and prevention when they need it. Overall, there is an urgent need to improve the alignment of common objectives between different teams of government sectors (health, justice and protection) and international agencies. For instance, carrying out joint campaigns to disseminate information about local routes of care and prevention, and to provide basic health services for SGBV victims. Therefore, it is urgent that health policies and programs to prevent SGBV within humanitarian crises become responsive to the needs and circumstances of migrant women and girls. Innovation seems to be missing to shape SGBV care and response in migration settings in ways that make it possible to guarantee access to quality, safe, integrated, efficient and women-centered sexual and reproductive healthcare services. To achieve so, we need to improve research to inform a more equitable and gender-sensitive SRH services, seek to raise awareness of the differential health threats faced by migrant women like SGBV, and promote innovation in this area in the form of local migration policy.

Contributions from the authors

Mariana Calderón-Jaramillo, Diana Parra and Juan Carlos Rivillas were in charge of the concept, method, software, validation, formal analysis, investigation and data analysis. Marta Royo was responsible for acquiring funding. Mariana Calderón-Jaramillo and Diana Parra were responsible for writing the first draft. Luz Janeth Forero and Marta Royo provided a critical review and Mariana Calderón-Jaramillo oversaw inputs and manuscript critical reviews. Mariana Calderón-Jaramillo and

Juan Carlos Rivillas reviewed and edited the full manuscript. The final version of the project reached full consensus.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

- Albaladejo, A., 2018. Contraceptive shortages mean Venezuela’s people face a sexual health emergency. *BMJ* 360, k1197. Retrieved from: <https://www.bmj.com/content/360/bmj.k1197>.
- Alba-Niño, M., Ramírez-Martínez, C., Carreño Paredes, M.T., Yelitzka, E., Maldonado Parada, K.A., 2018. El trabajo sexual una de las múltiples violencias de la mujer migrante. In: Alborno-Arias, N., Mazuera-Arias, R., Ramírez-Martínez, C (Eds.), *Territorios: Frontera, Migración y Realidad Social*. Ediciones Universidad Simón Bolívar, Cúcuta [Available from: https://bonga.unisimon.edu.co/bitstream/handle/20.500.12442/3281/Cap_3_TrabajoSexual.pdf?sequence=4&isAllowed=y].
- Bermúdez, Y., Mazuera-Arias, R., Alborno-Arias, N., Morffe Peraza, M.A. (2018). Informe Sobre la Movilidad Humana Venezolana. Retrieved from: <https://cpalsocial.org/documentos/570.pdf>
- Consejo Nacional de Política Económica y Social (CONPES). Documento Conpes 3950. Estrategia Para la Atención de la Migración Desde Venezuela. 2018.
- Crenshaw, K., 1991. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev.* 43 (6), 1241–1299. [Available from: <https://www.jstor.org/stable/1229039?seq=1>].
- Feminicidios Observatory Colombia. Migrant Women Femicide Colombian Venezuelan Territory April to December 2018 [Internet]. Bogotá DC; 2018. Available from: <http://www.observatoriodefemicidioscolombia.org/attachments/article/374/FemicidiosMigrantVenezolanas.pdf>
- Gushulak, B., Weekers, J., Macpherson, D., 2009. Migrants and emerging public health issues in a globalized world: threats, risks and challenges, an evidence-based framework. *Emerg. Health Threats J.* 2. e10-e[Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3167650/>].
- Hill Collins, P., 2015. Intersectionality’s definitional dilemmas. *Annu. Rev. Sociol.* 41 (1), 1–20. [Available from: <https://www.annualreviews.org/doi/abs/10.1146/annurev-soc-073014-112142>].
- IAWG. 2020. MISP Process Evaluation Tools 2017 [Available from: <http://iawg.net/resource/misp531process-evaluation-tools-2017/>].
- INS. Protocol Public Health Surveillance, Gender Violence [Internet]. 2015. Available from: file:///C:/Users/angela.cifuentes/Downloads/PRO_Violencia_de_genero.pdf 99.
- INS. Instituto Nacional de Salud. Boletín Epidemiológico Semanal 10 de 2018. 2018. [Available from: [https://www.ins.gov.co/buscador-eventos/BoletínEpidemiologico/2018Boletín epidemiológico semana 32.pdf](https://www.ins.gov.co/buscador-eventos/BoletínEpidemiologico/2018Boletín%20epidemiológico%20semana%2032.pdf)]
- INS. Análisis de Riesgo en Salud Pública en el Marco del Flujo Migratorio. Boletín Epidemiológico Semanal 16 de 2019. 2019.
- IPPF& Profamilia. Evaluation of the Unmet Sexual and Reproductive Health Needs of the Venezuelan Migrant Population in Four Cities on the Colombia-Venezuela Border: Arauca, Cucuta, Riohacha and Valledupar 2019. [Available from: <https://profamilia.org.co/wp505Content/uploads/2019/05/Evaluation-of-the-sexual-and-reproductive-health-needs.pdf>]
- Kelly, L., 1987. The continuum of sexual violence. In: Hanmer, J., Maynard, M. (Eds.), *Women, Violence and Social Control*. Palgrave Macmillan UK, London, pp. 46–60 [Available from:].
- Keynaert, I., Guieu, A., 2015. What the eye does not see critical interpretive 510 synthesis of European Union policies addressing sexual violence in vulnerable migrants. *Reprod. Health Matters* 23 (46), 45–55. [Available from: <https://www.ncbi.nlm.nih.gov/pubmed/26718996>].

- Krause, S., Williams, H., Onyango, M.A., Sami, S., Doedens, W., Giga, N., et al., 2015. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the minimum initial services package. *Confl. Health* 9 (1), S4.
- Myers, A., Sami, S., Onyango, M.A., Karki, H., Anggraini, R., Krause, S., 2018. Facilitators and barriers in implementing the minimum initial services package (MISP) for reproductive health in Nepal post-541 earthquake. *Confl. Health* 12 (1), 35.
- OPS. 2020. Migration and Health in Las Américas [Internet]. Available from: https://www.paho.org/hq/index.php?option=com_content&view=article&id=13708:migration-health-americas&Itemid=72502&lang=es
- PLAFAM & SRI. 26 ª Ronda del Examen Periódico Universal Octubre 2016. Presentación Conjunta de: Informe sobre Venezuela PLAFAM Asociación Civil de Planificación Familiar 2016.
- Profamilia Association and the US Office of Foreign Disaster Assistance Abroad (OFDA-USAID), 2020. Health Services Inequalities Affecting the Venezuelan Migrant and Refugee Population in Colombia: How to Improve the Local Response to the Humanitarian Emergency?. Editorial Profamilia, Bogotá, DC. ISBN: 978-958-8164-83-0.
- Profamilia MSPS Encuesta Nacional de Demografía y Salud Tomo I. 2017. [Available from: <https://profamilia.org.co/wp-content/uploads/2018/12/ENDS-TOMO-I.pdf>]
- Robbers, G.M.L., Morgan, A., 2017. Programme potential for the prevention of and response to sexual violence among female refugees: a literature review. *Reprod. Health Matters* 25 (51), 69–89. [Available from: <https://www.ncbi.nlm.nih.gov/pubmed/29214917> .
- Tapales, A., Douglas-Hall, A., Whitehead, H., 2018. The sexual and reproductive health of foreign-born women in the United States. *Contraception* 98 (1), 47–51. [Available from: <https://www.ncbi.nlm.nih.gov/pubmed/29453946> .
- UN. 2020. Sustainable Development Goals SDG 2015 [Available from: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>.]
- UNFPA, MSPS, Profamilia. Política Nacional de Sexualidad, Derechos Sexuales y Derechos Reproductivos. 2014.
- World Bank. An opportunity for everyone. Venezuelan migrants and refugees and the development of Peru. [Internet]. First. World Bank, editor. World Bank and State and Peacebuilding Fund; 2019. 316 p. Available from: <https://openknowledge.worldbank.org/bitstream/handle/10986/32816/143724.pdf?sequence=3&isAllowed=y>
- Zimmerman, C., Kiss, L., Hossain, M., 2011. Migration and health: a framework for 21st century policy-making. *PLoS Med.* 8 (5), e1001034. [Available from: <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001034> .