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Barriers and facilitators to HIV prevention and care for Venezuelan migrant/refugee women and girls in Colombia

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ABSTRACT

Venezuelan migrant and refugee women and girls (VMRWG) face risks of exposure to and infection from HIV and threats of multiple forms of violence (including GBV) during and after migration. Yet, there is a lack of evidence on barriers and facilitators to VMRWGs' access to HIV prevention and care services this population at all stages of their migration. We addressed this evidence gap by conducting a qualitative study composed of fifty-four semi-structured interviews with practitioners (n = 24) and VMRWG (n = 30) in the two largest receiving cities of migrants in Colombia. We sought to identify perceived barriers and facilitators to HIV prevention and care to inform policies and programmatic efforts. Analysis followed a theory-informed approach using the Socio-ecological Model. Findings describe multi-level barriers to access to HIV prevention and care related to discrimination, gender-based violence, rigid gender norms, lack of information and system fragmentation. Policies that integrate community-based networks and support intersectoral work are pivotal to breach the gaps between services and communities and develop a gender-sensitive approach that tackles the relationship between gender-based violence and HIV risk.

1. Introduction

The Venezuelan humanitarian crisis has caused more than seven million Venezuelans to leave their country, and Colombia has received the largest proportion of migrants of any country (The United Nations Refugee Agency [UNHCR] 2022). Health has been a major driver of migration for Venezuelans given the country's underfunding of the healthcare system and lack of preparedness to deal with chronic and infectious diseases (Page and Taraciuk Broner, 2020). In Colombia, HIV prevalence among migrants/refugees from Venezuela suggests the HIV epidemic is growing (Wirtz et al., 2023). For Venezuelan migrant/refugee women and girls (VMRWG), violence (GBV) has been linked to growing HIV case rates in Colombian municipalities (C Correa-Salazar et al., 2023).

VMRWG face risks of exposure to and infection from HIV and threats of multiple forms of violence during and after migration (C Correa-Salazar et al., 2023).. Transit routes to Colombia and border crossings are controlled by guerrilla groups and gangs (Human Rights Watch 2020) who systematically inflict different forms of violence upon migrants/-refugees, including GBV (Vergara et al., 2018). Upon relocation in Colombian cities, VMRWG face discrimination and barriers to accessing social resources (i.e., public insurance, housing, education, and child services) (C Correa-Salazar et al., 2023). According to recent data, around 10% of VMRWG report having experienced at least one type of violence since their arrival in Colombia (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022). Overcrowding, lack of sanitation, exploitation, harassment, stigma and lack of information on services also impact the ability of VMRWG to access justice and HIV prevention and care in relation to incidents of GBV (Gómez, 2018). In this context, we understand barriers to access services as any behavior (microaggressions, enacted discrimination or refusal), condition, policy, and/or law that impedes VMRWG to use, employ and benefit from public services available in the best quality and efficient manner possible. Conversely, we understand facilitators as those factors

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promoting and improving access to information, services, social resources, or protections. Facilitators can be people, mechanisms, services, policies and/or laws. These definitions are coherent with the criteria for fulfillment of the right to health: accessibility, acceptability, availability, and quality (World Health Organization (WHO) 2016).

In 2021, Colombia passed a 10-year temporary protection statute for Venezuelans with irregular migration status to be able to access insurance and other social resources (education, housing, jobs) (ETPV according to its acronym in Spanish) (Ministerio de Relaciones Exteriores 2021). Even though the right to health is constitutionally protected in Colombia and the Colombian Constitutional Court and government regulations grant access to emergency medical services to all Venezuelan migrants/refugees, with broader access to care for children and pregnant women (Ministerio de Relaciones Exteriores 1984; Ministerio de Salud de Colombia 2019), migrant/refugee populations still face considerable barriers to access HIV prevention and care (Wirtz et al., 2023).

Historical barriers to healthcare for nationals in Colombia extend to migrants/refugees and impose barriers across the HIV care continuum. These obstacles relate to fragmentation of services (e.g., between rural and urban settings); separation of different levels of care; failure to insure underserved populations; underfunding and institutional mismanagement. Corruption and opaque resource allocation also foster poor quality care (Montoya et al., 2017). Barriers to treatment adherence relate to high cost, lack of information and restricted coverage (Gómez-Suárez et al., 2019), particularly for migrants/refugees (Wirtz et al., 2023). Rigid gender roles and GBV act as additional healthcare obstacles for both cis- and transgender women to HIV prevention and care (testing, treatment for PLWH, PrEP distribution and other preventive services) (Zea et al., 2021). Colombia has yet to adopt and implement policies and programmatic efforts that fully address the needs of migrants/refugees with a gender focus. Specifically, an approach that integrates HIV prevention and care with GBV services (C Correa-Salazar et al., 2023).

In this study, we base the analysis on barriers and facilitators for HIV prevention for VMRWG on the social-ecological model (SEM) (Bronfenbrenner, 1977). This model has been used to describe GBV as a pervasive and permanent reality for women and girls that impacts their health across the lifecycle and levels of experience, from the individual to political spheres of law and policy (Heise et al., 2019; Heise, 1998). The SEM comprises different spheres that can help frame and conceptualize how barriers and facilitators for HIV prevention operate in a misogynistic culture: i) micro personal experiences: household and family interactions of GBV and gender norms that impact behaviors and beliefs, socioeconomic status (SES) that limits girls' and women's chances, lack of support networks, school and gendered-interactions with peers; ii) *meso*: church, community networks, work access or lack thereof; iii) exo: social networks, neighborhood conditions and safety, service provision, local government and health institutions able or willing to provide sexual and reproductive care and barriers; and, iv) macro-level factors: laws, ideologies, culture and gender norms reproduced top-down (Bronfenbrenner, 1977; Heise et al., 2019; Heise, 1998). These interlocking levels create a context of GBV that can limit women and girls' opportunities, access to resources and potential when reinforced by conservative values and gender roles, and law and policies that do not consider gender as a determinant of health (Heise, 1998).

As shown, historical barriers to healthcare in Colombia have been attributed to the exo and macro levels, with policy and law failing to provide adequate coverage for disenfranchised populations or effectively distributing low-cost medicines and information (Montoya et al., 2017). This study centers VMRWG's voices to understand how the personal (micro) and community (*meso*) levels weave into structural barriers and facilitators of HIV prevention in Colombian cities, adding to the analysis of risks and barriers (Bowleg, 2012). Our study responds to calls for evidence through a participatory approach that addresses and analyzes the relationship between migration and HIV in the region (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022) using a gender lens that considers GBV as a driver for growing HIV cases among women and girls in Colombian cities (for detailed analysis on the relationship between migration and HIV case rates in Colombia see elsewhere (C Correa-Salazar et al., 2023)).

Our participatory approach is based in long-term relationships with community partners and grass-roots organizations (Cahill, 2010; Ritterbusch, 2012). Community partners co-designed and co-implemented every step of the methodology with the rest of the research team, centering their concerns and know-how (Cahill, 2010) (for more information on our methods see elsewhere (C Correa-Salazar et al., 2023)). We argue that this approach is necessary to produce a grounded understanding of discrimination-based barriers and implement differential policies and services that tackle risk factors related to gender amidst this humanitarian crisis and growing HIV epidemic.

In this community-based participatory study grounded on the SEM, we triangulate data from practitioners and Venezuelan migrant and refugee women and girls in Colombia to answer: i) What are perceived barriers to HIV prevention and care for VMRWG in Bogotá and Cúcuta? ii) What are perceived facilitators to access HIV prevention services and care for VMRWG in Bogotá and Cúcuta?; iii) How does GBV play into perceived barriers and facilitators?

2. Methods

2.1. Study design and procedures

We conducted a participatory qualitative study in the two largest receiving cities in Colombia. Cúcuta (roughly 700,000 people) is where most incoming migrants/refugees first seek healthcare, medications and treatments (Amnistía Internacional [Amnisty International] 2022). Bogotá, the capital and largest city in Colombia, has historically been a final destination for displaced, migrant and refugee populations, both internal and international (Migración Colombia 2019). This study was part of a larger four-year participatory project based in university-community collaborations where we worked closely with community peer leaders, community members, local feminist organizations, and local researchers.

The first phase of the project involved extensive and on-the-ground formative research. Between February and July 2021, 54 participants were invited to participate in semi-structured interviews from two different populations. We recruited twenty-four practitioners from academic institutions, health services, government agencies and non-governmental (NGO) human rights organizations ($N = 24$, 12 per study site). We used the Principal Investigator's (PI, CC-S) previously built networks to sample and invite participants. See Table 1 for demographics on this first sample. Practitioners were selected using purposive sampling (Lincoln and Denzin, 2000). Eligibility criteria included: being 18 years or older and working in an institution providing direct services to VMRWG (see Table 1). Sample was limited to one representative per organization and organizations were mapped during formative research to understand main actors, government agencies and civil society organizations working with our population of focus. From our original mapped group of actors working on HIV prevention and

Table 1
Key Informants (Practitioners) interviewed in Bogotá and Cúcuta ($N = 24$/ $n = 12$ per study site).

Demographics		N	%
Gender identity	Women	18	75
	Men	6	25
Type of organization	Humanitarian agencies	11	46
	Civil society organization	5	21
	Healthcare/Hospital	1	4
	Academic	1	4
	Government	6	25

care and violence prevention with VMRWG, we sampled one individual from each sector. We found most difficult to sample practitioners from public hospitals.

Concurrently, we invited thirty VMRWG ($N = 30$, 15 per study site) to participate in semi-structured interviews through partnership with a local organization. We used non-probabilistic purposive snowball and convenience sampling (Lincoln and Denzin, 2000). Sample size was determined using qualitative criteria of representation and the diversity principle (Lincoln and Denzin, 2000), and it was later assessed through thematic saturation (Saldaña, 2015; Creswell et al., 2011). While we grouped migrant and refugee status in one category of analysis given both faced similar challenges concerning migration, limitations to access care and experiences of violence at the time sampling was conducted, we acknowledge that 'migrant' and 'refugee' categories have distinct legal meanings. See Table 2 for demographics on this second sample. Eligible participants were self-identified women between 14 and 49 years of age living in Venezuela before 2013 (capturing different incoming migration waves before and after the humanitarian crisis was declared) and currently relocated in Colombia after terrestrial transnational migration. We sought a diverse sample that included known risk factors like age (through emancipated adolescents), women living with HIV, transgender women, and women with transactional sex experiences. We did not collect any type of data that could identify VMRWG during or after data collection. See Table 2 for demographics on VMRWG. Our partnerships and relationships of trust supported our work and we found that more VMRWG from reception communities were willing to participate than we expected to sample, so we applied qualitative criteria of diversity for interviews (Lincoln and Denzin, 2000; Creswell et al., 2011).

Table 2
VMRWG demographics ($N = 30$/ $n = 15$ per study site).

Demographics	N	%
Year of migration		
2014–2016	3	10%
2017–2018	18	60%
2019–2021	9	30%
Main reason for migrating		
Economic crisis	15	50%
Violence/persecution	5	17%
Health reasons	6	20%
Family reunification	4	13%
Border crossing		
Illegal crossing	16	53%
Official border pass	14	47%
Migration status		
Irregular status	27	90%
Legal status	3	10%
Age		
14–18	6	20%
19–23	7	23%
24–28	7	23%
29–33	3	10%
34–43	3	10%
44–48	3	10%
Race/ethnicity		
Mixed race	26	87%
Black/Afro Venezuelan	4	13%
Sexual orientation		
Straight	26	94%
Lesbian	1	3%
Other	1	3%
Self-reported HIV status		
Positive	1	3%
Negative	27	90%
Prefers not to report	2	7%
Have children		
Yes	20	67%
No	10	33%
Sexual violence survivor		
Yes	15	50%
No	6	20%
Prefers not to report	9	30%
Perceived risk of HIV exposure upon relocation*		
Yes	20	67%
No	7	23%
Teenage mother**		
Yes	16	53%
No	9	30%
Prefers not to report	5	17%

*Women who openly discussed risk behaviors, threats to sexual health and/or violence that endangered their health and increased their risk of being infected.

** Teenage mothers are women who had their first child between the ages of 11–17.

All interviews were conducted by the PI in Spanish. Interviews with practitioners were completed over zoom and those with VMRWG took place in-person in private locations. In some cases, VMRWG's interviews were co-conducted between the PI and one community leader to ensure trust. All participants provided verbal informed consent and were provided with contact information for the research team. VMRWG received a $15 USD incentive for participating.

2.2. Data analysis

All interviews were audio recorded and transcribed verbatim by team members and an external transcription service. The research team was composed of two research assistants, one member of the local partner organization and the P.I. We used a thematic analysis method for analysis, and transcripts were coded and analyzed in Spanish in Dedoose ® and selected quotes translated into English by the P.I. We followed an open coding strategy for the first coding cycle using an *a priori* code book and an axial coding strategy for the second phase, structuring results around research questions (Saldaña, 2015). We created a separate code to classify different experiences of violence and discussed them in relation to barriers and facilitators found across SEM levels (micro, *meso*, exo and macro). This supported the integration of the GBV lens to the analysis. To ensure homogeneous use of codes across coders, the first two interviews were coded by all members of the research team, inter-rater reliability was measured after each coding cycle (ranging from 84% to 95%) and weekly meetings were held to discuss findings for a period of six months. Discrepancies and errors were resolved through theory revision and group discussions. After coding was completed, we held meetings with community partners and practitioners to present findings and validate results in both study sites. Our study complies with guidelines of the COnsolidated criteria for REporting Qualitative research (COREQ) (Booth et al., 2014).

2.3. Ethics

The Institutional Review Board (IRB) of Drexel University provided ethics approval for the Crossroads in Two Colombian Cities Project (no. 2,009,008,067). The Ministry of Health and Social protection of Colombia provided the authors a reliance agreement to conduct the research. Both the IRB approval and the reliance agreement approved the use of oral consent for all participants. Oral consent was documented in audio. Our ethical approach is based on participatory care ethics (Cahill, 2010) that promotes socially responsible actions through the re-defining of subjects as active participants instead of vulnerable subjects (Cahill, 2013).

To protect the privacy and confidentiality (Cahill, 2013; Ritterbusch, 2013) of adults and emancipated minors (aged 14–17 years), we relied on community partnerships that promoted trust and engaged community leaders as co-researchers following a participatory research framework (for further information see elsewhere (C Correa-Salazar et al., 2023; C Correa-Salazar et al., 2023)). The IRB specifically waived the need for parental/guardian consent for emancipated minors after consideration of their migratory situation. However, recognizing the specific vulnerability of emancipated minors, no participants were sampled outside of local organizations' networks and peer-leaders'

referrals. We confirmed emancipation during screening. VMRWG received $15 USD incentives for their participation. All participants were informed of their right to leave or terminate the interview at any time.

3. Results

We found barriers and facilitators to access HIV prevention and care for VMRWG in Bogotá and Cúcuta across levels of the social-ecological model (SEM), including: i) micro personal experiences (family, socio-economic status (SES), support networks, school and the household); ii) *meso* (church, peer networks, work, institutions); iii) exo (social networks, neighborhood conditions, service provision, local government and health institutions) and, iv) macro-level factors (laws, ideologies, culture and gender norms) (Bronfenbrenner, 1977; Heise, 1998). We grouped our findings around the most significant barriers and facilitators described by participants, addressing how GBV hinders prevention and care efforts in different levels for VMRWG. However, while many of the barriers and facilitators have to do with GBV, there are other important factors uncovered by our study that go beyond GBV.

3.1. Perceived barriers to access HIV prevention and care for VMRWG

Salient barriers to access HIV prevention and care identified by participants in Bogotá and Cúcuta are listed in Table 3 according to the triangulation of findings from both groups.

3.1.1. Micro level: lack of information and violence in the household

Although 20% of participants migrated for health reasons and an additional 17% to escape persecution/violence, we found that discrimination, economic hardship and lack of a legal migration status impact health literacy and access to HIV prevention and care services for VMRWG. While VMRWG have a right to these services, lack of information, especially for pregnant women and adolescents, creates obstacles to access them when providers, out of ignorance or prejudice, violate their privacy, demand legal migration status or insurance coverage to perform testing and engagement in care. Practitioners expressed that VMRWG's lack of information and perceptions of discrimination result in challenges engaging migrants in care, which can increase HIV vulnerability, and delay detection of cases and prevention efforts.

Most participants indicated that breaches in confidentiality related to these vulnerabilities also hinder GBV reporting. Physical and sexual abuse were the most common forms of violence identified by participants. Fifty percent of VMRWG reported that they were survivors of sexual violence and 67% said that they had been exposed to violence after relocation, but none of them had reported these events for fear of deportation, revictimization and xenophobia. In the micro level, most VMRWG expressed GBV events related to household violence prevented them from accessing HIV prevention. They reported feeling limited by gender stereotypes and male partners' expectations of their behavior, which imposed barriers to prevention and deterred them from seeking testing or post-exposure prophylaxis for fear of violence (see Table 3).

The majority of VMRWG described the lack of a migratory permit and inability to access public insurance coverage through State-subsidies increased perceived barriers. Fifty percent of participants migrated to escape Venezuela's economic crisis but found no refuge in Colombia to support their basic needs. Practitioners described lack of safe housing, childcare, and jobs to secure economic independence from abusive partners as factors that increased violence-related barriers.

Table 3
Barriers to HIV services per SEM levels related to GBV.

Levels	Perspectives on key barriers for accessing services
Micro	*Lack of information on rights and system's functioning* There's nothing else to do than to go fight at the health centers and clinics to get patients seen because health personnel are telling women they can't be seen because they don't have insurance… if a woman needs a pregnancy exam or an HIV test, you must go fight because they don't know how, they lack the knowledge… (Female practitioner, International Organization, Bogotá). *Violence in the household/ Intrapartner violence linked to gender stereotypes* … he didn't help me [her partner]. He hit me and hit me in the belly when I was pregnant… I was afraid because he used to say that he was going to kill me and he was going to kill the baby because someone told him the baby wasn't his [stopping her from accessing services] (VMRWG in Cúcuta, 33 years).
Meso	*Discrimination and stigma* …if women don't feel safe it is unlikely that they will consult services because the institutions don't protect their privacy… their confidentiality… all the community is going to find out they are getting tested because… they were victims of sexual violence, that generates stigma on top of self-stigmatization for being a migrant. They rather not report rapes at all (Female practitioner, International Organization, Cúcuta).
Exo	*Barriers to reporting of cases* If a woman gets raped, she must make the claim within 48 h but not all of them can or will do that. Many denounce in a week, or a month so the health system is not going to guarantee the care that the woman needs, not even mental health care. They don't have any protections… (Female practitioner, International Organization, Cúcuta).
Macro	*Insufficient budget and coverage of the Colombian health system* The government produced a CONPES [law] on migration, but the truth is that it didn't increase coverage … rural institutions still don't have any budget to care for migrants and don't follow-up on cases of violence (Male practitioner, Government, Bogotá).

3.1.2. Meso level: stigma by providers

Participants described a lack of sensitivity among health care providers in sexual and reproductive health services (including mental health providers), hospitals, clinics, and police stations. VMRWG in this study consistently complained of being stigmatized by their migration status, age, and SES. All practitioners described lack of adaptation of services to VMRWG's contexts and needs as a barrier to denounce GBV events or access HIV prevention and care. Furthermore, most VMRWG complained of being stigmatized by sexual behaviors and blamed for violence. A male nurse explicitly suggests women could at least avoid an unwanted pregnancy if they carried condoms and asked rapists to wear one:

> …I told them: 'what if someone comes to abuse you and there's nothing else you can do? You're going to get raped. What if you have condoms and ask the rapist to wear one so you don't get exposed to unwanted pregnancies or STDs? You don't have to consent to rape… you will have PTSD but at least not an unwanted child' (Male practitioner, International Organization, Cúcuta).

This type of discrimination was commonly mentioned in relation to interactions with police by all VMRWG (see Table 3). Given that police reports are required in public hospitals to activate sexual protection protocols for HIV, as well as accessing post-exposure prophylaxis, lack of access to justice also imposes barriers to HIV prevention and care for VMRWG.

3.1.3. Exo level: GBV and information systems

Most practitioners and VMRWG reported lack of cultural understanding and a gender approach as barriers to accessing HIV care and reporting GBV (see Table 3). In sexual and reproductive services and HIV care, lack of integration of services with mental health counseling and mechanisms to report household or community violence were cited as a barrier given VMRWG's contexts (lack of transportation resources to make different trips to access HIV and report incidents of violence, lack of counseling in community locations, mistrust in government institutions). Neighborhood conditions and health intuitions' requirements act as obstacles for prevention.

For most practitioners, stigmatization in the institutional level was perceived to be revictimizing by VMRWG, and a general flaw of the

public system. These barriers hinder GBV documentation on a social level. A practitioner explains about missing women in borderlands:

> We are finding many unidentified women's bodies… wrapped in bags in the outskirts of the city… women say that when they were crossing the border they were separated from the men and they say 'we were 7 but only 2 of us arrived in Colombia'. So what is happening to murdered women's bodies? The Colombian State is not reporting this violence… How do women just disappear? (Female practitioner, Civil society actor, Cúcuta)

The institutional lack of attunement with VMRWG's contexts and general lack of cultural understanding of VMRWG's needs imposes barriers to HIV prevention and care in the exo level and increases impunity on cases of violence for most participants. Ninety percent reported a negative HIV status, but it is possible that these barriers negatively impact case reporting.

3.1.4. Macro level: insufficient coverage and cultural values

In the macro level, all practitioners related barriers to insufficient funding for HIV prevention and care, which hampered the implementation of programs, especially those relying on outreaching for the most vulnerable groups of migrants/refugees. Similarly, all VMRWG perceived insufficient mechanisms to access HIV information, prevention mechanisms (like condoms), access post-exposure measures or report violence. Lack of coverage resulting from insufficient funding, scarce resources and limited personnel were common themes for participants. Most practitioners explained how the inability of the system to address migrants/refugees needs negatively impacts the follow-up of GBV cases reported during and after migration, migrant-specific programs that support HIV and sexual and reproductive services upon relocation (see Table 3).

Even when programs and policies exist, some practitioners described a lack of understanding of how to breach the gap between services and populations due to cultural values on gender norms. These barriers to care demonstrate a lack of gender training and sensitivity among most providers in service provision and institutions that stems from the system's lack of policies on gender-sensitive training. A practitioner explains: "…Cúcuta is a very misogynistic, patriarchal culture and in that sense, it permeates how we operate" (Male practitioner, International Organization, Cúcuta). Thus, providers and institutions are not regarded as changeable because they respond to a systemic way of operating. For most VMRWG and practitioners the need for intersectoral approaches that integrate insurance coverage, outreaching and violence prevention using a gender perspective to improve access to HIV prevention and care is urgent.

3.2. Perceived facilitators to access HIV services

From the triangulation of findings emerged several ways in which current programs, policies and community resources facilitate access to HIV prevention and care. Found facilitators rely on interpersonal relationships, community outreaching and institutional policies. These mechanisms included training of community leaders, programs that sought to establish partnerships with community organizations and peer-led networks that breach the gap between migrants and services, the waiving of requirements to access services and the intention of policy makers to promote access to general care with insufficient resources (see Table 4).

3.2.1. Micro level: training in community health and community education

Both groups of participants described the important role that community actors play in delivering HIV prevention and care. In the micro level, being trained to implement HIV care in community settings and identify GBV, was a facilitator to promote trust, break geographic and information barriers and engage migrants in care. All VMRWG that had been trained in HIV prevention and violence detection felt useful while helping others in their own contexts. They described acting as liaisons between migrant communities and services, mainly those provided by NGOs and humanitarian actors. A VMRWG explains: "We talk about women's stuff and things you see and that's how you gain experience and learn more. I started going because of a peer leader in my community…" (VMRWG in Cúcuta, 37 years).

Table 4
Perceived facilitators that promote access to HIV services related to GBV.

Levels	Perspectives on key facilitators
Micro	*Training in community health, HIV, and violence prevention* We have trained community leaders for two, three years now. Everyone who wants to get trained [in HIV testing], can be trained by doctors and nurses to implement services, people capable of doing the tests… (Female practitioner, civil Society Actor, Cúcuta)
Meso	*Peer-led networks of community care* Peer leaders split up the territories to cover them, so there are leaders for every area, and they communicate between them the needs and care they want and have found different strategies to work with NGOs… (Female practitioner, International Organization, Cúcuta)
Exo	*Integration with community-based networks* One of the ways in which we are really going to make an impact is co-educating the population through outreaching. In their own language and organizing with the communities, distributing information so they know what's available and can inform others… Working with the whole community, we can make sure that resources reach them (Female practitioner, Civil Society Actor, Cúcuta). *Waiving of requirements to access services* To provide the migrant and refugee population with sexual and reproductive care services we do not require any type of migratory permit … their migration status doesn't matter (Female practitioner, civil Society Actor, Cúcuta). *Mental health services* Something important to have for migrant women, especially for women, not only because of violence but also because of migratory grief is mental health services (Female practitioner, Civil Society Actor, Bogotá).
Macro	*Intersectoral work* Every department and national working group has a focus… our group participates in the gender one where all the organizations that respond to this issue participate, also in issues regarding gender-based violence for women, children or minorities. That's where we integrate our work and design the path to follow cases (Female practitioner, Government, Bogotá). *Institutional willingness to help* Let's say that Colombia is trying to guarantee care as much as possible from its public healthcare system that has finite resources and limitations, but we are trying to provide the bare minimum (Male practitioner, Government, Cúcuta).

3.2.2. Meso level: peer-led networks of care

Building on the micro level, participants described peer-led networks of care as a feasible, low-cost, and effective strategy to promote HIV prevention and engagement in testing and care. Most participants described migrants/refugees feeling more comfortable talking to peers that understood their specific needs, contexts and experiences when accessing care and agreeing to testing, especially adolescent girls. All VMRWG contrasted the treatment, care, and rights protection they got at hospitals versus the ones received in community locations, evaluating the former as culturally sensitive and accepting. As peers understand information limitations and economic constraints, they develop strategies especially focused to engaging migrants in care. Linking support networks in reception communities through which VMRWG can access social resources like food, childcare and temporary housing was also described as a good strategy to engage migrants in HIV prevention and protect victims of GBV.

3.2.3. Exo level: integration of services

According to both groups of participants, perceived effective services are a result of community engagement strategies that integrate different types of services (HIV, violence prevention workshops, mental health counseling), waive access requirements like legal migration status, fees for medications and formal police claims to access violence protection

protocols (i.e. abortion, prophylaxis, exams). Integration between community-based networks formed upon relocation and institutional services facilitates efficient delivery of HIV care, promotes trust, and breaches the gap between services and communities as described by most participants (see Table 4).

In the exo level of healthcare and institutional regulations, mental health services were especially highlighted by most participants as paramount to provide counseling and guidance on HIV exposure, violence, and relocation challenges. A practitioner explains: "We developed different pedagogical activities with women on health rights, mental health and the Colombian law in terms of rights and access…" (Female practitioner, civil society organization, Bogotá).

However, our findings describe how these facilitating factors and institutional willingness to adapt to migrants' contexts were mostly -if not exclusively- found in civil society and international humanitarian agencies working with migrants and refugees in Colombia.

3.2.4. Macro level: intersectoral work and willingness to help

Building on the previous level, our findings pointed to integrated services and intersectoral platforms that used culturally appropriate approaches as critical to improving HIV prevention and care. Intersectoral platforms (like The Interagency Group for Mixed Migration Flows -GIFMM in its Spanish acronym- created at the end of 2016 by the International Organization for Migration -IOM- and the United Nations High Commissioner for Refugees -UNHCR- to respond to the increasing flow of people arriving from Venezuela) were found to be key in this context (see Table 4). These platforms share experiences and challenges to service provision, facilitating communication, prioritizing needs, and allocating funds where they are most needed. By integrating actors in one platform, information systems and case-follow up was also found to improve policy implementation and program delivery in the macro level.

4. Discussion

Our study responds to the lack of evidence on barriers and facilitators related to HIV prevention and care amidst a growing epidemic (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022) and humanitarian crisis (Doocy et al., 1; Broner, 2020), as well as high rates of GBV in Colombia. The SEM model supports the understanding of specific factors across different levels (from personal experience to institutional and policy applications) that can help promote targeted programmatic efforts and strategies, centering women's and girls' voices and implementing a gender lens to understand GBV as a determinant of health (Heise et al., 2019; Heise, 1998). The main contribution of this study is to present research that relates migration and integration patterns with HIV prevention and care, including the conceptualization of GBV as an important factor impacting poor prevention outcomes for migrant women and girls amidst a humanitarian crisis (Broner, 2020) and growing epidemic (C Correa-Salazar et al., 2023; Norwegian Refugee Council (NRC) 2020).

Stigmatization of migrants, rigid gender norms, and experiences of GBV relate to barriers to access prevention, post-exposure prophylaxis, counseling in relation to experiences of violence and continue HIV-related care among VMRWG. Added to lack of information on system's functioning, and lack of culturally sensitive approaches to VMRWG's needs that include contextual vulnerabilities, were among the main factors found to hinder HIV care in Bogotá and Cúcuta. Gender norms and conservative cultural values across levels shape institutional practices (including providers' enabled behaviors) that blame women for violence and revictimize them through imposed barriers. These findings present novel evidence and argue in favor of training providers in a gender approach to health.

Given that the lack of a legal migration status has been associated with lower levels of education, job access, income, food security and worse mental health outcomes (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022), to guarantee effective HIV prevention and care for VMRWG would entail effectively implementing policies like the Temporary Migration Statute (ETPV) and others that tackle exo and macro determinants of HIV prevention and care. The lack of stable jobs and housing hinders VMRWG from accessing testing or post-exposure measures, as well as independence from abusive partners and families. Similar to other studies, low SES was also found to be linked to not knowing partner's status and not wearing condoms (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022), factors that need to be addressed from the level of personal experiences in households and community settings, but cannot be done efficiently if VMRWG lack the support in the *meso* and exo levels. Thus, integration of HIV prevention and care, social resources (childcare, education, jobs, housing) and violence protection mechanisms (including mental healthcare and counseling) presents as a feasible strategy to address both barriers and needs (Doocy et al., 1; Broner, 2020; Norwegian Refugee Council (NRC) 2020). In a context where HIV prevention and care barriers are related to GBV, addressing one dimension of the problem without the other may hinder effectiveness of programs (Hatcher et al., 2019).

Intersectoral work, for example training providers in gender and culturally sensitive praxis and information dissemination through peers, are strategies that target barriers and address GBV across levels of the SEM. As mechanisms that address GBV and barriers, these facilitators can be implemented to improve engagement in prevention efforts and care while supporting community trust. Specific barriers related to lack of trust, disinformation and discrimination based on gender and lack of a legal migration status, can also be addressed through actions that prioritize community-based efforts, information on programs available through local channels, and outreaching by community peers. Given the high levels of xenophobia and victim-blaming in this context, mechanisms that tailor services to migrants' needs can prove useful to implement combined prevention packages that include information, testing for HIV and STDs, sexual and reproductive health services, mental health counselling, PrEP, PEP and ART therapies and post-exposure prophylaxis access. Services that are community-based and peer-delivered are useful to address growing HIV case rates and GBV in reception communities (C Correa-Salazar et al., 2023). This is the strongest point of evidence for such services.

Considering that facilitators that promote HIV prevention and care in Bogotá and Cúcuta currently rely mostly on non-State actors, macro level challenges moving forward should include integrating services initially provided by the humanitarian sector effectively into the public health system. This is pivotal as migrants strive towards integration into reception communities (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022). As HIV care passes from international actors to government institutions, it is paramount that collaboration occurs to sustain prevention and care. Efforts ought to capitalize on built local networks and models of peer delivery for policy implementation, approaches that have been successful in other contexts (Febres-Cordero et al., 5). Integration between government, humanitarian actors and community-based services could also help address historical barriers to access healthcare related to fragmentation of services, separation of levels of care, misinformation and lack of trust (Montoya et al., 2017).

A pivotal point based on our findings relates to the importance of open border services and policies. As migrants/refugees continue to enter Colombia for treatment and care but establish circular migration patterns, there is a need to ensure that services are available regardless of migration status and coverage. Facilitating cross-border migration can also help prevent GBV, avoiding unnecessary barriers for VMRWG. Given Colombia's apparent disposition to welcome migrants through innovative policies, this key step is coherent with a gender-focus (Ministerio de Relaciones Exteriores 2021).

There are some limitations in our methods and results. Our qualitative findings are informed by our partnership with local organizations

and may be biased towards the population we worked with. Given that we limited sampling to two study sites, findings in Bogotá and Cúcuta cannot be interpreted as common across all Colombian cities. However, our methodology mitigates social desirability bias, promotes honesty and is informative of VMRW's experiences given our participatory approach, and long-term collaboration with VMRWG. The diversity of the practitioners' sample also helps prevent bias towards one sector over another, but a potential limitation is that only one participant from public hospitals was sampled.

Our findings align with international recommendations that have stressed the potential of migrants' and women's leadership in reception communities, a goal that should not be lost in post-conflict contexts like Colombia. Studies have shown that comprehensive GBV programs can be successfully integrated into existing healthcare services through intersectoral work and embedded into communities to increase uptake of HIV prevention and care, support trust and improve access to justice (Endler et al., 2020).

5. Conclusions

This study responds to the lack of evidence on barriers and facilitators related to HIV prevention and care for VMRWG amidst a growing HIV epidemic (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022), high rates of GBV and a regional humanitarian crisis (Broner, 2020). We present novel evidence to support peer-led community interventions that integrate mental health care, HIV prevention and violence protection protocols. We center women and girls' voices to analyze the relationship between migration and HIV risk (RedSomos, Ministerio de Salud y Protección Social, Universidad Johns Hopkins 2022) using a gender lens that considers GBV as a driver for growing HIV cases among women and girls in Colombian cities (C Correa-Salazar et al., 2023). We describe barriers and facilitators across SEM levels answering the role violence plays in reinforcing barriers and hindering facilitators, but also the role of community support in the promotion of health and prevention efforts.

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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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