

THE DANGERS OF FORCED DISPLACEMENT:

Chronic and Emerging Health Needs of Displaced Venezuelans in the Americas Region



Venezuelan migrant Katerine Valero, 29, and her children Dariusca, 8, left, and Wilkerson, 4, rest outside a strip mall in Bogota, Colombia, Tuesday, Feb. 9, 2021. (Credit: Fernando Vergara/AP)

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The when, where and how of informed disaster giving

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ACRONYMS

ACHR- American Convention on Human Rights

ADHR- American Declaration of Human Rights

CEDAW- Convention on the Elimination of Discrimination Against Women

CRC- Convention on the Rights of the Child

EJE- Extra Judicial Execution

HIV/AIDS- Human immunodeficiency virus/acquired immunodeficiency syndrome

IDP- Internally Displaced Person

IMF- International Monetary Fund

IOM- International Organization for Migration

LGBTQI+ - Lesbian, Gay, Bisexual, Transgender, Queer, Inter-sex, and other forms of sexual and genderidentity

MHPSS- Mental health and psychosocial support

NGO- non-governmental organizations

OAS – Organization for American States

OHCHR – Office of the UN High Commissioner for Human Rights

STIs- Sexually transmitted infections

UDHR- Universal Declaration of Human Rights

UN- United Nations

UNHCR- United Nations High Commissioner for Refugees

USD- United States dollars

WHO- World Health Organization

RESEARCH QUESTION, ANALYTICAL FRAMEWORK, AND METHODOLOGY

RESEARCH QUESTION

This paper comprehensively examines the health needs of Venezuelans forcibly displaced from Venezuela into the Americas region, with a particular focus on women and children; addressing the question:

1. *What are the most pressing and under-resourced health needs of forcibly displaced Venezuelan migrants and refugees in the Americas region?*

ANALYTICAL FRAMEWORK

This research employs an entirely desk-based approach to reviewing primary and secondary literature produced by scholars, inter-governmental organizations, governmental agencies, non-governmental organizations (NGOs), and journalists. The literature used and referenced will include a mixture of qualitative and quantitative data. Through a comprehensive review of available health data (to include nutrition and food security) and related social and contextual dynamics and linkages, we will present and discuss an understanding of the most pressing and under-resourced health needs of displaced Venezuelan migrants and refugees in the Americas region.

In 1948, the World Health Organization (WHO) defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.⁷ This is the definition of health in which this research is framed, as opposed to other approaches such as assessing health as the ‘absence of a disease’ as argued by

Boorse, or a state of physical well-being as posited by Callahan.

It is critical to understand the lived experiences of displaced people when attempting to design support strategies. Thus, Non-Governmental Organizations (NGOs) and United Nations (UN) agencies' human rights and humanitarian

reports are crucial to ground this desk-based research. UN agencies and NGOs, notably NGOs, tend to understand best the perspectives and experiences of displaced persons in humanitarian settings as staff members are often from the same communities or country in which displacement is occurring or are on the frontlines of service provision, continuously in contact with the displaced population about its needs, wishes, and concerns. These reports and related data will support the integration of the perspectives and lived experiences of migrants and refugees without requiring interviews, which is outside the parameters of this study.

Analysis of the health needs of refugees and other displaced populations is linked to larger forces associated with state responsibility, capacity, and interest in public health. Understanding access of displaced persons to the protection, provision, and systems of the state is fundamental to public health, including those who may be on the move.

ETHICAL CONSIDERATIONS, FEASIBILITY, AND CHALLENGES

The UN has identified a significant gap in the health data of Venezuelan migrants and refugees in the Americas region due to the lack of health and social services registration data for those with irregular status. Additional protection risks are associated with official registration and accessing formal, publicly

available healthcare for displaced female-headed households, one of the target demographics for this study. This results in a lack of nuance and potential gaps in publicly available data; additional primary research may be required to yield a truly comprehensive view of displaced Venezuelans' most pressing health needs in the Americas region.

It is important to note that this study will not include precise locations of irregular migrants and refugees and any other potentially identifying, private information. This is necessary to protect the safety and security of the displaced population facing real threats and fears of violence or other human rights abuses should authorities or non-state actors identify them.

Relatedly, this study focuses on each country within the Americas region that hosts the most displaced Venezuelans, prioritizing the specific conditions on the ground and the population's greatest need of support currently. Central America and Mexico were not examined.

Thus, recommendations and analysis of this study reflect a holistic view of the health and well-being needs of displaced Venezuelans instead of purely medical research.

Multiple categories of health needs will be examined in this report. The types of these needs and corresponding healthcare can be found in the following table.

Mixed migration Terminology: 'Mixed flows' is a multi-valent term. Adopting the definition of the Mixed Migration Centre, we use combined flows to denote cross-border movements of people, including refugees fleeing persecution and conflict, victims of trafficking, and people seeking better lives and opportunities. Motivated to move by these multiple factors, people in mixed flows have various legal statuses and vulnerabilities. Although entitled to protection under international human rights law, they are exposed to multiple rights violations along their journeys. An overview of this concept through the lenses of different organizations is well-presented by the Mixed Migration Hub.¹

The UN defines displacement from Venezuela as a 'mixed migration flow' of migrants and asylum seekers.¹ According to the Refugee Convention, a refugee has a well-founded fear of persecution for reasons of race, religion, nationality, membership in a social group, or political opinion.¹ While some displaced Venezuelans meet this definition, many do not, nor do they meet the conventional definition of a migrant, 'someone who voluntarily leaves their country of origin to seek a better life and who does not face impediments to returning home'.¹

An economic and political crisis, characterized by widespread and systemic human rights violations across the country -- has forcibly displaced nearly 5 million Venezuelans from their homes into host countries in the Americas region.¹ Although many displaced Venezuelans do not meet the international definitions of a refugee or migrant, they qualify as refugees under the less narrow definition in the Cartagena Declaration of 1984, which offers a more context-specific definition of a refugee applicable to the Americas region, extending legal protection to 'persons who have fled their country because their lives, security or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights, or other circumstances which have seriously disturbed public order'.¹

List of major categories of health needs and healthcare	
Sexual and reproductive health	<ul style="list-style-type: none"> • Family planning • Pregnancy and childbirth • Sexual and reproductive health of minors
Child health	<ul style="list-style-type: none"> • Acute illnesses • Nutrition, growth, and development • vaccinations
Communicable diseases	<ul style="list-style-type: none"> • Epidemic-prone diseases • Skin infections • Parasitic diseases • TB • STIs and HIV/AIDS
Non-communicable and chronic diseases	<ul style="list-style-type: none"> • Diabetes, cardiovascular and lung diseases • Arthritis • cancers
Dental health	<ul style="list-style-type: none"> • acute • prevention
Injuries	<ul style="list-style-type: none"> • Emergency care
Sexual and gender-based violence	<ul style="list-style-type: none"> • Prevention • Holistic care for survivors
Mental health	<ul style="list-style-type: none"> • Depression, prolonged grief disorders and suicide • PTSD and reactions • Substance use disorders • Perpetration of domestic or sexual violence

1. BACKGROUND: THE INTERSECTION BETWEEN HEALTH AND FORCED MIGRATION

This section introduces the intersection between health and forced migration to provide critical background information, key concepts, policies, and considerations associated with health and forced migration. These are key to understanding the approaches and priorities of forcibly displaced Venezuelans in the Americas region. We introduce health and forced migration, then turn to health needs and care in forcible displacement contexts. Lastly, we discuss the barriers to healthcare access displaced people face outside of their home country.

HEALTH AND FORCED MIGRATION

Over the last century, there have been significant improvements in health indicators worldwide. Progress in higher-income countries has improved life expectancy, and middle and lower-income countries have also seen steady improvements.¹ Life expectancy in Latin America, for example, increased from 68.2 to 74.5 between 1990 and 2017.² The factors that drive this global progress are relevant to analyzing the health of forcibly displaced persons.³ Generally speaking, improvements in health outcomes have not resulted from advancements in medicine. Instead, advances in the field of public health have fueled these developments.⁴

There are two notable streams of action that have been critical in improving public health outcomes: first; a variety of environmental improvements regarding water, sanitation, working conditions, housing, and other means of reducing health risks for the public, and second; the development of preventative health systems addressing, primarily, maternal, neonatal, and children's health through measures such as immunization, growth monitoring, and antenatal care.¹

Environmental and preventative health systems improvements commonly support public health, defined as the health of the community and population versus the individual.⁵ And while the roles of civil society and the private sector as they relate to supporting public health are increasing over time, the foundation for such activities related to public health outcomes remains the responsibility of the state and associated civic provision.⁶ State responsibility for public health logically impacts social and economic development; therefore, health investment is seen as a sound monetary policy that supports national interests.⁷

Understanding that health outcomes are linked with broader public health improvements and individual medical treatment is also why understanding state responsibility, capacity, and willingness to support public health is critical to understanding the health of forcibly displaced populations. Internally displaced persons (IDPs) and refugees are - according to various international, regional, and domestic

¹ Fiddian-Qasimiyeh, E., G. Loescher, K. Long and N. Sigona 'Health and forced migration' in Ager, A. The Oxford handbook of refugee and forced migration studies Oxford (2014) Oxford University Press

² OECD 'Life Expectancy at Birth' (2020)

³ Fiddian et al.

⁴ Ibid

⁵ Ibid

⁶ Ibid

⁷ Ibid

legal protection frameworks - owed state protection. Access to this protection, provision, and service systems of the state is fundamental to the entire population's health, including displaced persons. The health of displaced populations should not be viewed principally through the specific health risks associated with a person's migration experience. However, those may be considerable because health vulnerabilities are more closely linked with weak protection, poor provision of services, and associated impeded access to systems that result from their status as displaced people.

The factors shaping weak protection, provision, and access to health systems are a complicated mixture of state, institutional, and community interests.⁸ For example, in Chile, the law guarantees access to all levels of healthcare for the international migrant population. However, research indicates that the specific healthcare needs of refugees and asylum seekers are not adequately covered due to barriers in social integration, such as information about healthcare options and lengthy wait times for legal status determinations of refugees.⁹

Displaced persons' health is also a prerequisite for realizing solutions for their displacement through integration with local host communities, resettling elsewhere, or voluntary return home with safety and dignity. Health is also a prerequisite to realizing their fundamental human rights and rebuilding and recovering from their displacement journeys.

HEALTH NEEDS AND CARE PROVISION IN FORCIBLY DISPLACED CONTEXTS

Directly following a disaster or conflict that triggers a large-scale population movement, the most pressing health concerns tend to be around infectious disease and poor nutrition, which reflects the disruption of access to adequate clean water, sanitation facilities, and food supply, respectively. These risks tend to be associated with the displaced person's journey, though often will pre-date such conditions. In the case of Venezuela, however, a combination of various internal factors, notably economic collapse and corruption, coupled with increasing violence and insecurity, are driving forced displacement in a more prolonged manner instead of conditions that trigger a mass exodus seemingly overnight. This is a critical distinction in analyzing the vulnerabilities and needs of displaced Venezuelans compared with other displaced populations. Health needs differ in emergency interventions.¹⁰

Another key to understanding the contributing factors to the health of refugees and migrants in host countries is the concept of the so-called 'healthy migrant' effect posited by Fennelly.¹¹ This essentially illustrates the trajectory of the health status of migrants who may initially be in better health than is typical for hosting communities, to a decline in health status that often then goes below that of the host population. Spitzer's research in 2011 elaborates further on the healthy migrant effect, demonstrating that migrants' initial health advantage is generally related to factors linked with mobility, including economic standing and educational attainment. Over time, however, such standing may decline, with diet implicated as a significant factor. The urban underclass's high fat, low vegetable diets into which many migrants and refugees assimilate increase the risk of chronic conditions such as heart disease, stroke, and diabetes. These deficient diets, combined with restricted access to healthcare due to immigration status and an increasing evidence base that suggests it is the 'embodiment' of the

⁸ Ibid

⁹ Carreño-Calderón A, Cabieses B, CorreaMatus ME (2020) Individual and structural barriers to Latin American refugees and asylum seekers' access to primary and mental healthcare in Chile: A qualitative study

¹⁰ Van Praag, Oriana 'Understanding the Venezuelan Refugee Crisis' The Wilson Center (2019)

¹¹ Fennelly K. The "healthy migrant" effect. Minn Med (2007 Mar).

experience of exclusion and marginalization dramatically and negatively affects displaced persons' health, making for poor long-term outcomes.¹²

Resettling refugees versus persons immigrating due to economic motives tend to be inadequately vaccinated, have nutritional deficiencies, and struggle with infectious diseases such as schistosomiasis, hepatitis, various infections, and a range of mental health ailments. Those seeking to immigrate for economic motives rather than fleeing violence, persecution, or other human rights abuses tend to have had access to better healthcare during their lives and are living with less risk of exposure to many vulnerabilities that would increase health-related needs.¹³ So, while refugees may not experience the 'healthy migrant' effect, they are vulnerable to the drivers and threats of declining health associated with their resettlement or integration.

These are trends that also hold in the Americas region. Due to the increasing complexity of displacement contexts and the diversity of migrant populations, the problem of overlapping medical conditions further challenges appropriate interventions. Polymorbidity, often arising at an early life

Globally, forcibly displaced populations are increasingly facing the triple burden of chronic non-communicable diseases (e.g., diabetes, cardiovascular diseases, respiratory conditions, and cancer), infectious diseases (e.g., tuberculosis, HIV, hepatitis), and psychiatric illnesses (e.g., post-traumatic stress disorder, depression).¹

stage has become a risk factor among displaced people in some regions. The impact of community-acquired infections leading to intensive care unit admission appears to be much higher in refugees in host countries than in the autochthonic population.¹⁴

Mortality rates among the displaced are higher for the entire migrant population; however, the people most vulnerable to premature death are typically children, with women facing increased risk due to biological and social factors. 'Biology is responsible for women's higher risk of reproductive tract infections and infants' unique dietary needs. Sociocultural norms may dictate that women have little control over financial resources and transport.'¹⁵ Older, forcibly displaced people also experience increased exposures that may exacerbate pre-existing physical ailments and negatively experience the disruption of support networks.¹⁶ Data examining the health needs of older, displaced persons in humanitarian settings is sorely lacking and requires further and more systematic research.¹⁷

BARRIERS TO ACCESSING HEALTHCARE FOR DISPLACED PERSONS IN HOST COUNTRIES

It is crucial to support improved health outcomes for refugees and others displaced outside their home countries, both before and during flight. The design of health interventions must acknowledge the

¹² Ibid

¹³ Fiddian et al.

¹⁴ Abbas et al. 'Migrant and refugee populations: a public health and policy perspective on a continuing global crisis' (2018)

¹⁵ Al Gasseer N, Dresden E, Keeney GB, Warren N. Status of women and infants in complex humanitarian emergencies. J Midwifery Womens Health (2004 Jul-Aug)

¹⁶ Abbas et al

¹⁷ Fiddian et al

mental and physical health risks and structural barriers a displaced person experiences when integrated into a host community or having reached a temporary residence and be complementary to the state services provided to those who qualify or can afford them.

Legal and economic barriers to healthcare access reflect national policies and resettlement conditions, as not every country in the Americas region offers universal access to healthcare. Thus, an individual's legal status and economic status are the two main factors that determine whether a displaced person has access to required healthcare. Elements such as language and availability of translation services, combined with trust in health service providers, are also critical factors affecting whether displaced persons can receive health care and the quality of that care.¹⁸

Social factors additionally influence health outcomes for displaced persons. Such determinants include lifestyle, diet, and expectations around clinical encounters or presentation of health needs.¹⁹ Additionally, there is increasing recognition that social conditions related to marginalization and discrimination influence the health of refugees and other displaced persons., Realities such as disconnection from the community, downward employment mobility, and experiencing racial harassment all contribute to social stress that exacerbates pre-existing or new mental health conditions, as well as physical suffering.²⁰ Analysis of social determinants of health strongly supports the correlation between income inequality and mortality at the population level.²¹ An anthropological analysis of the marginalization of refugees and displaced persons, a concept also known as 'othering' or viewing and treating displaced persons as 'less than' or 'outsiders,' underscores the vulnerabilities of displaced persons, notably around mental health.²²

¹⁸ Ibid

¹⁹ Ibid

²⁰ Asgary, Ramin, and Nora Segar. "Barriers to Health Care Access Among Refugee Asylum Seekers." *Journal of health care for the poor and underserved* 22.2 (2011)

²¹ Ibid

²²Grove, N. J. & Zwi, A. B. 'Our health and theirs: Forced migration, othering, and public health.' *Social science & medicine* (2006).

2. CONDITIONS INSIDE VENEZUELA DRIVE EXTERNAL MIGRATION, INCREASE HEALTH AND SAFETY VULNERABILITIES OF DISPLACED PERSONS

Between the start of the Venezuelan displacement crisis in 2015 and October 2021, approximately 5.19 million refugees and migrants from Venezuela have moved outside their country of origin. Some 4.87 million are hosted in the Latin America and Caribbean region. According to the UN High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM), the Venezuelan external displacement is the largest in recent history in Latin America and the Caribbean and remains ongoing to date.²³

As a point of comparison, since the onset of the Syrian humanitarian crisis in 2011, over 6.8 million Syrians have fled the country. According to UNHCR statistics—the Venezuelan displacement is the second-largest ongoing displacement of refugees and migrants worldwide, followed by Afghanistan, South Sudan, and Myanmar.²⁴

However, the displacement crisis in and from Venezuela has not received the same international attention as the displacement and humanitarian crises in Syria, Afghanistan, South Sudan, and Myanmar. In part, this is because pre-existing legal frameworks do not easily categorize the Venezuelan displacement as a pure refugee response, and the economic status of many of the hosting countries is relatively strong.²⁵ These two elements, linked with increasing humanitarian needs worldwide, particularly the recent Afghanistan humanitarian and displacement emergency, contribute to a perception that Venezuelan migrants have a comparatively less humanitarian need and do not require the resources and attention other situations may warrant.

According to the UN, as of June 2021, of the USD 1.44 billion required to meet the humanitarian needs of displaced Venezuelans in the region, only USD 378.5 million or 26.3 percent of the funds has been raised for humanitarian response efforts.

ECONOMIC COLLAPSE

As of September 2021, around three-fourths, or 76.6% of Venezuelans residing inside Venezuela, live in extreme poverty, up from 67.7% the prior year.²⁶ Such a rise is attributed to the COVID-19 pandemic and chronic fuel shortages. At least 20% of respondents reported they could not put gasoline in their cars, a significant barrier to income generation and access to healthcare and related services.²⁷

Years of economic mismanagement coupled with high levels of official corruption and a stark decline in oil prices between 2013-2016 contributed to the current economic crises of widespread poverty, chronic food shortages, medicine, and other necessities. In other words, deteriorating human rights conditions associated with fundamental rights *inter-alia* has led to an 'inadequate standard of living for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in the circumstances beyond his control' leading to

²³ InterAgency Coordination Platform for Refugees and Migrants from Venezuela (R4V)

²⁴ UNHCR 'Refugee Statistics'

²⁵ Van Praag

²⁶ Reuters 'Extreme Poverty in Venezuela rises to 76.6%- study' (2021)

²⁷ Ibid

forcibly displaced Venezuelans seeking safety, rights, and more stable lives outside their home country.²⁸

The Venezuelan economy has contracted by 80% since 2012, with Financial Times labeling it one of the ‘most significant economic meltdowns in Latin American history.’²⁹ According to the International Monetary Fund (IMF), per capita gross domestic product dropped a staggering 87 percent over the past decade, from \$12,200 a year in 2011 to \$1,540 as of May 2021.³⁰ While there are signs at the time of this report that the Venezuelan economy may be turning a corner, it does not negate the loss of income-generating opportunities inside Venezuela.³¹ Such losses deprive Venezuelans the ability to meet daily food, nutrition, and other needs such as medicine, fuel, and rent/housing, forcing them to rely on harmful coping mechanisms such as eating half or quarter portions of a meal to ensure each family member had some food to eat and skipping doses or entire treatments of medicine and visits to medical providers.³²

CONSEQUENCES OF ECONOMIC COLLAPSE: PUBLIC INFRASTRUCTURE AND SERVICES

In addition to negatively impacting individuals, the impact of the Venezuelan economic crisis has magnified a general collapse of the country’s public infrastructure and services, yielding other health and related consequences for the Venezuelan population.³³ For example, the national electricity system has been experiencing problems since 2017, which has implications for hospitals, growing more severe in 2019, with one NGO documenting 23,860 power failures nationwide between January and May 2019, an average of more than 158 per day.³⁴ During 2019, there were also four nationwide electrical blackouts, in which the majority of the country was left without electricity for several days. In response, the government launched an electricity rationing plan that mandated daily, three-hour power cuts affecting an estimated 18 million Venezuelans and hundreds of schools and hospitals.³⁵ In practice, the cuts tended to be much longer and more frequent than as outlined in their plan, with some cuts lasting more than a week.

Relatedly, access to water was and remained a severe problem. A study by the news site *Prodavinci* found that 9.78 million people had their water rationed during 2016 and 2017, receiving it an average of two days a week. The situation continued to worsen in 2018, with 38 percent of households receiving water just a few days a week and 33 percent receiving it once a week or less, compared to 23 percent in 2017. Additionally, 23 percent of the households did not have access to potable water.³⁶

CONSEQUENCES OF ECONOMIC COLLAPSE: HEALTH AND FOOD SECTORS

The consequences of such problems are also most acute in the health and food sectors. Venezuelans are eating less often and less healthfully. Food is both incredibly scarce and expensive, resulting in alarming rates of malnourishment—nearly four times that experienced under the previous

²⁸ Article 25 Universal Declaration on Human Rights

²⁹ Bloomberg ‘Maduro’s Reluctant Reforms May Hald Venezuelan Economic Freefall’ (2021) I

³⁰ Financial Times ‘Has Venezuela’s Economy Bottomed Out?’ (2021)

³¹ Ibid

³² International Rescue Committee ‘Needs Assessment Report: Venezuelan Migrants in Colombia: expansion’ (2018)

³³ Van Praag

³⁴ Lopez, Aixa ‘En Los Primeros Cinco Meses de 2019 hubo a Diario 158 Fallas Electricas’ (2019)

³⁵ Prodavinci ‘Las Horas Oscuras’ (2019)

³⁶ Encovi ‘Encuesta Nacional de Condiciones de Vida 2018’ (2018)

Chavez administration. In 2018, the NGO Caritas found that 65% of children in poor neighborhoods were malnourished or at risk of becoming so, and more than 13 percent suffered from moderate or severe acute malnutrition. Such incidence was even higher among pregnant women, with 28 percent documented as having moderate acute malnutrition and 21 percent severe acute malnutrition.³⁷

The national healthcare system has fully collapsed, linked to the country's economic collapse. Medicine imports decreased by 70 percent between 2012 and 2016 due to price controls, a dysfunctional currency exchange system, and rising debt.³⁸ In October 2018, the Venezuelan Pharmaceutical Federation announced that 85 percent of essential medicines were scarce, meaning that Venezuelans were only able to find about one and a half out of every ten medications they required.³⁹ Those most impacted by such medicine shortages were patients requiring acute, long-term care for conditions such as cancer, cardiac disease, and other chronic illnesses such as HIV and AIDS. An internal UN document from 2019 reported that the lives of 300,000 people were at risk because they had not received the medicine they required for more than one year.⁴⁰ Hospitals and other medical facilities can only operate sometimes and not fully. A 2019 National Hospital Survey found that half the medication and 27 percent of the supplies needed in operating rooms around the country were not available, with operating rooms in use 27 percent of the time, intensive care units in use 40 percent of the time, and emergency rooms 85 percent.⁴¹ The burden associated with the lack of supplies and medicine falls on the patients and their families, already struggling to find food to survive. Consequently, many patients die from preventable causes.

The collapse of the public health system also has consequences for managing infectious diseases, including some previously controlled or even eliminated. Between 2007 and 2015, one single case of measles was documented in Venezuela. Since June 2017, however, there have been more than 9,900 cases of measles reported, with 6,700 cases confirmed, 79 of which have been fatal.⁴² Likewise, there were zero cases of diphtheria between 2006 and 2015, but more than 2,800 cases were reported, 1,700 confirmed, and of those, 286 were fatal since then.⁴³ Malaria has skyrocketed into an endemic, with close to 36,000 cases recorded in 2009 and over 414,000 cases in 2017. Tuberculosis is also rising, from 6,000 cases in 2014 to 13,000 cases in 2017, the highest in forty years.⁴⁴ HIV/AIDs statistics are also concerning. A joint Human Rights Watch/Johns Hopkins University report found that Venezuela was the only country in the world where large numbers of people living with HIV have been forced to discontinue their treatment due to a lack of medicine. A 2018 government report found that 9 out of every ten people registered for antiretroviral medicine treatment were not receiving it. The numbers are likely higher.

HUMAN SECURITY AND HUMAN RIGHTS VIOLATIONS

In addition to migration drivers associated with the collapse of the economy and related public health failures, people fled the country due to extremely high levels of violence and insecurity. Venezuela has been documented as one of the most violent countries in Latin America over the last six years. In 2015

³⁷ During the prenatal stage, not having enough nutrients can lead to birth deficiencies and developmental challenges, the inability of a breastfeeding mother to lactate. They may place the mother's health at risk

³⁸ Barrios, Douglas 'Venezuela: Anatomía de un Colapso' (2018)

³⁹ Silva, Jose 'Fefarven Advirtio que existe un 85% de desabastecimiento de Medicinas' (2018)

⁴⁰ Nichols, Michelle 'Venezuelans facing unprecedented challenges, many need aid' (2019)

⁴¹ Medicos por la Salud 'ENH 19: Ecueta Nacional de Hospitales' (2019)

⁴² PAHO 'Epidemiological Update Measles' (2019)

⁴³ PAHO 'Reseña sobre situaciones relacionadas con el acceso a la salud atendidas en CAREF en contexto de COVID-19' (junio 2020)

⁴⁴ Ibid

And 2016, Venezuela ranked as the second most violent country in Latin America with 59 homicides per 100,000 people⁴⁵. In 2017, Venezuela became the most violent place in the region, with 89 homicides per 100,000 people on average.⁴⁶ According to the Venezuelan Observatory of Violence, there were 81.4 violent deaths per 100,000 people in 2018- again the highest rate in Latin America.⁴⁷ Slightly dipping to 60.3 homicides per 100,000 people in 2019, Venezuela remained the most violent place in Latin America.⁴⁸ In 2020, Jamaica passed Venezuela on the list of the most violent countries in Latin America with 46.5 homicides per 100,000 people, though Venezuela was a close second, averaging 45.6 homicides per 100,000 people.⁴⁹ The UN considers any homicide rate of 10 per 100,000 citizens or above to be an epidemic.⁵⁰ The Venezuelan people have been experiencing a violence epidemic—in the eyes of the international community—for at least the past six years, which coincides with one of the largest displacements the region has ever experienced.

Among the documented homicides over the past year, the rise in extra-judicial executions (EJEs) is especially worrisome. EJEs are defined as killing a person by governmental authorities outside of any formal judicial or legal process. According to international law, they are unlawful under all circumstances as codified in every major human rights instrument attaining *jus cogens* status as a non-derogable norm. In 2017, the government created a rapid-response unit to combat organized crime and drug trafficking, the Special Action Forces (FAES). The group is cited by the UN High Commissioner for Human Rights (OHCHR) as carrying out repeated EJEs, 205 in 2018 and 275 in the first quarter of 2019 alone, in the context of security operations in poor neighborhoods.⁵¹ Those numbers are also expected to be much higher.⁵²

EJEs are one component of a larger pattern of government repression of civil and political rights, excessive force by security forces against peaceful protesters, and high rates of arbitrary arrest during the protests of citizens the authorities perceived were advocating for Maduro to be overthrown.⁵³ Detention, torture, and cruel treatment have been well-documented by OHCHR, and adhering to the rule of law is problematic for a government actively repressing its own citizens.⁵⁴

Thus, the state of Venezuela, through the commission of extrajudicial executions well-documented by reputable human rights organizations, violates its binding international legal obligations and is in breach of the law.⁵⁵

This unhealthy reality has forced Venezuelans to flee from such deprivation and violence to another country for survival and meeting basic human needs.⁵⁶

CONCLUSION

⁴⁵ Insight Crime 'Homicide Roundups 2016-2019.'

⁴⁶ Ibid

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ Ibid

⁵⁰ UNODC 'Global Study on Homicide: Homicide Patterns, trends and criminal justice response' (2019)

⁵¹ Human Rights Council 'Report of the UN High Commissioner for Human Rights on the situation of Human Rights in the Bolivarian Republic of Venezuela' (2019)

⁵² Ibid

⁵³ Ibid

⁵⁴ Ibid

⁵⁵ Aceves, William J 'When Death Becomes Murder: a Primer on Extrajudicial killing' (2018)

⁵⁶ International Rescue Committee 'Needs Assessment Report: Venezuelan Migrants in Colombia: expansion' (2018)

A complex web of political problems inside Venezuela, including corruption, resource mismanagement, and violence, creating conditions that deprive the Venezuelan populations of access to *inter-alia* safety, electricity, water, and money, has a severe knock-on effect on residents' health and wellbeing. Their displacement journey introduces additional risk factors.

The Venezuelan people's fundamental human rights – enshrined in the Universal Declaration of Human Rights (UDHR), and binding international legal obligations the state of Venezuela has acceded to under the International Covenant on Civil and Political Rights (ICCPR) as well as the International Covenant on Economic, Social and Cultural Rights (ICESCR) related to *inter-alia* an inadequate standard of living, health, income-generating opportunities, safety, even the right to move around freely has been effectively deprived of them by the State.

3. THE RIGHT TO HEALTH: INTERNATIONAL LEGAL OBLIGATIONS AND FRAMEWORKS

This section analyzes healthcare as a human right under international law to underscore the fundamental human right to health that all people, regardless of their nationality, gender, ethnicity, are entitled to under the law. More importantly, it provides analysis associated with the Inter-American System of Human Rights, the Americas regional mechanism for human rights promotion and protection.

HEALTHCARE AS A HUMAN RIGHT: INTERNATIONAL LAW

The right to health, otherwise ‘the right to the enjoyment of the highest attainable standard of physical and mental health,’ is a fundamental human right on its own under international law and is also a component of the right to live a dignified life. First articulated in the 1946 WHO constitution, the right to health is defined in its preamble as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.’⁵⁷ It further elaborates that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.’⁵⁸ The customary Universal Declaration of Human Rights (UDHR) confers the right to health through article 25 as part of the right to an adequate standard of living, and the right to health was further enshrined in article 12 of the binding 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). There is no derogation clause in the ICESCR, and the UDHR is considered customary. Therefore the right to health is a non-derogable international legal obligation states have that they may not breach under any circumstances. Since the ICESCR, additional human rights treaties such as the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities have articulated the right to health, or elements of it, such as the right to medical care, for particularly vulnerable groups. There is human rights treaty monitoring bodies, and in 2002 the WHO and what is now known as the Human Rights Council created the mandate of the Special Rapporteur to bring attention to the right of everyone to attain the highest standard of physical and mental health. Such progress at the international level, according to OHCHR, has helped clarify the nature of the right to health and how it can be achieved.⁵⁹

The right to health also has a knock-on effect related to realizing other human rights. This means that, on the one hand, violation of one’s right to health may impair the ability to enjoy other fundamental rights such as the right to education or work. On the other hand, supporting the realization of the right to health enables people to gain an education or skills training to assist with employment or helps them in overcoming or managing mental health conditions and trauma that may negatively impact their lives.

⁵⁷ WHO ‘Constitution of the WHO’ (2006)

⁵⁸ WHO ‘Constitution of the WHO’ (2006)

⁵⁹ OHCHR/WHO ‘The Right to Health Fact Sheet no. 31’

What does the right to health entail according to international law?

1) It is an inclusive right. This means that it is not just related to access to healthcare and the building of medical facilities; it is related to a much more holistic definition of an ability to live a healthy life. The Committee on Economic, Social, and Cultural Rights (the main treaty monitoring body for the ICESCR) outlines 'underlying determinants of health' that are equally critical components of realizing the right to health.

Such determinants include:

- Safe drinking water.
- Safe food.
- Adequate nutrition and housing.
- Healthy working and environmental conditions.
- Health-related education and information.
- Gender equality.¹

2) The right to health contains freedoms, including being free from non-consensual medical treatment, such as medical experimentation and research, forced sterilization, the right to be free from torture, and other cruel, inhuman, or degrading treatment.¹

3) The right to health contains entitlements:

- The right to a health protection system provides equality of opportunity for everyone to enjoy the highest attainable level of health.
- The right to prevention, treatment, and control of diseases.
- Access to essential medicines.
- Maternal, child, and reproductive health.
- Equal and timely access to essential health services.
- The provision of health-related education and information.
- Participation of the population in health-related decision-making at the national and community levels.¹

4) Health services goods and facilities must be provided to all free from discrimination of any kind.

- Non-discrimination is not only a cardinal principle with regards to human rights protection and realization but also critical to the enjoyment of the right to the highest standard of health.¹

5) All services, goods, and facilities must be accessible, acceptable, and of good quality.

- In terms of availability, this means that states must have sufficiently available facilities, goods, and services.
- In terms of accessibility, the facilities and services must be physically accessible and safe for all, including people with disabilities, children, older persons, and other vulnerable groups, and financially accessible and free from discrimination of any kind. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format- including for those with disabilities, but done in a manner that does not impair the right to have personal health data treated confidentially.
- Acceptable means the facilities, goods, and services should respect medical ethics and be gender-sensitive and culturally appropriate.¹
- Good quality means the healthcare must be scientifically and medically appropriate. This requires skilled and well-trained healthcare professionals, scientifically approved and unexpired drugs and hospital equipment, proper sanitation facilities on site, and safe drinking water.¹

THE INTER-AMERICAN SYSTEM OF HUMAN RIGHTS

The Latin American regional human rights framework for promoting refugee protection maintains the integrity of international refugee law while effectively leveraging international human rights law to expand rights protection and promotion for people in need. The hospitable approach by Latin American states toward people in need of protection to include displaced persons is institutionalized through the Organization of American States (the “OAS”) and its organs to include the OAS General Assembly, the Inter-American Commission on Human Rights (“The Commission”) and the Inter-American Court of Human Rights (“The Court”).

Related regional legal frameworks include the American Convention on Human Rights (ACHR) and the American Declaration on Human Rights (ADHR). Taken together, these respectively provide treaty and charter-based instruments for the people, states, and institutions of the Americas to utilize continued protection for refugees and other people in need throughout the region.

Over the past three decades, there has been a global trend toward increasingly illiberal approaches, including restrictive policies affecting refugees and asylum seekers vis a vis refugee law and policymaking. However, against this backdrop is the approach taken by Latin American states, which appears to “buck this restrictive trend.”⁶⁰

From an institutional perspective, the OAS and its Charter birthed and now comprise the totality of the contemporary Inter-American system, which is renowned among transnational human rights structures for championing international human rights law. All 35 independent states of the Americas are currently members of the OAS, and the organs most relevant to the protection of asylum seekers and refugees are the governing General Assembly. It has adopted several critical resolutions concerning protecting refugees and asylum seekers in the region, the Commission, and Court. Both the Commission and the Court have sculpted a crucial framework for protecting asylum-seekers and refugees through the creative interpretation of the regional human rights framework developed by the OAS, with the main instruments being the OAS Charter, the ADHR, and the ACHR.

Examining the language used throughout these legal instruments defining scope and applicability underscores the steadfast commitment of Latin American states toward human rights promotion and protection. For refugees and others displaced or otherwise experiencing a human rights abuse, the Inter-American system is available to promote and protect human rights well beyond the last resort “safety net” of international refugee law because the language is framed around every person being entitled to rights as opposed to orienting the right toward a narrow subset of people.

The right to health in the Inter-American System of Human Rights is well codified through various binding and non-binding instruments such as the American Declaration on the Rights and Duties of Man and the Cartagena Declaration. A landmark ruling by the Inter-American Court of Human Rights recognizes the ‘right to a healthy environment’ issued on 6 February 2020, so it is clear that the right to

⁶⁰ Cantor, D.J. ‘Bucking the trend? Liberalism and illiberalism in Latin American refugee law and policy in Cantor, D.J., L.F. Freier and J. Gauci(eds) *A liberal tide? Immigration and asylum law and policy in Latin America* (2015)

health is a fundamental right under international law and further enshrined in regional legal frameworks and jurisprudence of concern to this research.⁶¹

4. CRITICAL HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN THE AMERICAS REGION

DATA AVAILABILITY AND CHALLENGES WITH HEALTH DATA COLLECTION ON DISPLACED PERSONS

It is challenging to secure publicly available data associated with the health needs of displaced persons for several reasons. This reality is also reflected in our estimation that the data in this report is not comprehensive.

Inside Venezuela, the government has suppressed public health data for at least two years, and it is very difficult to ascertain conditions and well-being of those externally displaced as well as the current health of the remaining population inside

Venezuela.⁸² The collapse of the public health system, which includes national disease surveillance, has exacerbated this data gap. Consequently, the state of Venezuelans' health before their displacement cannot be confirmed, presenting challenges for host communities and countries to prepare supportive reception and living conditions for those seeking refuge within their borders.

For reasons primarily linked to safety and security, some displaced persons also prefer to remain undocumented and are thereby not included in health/population data collection efforts. This is not unique to the health sector, nor the Americas region; instead, this is a trend across all displacement contexts related to violence and insecurity.

REGIONAL TRENDS

As of January 2022, of the approximately 6.04 million refugees and migrants from Venezuela outside of



⁶¹ Tigre, Maria Antonia 'Inter-American Court of Human Rights Recognizes the Right to a Healthy Environment (2020)

their country of origin, some five million are hosted in the Latin America and Caribbean region.⁶² The number of displaced Venezuelans in the Americas region is therefore approximately equivalent to the populations of Ireland or New Zealand in 2021.⁶³ The two countries outside of Latin America that host the highest numbers of displaced Venezuelans are Spain and the United States. Taken as a whole, this is the most significant movement of refugees and migrants in the recent history of Latin America and the Caribbean.

Analysis indicates that 2022 will see an increase in the forced displacement of Venezuelans from inside Venezuela to reach nearly 8.9 million people from 6.05 million as of the end of 2021.⁶⁴ Those in need of humanitarian assistance is expected to markedly increase from 4.6 million people in need across the region to 8.4 million, and the UN response planners anticipate 3.82 million of

According to the UN's Regional Refugee and Migrant Response Plan for 2022 (RMRP 2022), the humanitarian needs of displaced persons in the Americas region will continue to grow throughout 2022. Their needs will continue to be exacerbated by the secondary effects of COVID-19, notably linked to economic downturns, coupled with governance and human rights-related challenges.

8.4 million people to be in need by the end of the year.⁶⁵ This means that needs are growing and outpacing the capacity of the UN humanitarian system to respond, underscoring the urgency of increased strengthening of public institutions and overall governance capacity to respond. However, many pass-through Colombia *en route* to other destinations, primarily Peru and Ecuador.

Starting in March 2020, countries across the world, including the Latin America and Caribbean region, instituted measures to curb the spread of the COVID-19 pandemic, including border closures and movement restrictions that significantly limited the regular flow of refugees and migrants from Venezuela. As a result, there is an increase in irregular migration flows to date, with displaced Venezuelans becoming even more vulnerable due to their loss of already limited economic and social support, impacting their health and well-being.

In densely urban areas, physical distancing is nearly impossible, leading to additional stigma by host communities, including negative perceptions associated with a fear of spreading viruses.

Latin American countries have been relatively successful in providing a comprehensive vaccine response (non-COVID-19), to the extent that some displaced persons were receiving the same vaccination multiple times during their displacement journey. In a show of solidarity and support for Venezuela's displaced, regional countries announced in October 2019 that they would collaborate to reduce vaccine duplications while ensuring all displaced Venezuelans in the region were vaccinated. The RMRP 2022, drawing from data shared by health ministries, reports that COVID-19 vaccines were administered to more than 477,139 refugees and migrants from Venezuela in Bolivia, Brazil, Colombia, Ecuador, and Peru. Thirty percent (144,152) have received total doses of the vaccine. Unfortunately, this number does

⁶² InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'Explanatory Note for November's Venezuelan Refugee and Migrant Figures' (2021)

⁶³ World Population Review 'Total Population by Country- Venezuela'

⁶⁴ InterAgency Coordination Platform for Refugees and Migrants from Venezuela (R4V)

⁶⁵ Ibid

not near that needed to provide sufficient vaccine coverage for the entirety of displaced Venezuelans in the region.⁶⁶

A growing number of countries have reported increased inclusion of displaced persons in national vaccine plans. According to the IOM, five out of seven countries in North America, Central America, and the Caribbean immunize refugees and asylum seekers, alongside five out of nine countries in South America.⁶⁷ The Colombian government has provided vaccines to the recently regularized Venezuelans. In Peru, authorities have opened a vaccination registry for displaced persons regardless of their status. In Trinidad and Tobago, the authorities have stated that migrants have access to vaccines available to all country residents.⁶⁸ Other countries are not transparent about their plans to include displaced Venezuelans in national vaccine programs. Argentina, for example, requests proof of regular stay or a national identity card.⁶⁹

Unfortunately, the health needs of displaced Venezuelans go well beyond vaccinations, and access to other types of healthcare is mainly inconsistent country-by-country and relatively poor across the region. Between 2018 and 2019, IOM's nonrepresentational surveys indicated that between 5 and 15 percent were suffering from chronic diseases or other health conditions in the handful of countries receiving Venezuelans for which data is available.⁷⁰ One of the main distinctions between nations and the ability of displaced persons to access healthcare is whether the government has universal health care or requires health insurance. While, in theory, displaced persons can access emergency health care in nearly all countries in the region, there are differences in how countries define care. Most definitions would not meet the holistic health needs of the displaced population.⁷¹

The RMRP also indicates that the pandemic has increased the need for mental health and psychosocial support (MHSPSS) and clinical care for rape and intimate partner violence survivors due to the increase of such incidents across the region. Providing quality sexual and reproductive health services for women of reproductive age and care for survivors of gender-based violence is another growing need across the region.

One significant indicator of whether and to what degree displaced Venezuelans can access the healthcare they need in host countries is the legal status and associated right to stay parameters that the host authorities confer on the displaced individuals. Latin American countries have generally welcomed displaced Venezuelans; however, reception conditions and related policy and practice to support displaced Venezuelans vary by states' obligations under international, regional, and domestic legal protection frameworks. The RMRP 2022 indicates that increased irregularity of status coupled with the continued forced displacement from Venezuela and compounding contextual elements associated with economic insecurity impacts displaced persons' ability to access healthcare and well-being support is required to start to recover and rebuild their lives after a period characterized by extreme uncertainty, an ongoing pandemic, other public health concerns, and mobility across national borders.

⁶⁶ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

⁶⁷ Arceta, Dinorah 'COVID-19 Vaccines for Displaced people in Latin America and the Caribbean' (2021)

⁶⁸ Ibid

⁶⁹ Ibid

⁷⁰ Selee, A; Bolter, J 'An Uneven Welcome: Latin America and the Caribbean responses to Venezuelan and Nicaraguan Migration' Migration Policy Institute (2020)

⁷¹ Ibid

COVID-19 EXACERBATES VULNERABILITIES OF FORCIBLY DISPLACED PERSONS WHO HAVE CHALLENGES ACCESSING TREATMENT AND VACCINES

The COVID-19 pandemic has created additional challenges for the world's inhabitants, with marginalized populations and other people with pre-existing vulnerabilities experiencing disproportionately adverse effects. These consequences span not only health but a range of different indicators such as socio-economic impacts.

The collapse of informal economies and loss of jobs across the region during COVID-19 has exacerbated inequalities across Latin American and Caribbean countries and has increased

health inequalities among migrant communities.⁷² Such an economic downturn and loss of income have resulted in many refugees and Venezuelan migrants lacking money for rent and being forced into homelessness.⁷³

Displaced persons in the Americas region have been disproportionately affected by the secondary economic effects of COVID-19, such as:

- Low rates of economic inclusion.
- Limited access to social protection systems.
- Lack of support networks.
- Discrimination.
- Legal exclusion.
- Lack of knowledge of administrative processes.

COVID-19 cases rose sharply during the summer of 2021 in several countries in the Latin American region, despite relatively significant progress in vaccination efforts. Such rises in case numbers have led governments to reinstate or implement new movement restrictions, consequently impacting Venezuelans' ability and associated rights to flee their homes and seek safety in another location.

The growing militarization of borders in the region, border closures, and deportations from Chile and countries in the Caribbean, have altered the migratory landscape, potentially in breach of international legal obligations associated with the cardinal refugee law principle of non-refoulement. Such border closures, deportations, and militarization have prompted the InterAmerican Commission on Human Rights (IACHR) to release a statement calling on states in the Americas to adopt migration and border management policies that incorporate human rights approaches.⁷⁴ The UN Special Rapporteur on the Human Rights of Migrants issued a statement calling on Chile to cease the arbitrary and collective expulsion of migrants, and UNHCR and IOM issued a report on the need for safe pathways for refugees and migrants following a shipwreck in the Caribbean in which at least two displaced Venezuelans died.^{75 76}

For displaced women, sexual and gender-based violence was further exacerbated in the context of lockdowns. Older displaced persons and those with disabilities also experienced minimal access to healthcare, as well as food, during the pandemic.

⁷² Zambrano-Barragán P, Ramírez Hernández S, Freier LF, Luzes M, Sobczyk R, Rodríguez A, Beach C. The impact of COVID-19 on Venezuelan migrants' access to health: A qualitative study in Colombian and Peruvian cities.

⁷³ UNHCR 'Data Reveals Plight of Venezuelan Refugees and Migrants Evicted in Pandemic' (2021)

⁷⁴ OAS 'IACHR Calls on States in the Americas to Adopt Migration and Border Management Policies that incorporate a Human Rights Approach' (2021)

⁷⁵ OHCHR 'Chile: Arbitrary and Collective Expulsion of Migrants must stop- UN Experts' (2021)

⁷⁶ UNHCR/IOM 'Latest Caribbean Shipwreck tragedy underscores the need for safe pathways' (2021)

There is no straightforward, systematic regional approach to COVID-19 treatment and vaccine access. Even as the states include displaced persons in national vaccine programs, there is no confirmation that Venezuelans are gaining access due to a lack of data and disaggregated public health data.⁷⁷ Access to COVID-19 treatment is directly correlated to legal status and generalized access to public healthcare facilities or the ability of individual persons to fund very costly private medical treatment.

LEGAL STATUS IS KEY TOWARD ACCESSING PUBLIC HEALTH AND OTHER STATE-PROVIDED SERVICES

Across every single context examined, access to healthcare due to irregular immigration status frequently resulted in the exclusion from comprehensive healthcare coverage. If a country has a universal healthcare policy in place or not, possessing legal status through inter-alia residency permits is the leading indicator of the likelihood of displaced Venezuelans accessing their right to healthcare in any given country context.

Without the appropriate legal authorization to reside in a host country, this research found that many displaced Venezuelans resort to harmful coping mechanisms to secure adequate resources to survive. Some of these coping mechanisms have a direct effect, others a secondary or tertiary impact, on the displaced person's health. For example, survival sex can result in increased STIs/HIV transmission rates and mental trauma. Child labor can result in exploitation and abuse of minors, and street begging can result in exposure to the risk of sexual and gender-based violence, unsanitary conditions, or exposure to infectious diseases. Displaced Venezuelans may resort to these harmful coping mechanisms to survive without a reliable income. Lack of legal status prevents state-provided healthcare and other services such as primary education for children and social security. This limits the capacity to focus on recovering and regaining control of their lives.

WOMEN AND GIRLS

This research shows that without access to legal status, the ability of displaced Venezuelans to access healthcare and other services is extremely hamstrung if not prohibited in many contexts. Supporting displaced Venezuelans in the Americas region to secure legal status in their host context is a collective priority for governments, donors and the rest of the international community as will be detailed further in our recommendations.

According to the evidence examined for this study, displaced women and girls, especially if they are traveling alone, face increased health and safety risks and require more frequent specialized care to improve their health outcomes. Gender-based violence, pervasive before COVID-19, has increased exponentially due to lockdowns, economic downturns, and increased worldwide mobility and exploitation. In the Americas region, heightened border controls and movement restrictions to curb the spread of COVID-19 has forced women, girls, and other vulnerable groups to take unsafe routes to seek safety in host communities and has further increased the risk of gender-based violence to include rape,

⁷⁷ Arceta

survival sex, various forms of sexual exploitation, and human trafficking.⁷⁸ To note, young men, are also increasingly resorting to survival sex as a coping mechanism along transit routes.⁷⁹ Intimate partner and domestic violence are also a continued concern. Associated access to psychosocial care is sorely lacking across the region. With public health institutions already under significant strain due to COVID-19 case management, increased risk and incidence of sexual violence, unmet humanitarian needs, and xenophobia have led to heightened stress and a deterioration in psychological well-being, particularly among displaced persons engaging in sex work, living in situations of prostitution, transgender women and people living with HIV.⁸⁰

OTHER POPULATION GROUPS WITH VULNERABILITIES

Many elderly migrants experience chronic conditions such as cardiac disease, liver/kidney disease, cancer, or diabetes, exacerbated by poor access to nutrition and require regular medical treatment and occasional additional living assistance. This study found that regardless of the ability to access public healthcare treatment for such chronic conditions legally, the state capacity to provide treatment is sorely lacking. State resources do not match the demand and those without legal status are the first restricted from access.

Likewise, for disabled, displaced Venezuelans, access to specialized healthcare is severely limited or unavailable. They may also face unique challenges in accessing the information and resources to inform them of their healthcare options. Foreexample, children with learning disabilities are not accessing the specialized care they require to become self-sustainable eventually; people with differing cognitive abilities are challenged in understanding health access information in the standard format it is provided.

- *Elderly persons*
- *People with disabilities*
- *Members of the LGBTQI community*
- *Indigenous Peoples*
- *Unaccompanied and/or separated children*

Members of the displaced LGBTQI+

Venezuelans face additional vulnerabilities and healthcare needs compared to heterosexual, cisgender displaced persons. This study identified two main areas for support of this displaced community, one linked to other mental health and psychosocial support to address ongoing discrimination and xenophobia targeted at displaced Venezuelans. The second need is to prevent and treat STIs, including HIV/AIDS. These services were lacking in nearly every geographic context examined.

The presence of displaced Indigenous peoples from Venezuela is nearly invisible in the data yet confirmed by NGO sources. These Venezuelans are significantly neglected by 'traditional' service providers due to culture, location of residence, and language. The UN has identified displaced Indigenous peoples from Venezuela as one of the groups experiencing a disproportionately negative impact from discrimination, language barriers, lack of technical capacity, and visibility, and are a vital population demographic to target for health interventions and culturally sensitive support.⁸¹

⁷⁸ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2020' (2020)

⁷⁹ Ibid

⁸⁰ Ibid

⁸¹ Ibid

Lastly, unaccompanied children and adolescents on the move were found to have additional vulnerabilities linked to the high prevalence of irregular migratory status across the region.⁸² Displaced Venezuelan unaccompanied children and adolescents also face increased risk of violence, abuse, exploitation, and neglect, including recruitment by armed groups and child labor, while also being at heightened gender-based violence risk, trafficking, smuggling, discrimination, and exposure to COVID-19. Children and adolescents often lack access to national education systems, policies, and other essential services such as water and sanitation, nutrition, and child protection services.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Across every geographic context examined for this study, mental health care and psychosocial support were significantly lacking given the documented prevalence of mental health conditions among displaced Venezuelans, particularly women and girls, and youth of all genders.

Displaced persons from Venezuela likely have experienced trauma at home and additional stress related to their displacement journeys, settlement, and integration. Common mental disorders were identified among displaced Venezuelans at rates higher than host country nationals. Such conditions include depression, anxiety, and post-traumatic stress disorder (PTSD). Many displaced persons lack access to mental health services or experience significant barriers linked to accessing them and face the risk of disruptions in continuity of care that can have profound, adverse outcomes on a patient, escalating to increased suicidal ideations.⁸³ Addressing the mental and physical healthcare needs of displaced Venezuelans and the communities hosting them will undoubtedly be vital to unlocking the potential for displaced Venezuelans to recover from trauma and start to rebuild their lives and plan for the future.

CHRONIC CONDITIONS

As this study demonstrates, the state's capacity in the Americas region to meet its obligations to confer the right of health under international law to all those residing within their geographies is deficient. Practically speaking, states lack sufficient development resources to offer all public healthcare and other public services. This strain has resulted in widely inconsistent policies and practices associated with access to public healthcare and services for chronic conditions requiring regular access to treatment, such as cardiac, liver, or kidney disease, diabetes, HIV/AIDS, and cancer. Even countries such as Chile with universal healthcare policies cannot meet the demands placed on public health institutions by their citizens, not to mention displaced persons, forcing difficult policy decisions regarding who has access, centering on one's legal status. This reiterates how critical access to legal status in host countries is associated with access to medical care and is nearly interchangeable.

HUMAN RIGHT TO HEALTH: NOT REALIZED FOR DISPLACED VENEZUELAN IN THE AMERICAS REGION

While this study is not a legal analysis per se, it is evident that the fundamental human right to health for displaced Venezuelans is not being met. What is also clear, however, is that while displaced Venezuelans are often discriminated against—either legally for not having a status or socially through xenophobia for being from Venezuela—all states in the Americas region are struggling to support the

⁸² UNICEF 'Children on the Move, including Venezuelans and communities affected by COVID-19, Appeal'

⁸³ WHO 'Mental Health and Forced Displacement' (2021)

the human right to health for even their citizens due to COVID-19 pandemic and related secondary effects, notably economic downturns. Therefore, our recommendations essentially articulate development-oriented solutions, including public health system strengthening and expanded legal stay options for displaced persons that should be prioritized as sustainable solutions are urgently required.

5. CONTEXT-SPECIFIC DATA ON HEALTH NEEDS OF DISPLACED VENEZUELAN IN THE AMERICAS REGION

The following section outlines how the region has approached receiving displaced Venezuelans by identifying positive and problematic approaches and then provides country-specific data on health needs from countries in the Americas hosting high numbers of displaced Venezuelans. We review countries with universal healthcare policies and then explore countries with insurance systems. An examination of barriers to access healthcare, as well as the specific health needs of displaced Venezuelans in host countries, is included in each section, providing as much data as is available, noting the limitations associated with access to health data of displaced persons generally, and of Venezuelans, in particular.

REGIONAL RESPONSES ⁸⁴

Most countries in the region have relatively low entry requirements; notably, for Venezuelans, this is shifting.⁸⁵ Several countries, such as **Chile, Ecuador, Peru, and Trinidad and Tobago**, have started requiring visas which are challenging for fleeing Venezuelans to obtain. Additionally, **Ecuador and Peru** have implemented new passport requirements for permits. As documented by the Migration Policy Institute in 2020, such conditions indicate that they are not slowing migration but have redirected many migrants from legal to illegal routes, which are more dangerous. Displaced persons are faced with risks associated with smugglers, human traffickers, and others intent on exploiting the displaced population for personal profit.⁸⁶ Efforts to harmonize regional policy and practice have therefore largely failed, resulting in inconsistent

TABLE 1
Entry Requirements for Venezuelans in Case-Study Countries, 2015 versus 2019

	Visa Required in Advance for Entry?		Passport Required for Entry?		Accepts Expired Passports from Venezuelans for Entry? (December 2019)
	End of 2015	December 2019	End of 2015	December 2019	
Argentina	No	No	No	No	Yes, national identity documents or passports that expired within the past two years
Brazil	No	No	No	No	Yes, passports that expired up to five years prior
Chile	No	Yes	Yes	Yes	Yes, passports issued in 2013 or later that have expired, until April 18, 2021
Colombia	No	No	Yes	Yes	Yes, passports that expired up to two years prior
Costa Rica	No	No	Yes	Yes	No, but will accept passports within a day of expiring
Ecuador	No	Yes	No	Yes	No
Guyana	Yes	No*	Yes	No*	No*
Mexico	No	No	Yes	Yes	No
Peru	No	Yes	No	Yes	Yes, passports that expired before August 28, 2018 accepted until August 28, 2023, and passports that expired August 28, 2018 or later accepted for up to five years after their expiration date
Trinidad and Tobago	No	Yes	Yes	Yes	No
Uruguay	No	No	No	No	No

* In theory, Venezuelans need a visa and a (valid) passport to enter Guyana, but in practice, this is not enforced. Sources: Argentine National Migration Administration, "Disposición 520/2019," *Boletín Oficial de la República Argentina*, no. 34,046 (January 31, 2019); 47–48; *Voz de América*, "Brasil acepta pasaportes venezolanos vencidos," *Voz de América*, August 5, 2019; Chilean Ministry of the Interior and Public Security, "Chile aceptará pasaportes y cédulas vencidas de venezolanos" (press release, April 22, 2019); Colombian Ministry of Foreign Relations, "Resolución Número 0872" (resolution, March 5, 2019); Costa Rican General Administration of Migration and Foreigners, "Resolución N° AJ-060-04-2019-JM," *La Gaceta: Diario Oficial*, no. 109 (June 12, 2019); 5–7; *El Tiempo Latino*, "Gobierno de Perú acepta pasaportes venezolanos vencidos," *El Tiempo Latino*, March 2, 2019.

⁸⁴ Table 1, source: Selee, A; Bolter, J "An Uneven Welcome: Latin America and the Caribbean responses to Venezuelan and Nicaraguan Migration" Migration Policy Institute (2020)

⁸⁵ Ibid

⁸⁶ Ibid

approaches by governments that result in inconsistent access to healthcare and other support services.⁸⁷

WELCOMING THE DISPLACED: POSITIVE PRACTICES

Several countries, including Colombia, Ecuador, Peru, and to a lesser degree, Trinidad and Tobago, have initiated mass regularization campaigns to confer Venezuelans legal status, **Brazil**, through *Resolução Normativa CNIG No. 126* of March 2017, provides Venezuelans temporary residence for two years.⁸⁸ **Argentina** and **Uruguay** have been some of the most welcoming countries for displaced Venezuelans, providing them legal residence based on the MERCOSUR Residency Agreement in force since 2009.⁸⁹ A few countries have integrated special legal arrangements into their policy and practice to better support displaced Venezuelans. In **Peru**, for example, the *Permiso Temporal de Permanencia (PTP)* has been granting temporary residence permits to Venezuelans since January 2017.⁹⁰ **Colombia** initially took a similar approach, introducing a temporary permit, *Permiso de Permanencia (PEP)*, and Border Mobility Cards in 2017. However, both programs have been suspended. Last year, **Colombia alternatively issued** a Temporary Statute of Protection, allowing displaced Venezuelans to acquire a resident visa for ten years.⁹¹ Chile announced the entry into force of the 'Visa of Democratic Responsibility' for Venezuelan citizens in April 2018.⁹²

WELCOMING DISPLACED PERSONS: PROBLEMATIC APPROACHES

When the Venezuelan displacement surged in 2015, migrants could enter nearly all Latin America / MERCOSUR countries without obtaining a visa before traveling and could also enter about half of the countries in the region without a passport. Such ease of movement resulted from about two decades of regional work to engage integration through mobility agreements. Such agreements were critical to supporting displaced Venezuelans to access a place of refuge. It would have been expensive, complex, and therefore prohibitive for many Venezuelans fleeing to obtain such required documentation in advance.⁹³ While there have been pledges and commitments by regional countries to keep borders open to welcome displaced Venezuelans through the Quito Process, a non-binding regional cooperation forum, such promises have not been fully realized, and COVID-19 measures have added additional complications.

Ecuador, Mexico, and Panama did not make any additional legal arrangements to receive and benefit displaced Venezuelans, instead choosing to provide legal stay using pre-existing immigration categories, leading to mixed results.⁹⁴ In **Mexico**, most applications for refugee status have been accepted, though the significant backlog of cases coupled with reports of forced returns and extortion by Mexican border officials does little to support the rights and protection of displaced Venezuelans, nor does it appear to be in line with Mexico's binding legal obligations to offer protection and support to displaced persons

⁸⁷ Ibid

⁸⁸ Ibid

⁸⁹ Acosta, Diego, and Luisa F. Freier. 2015. "Turning the Immigration Policy Paradox Upside Down? Populist Liberalism and Discursive Gaps in South America." *International Migration Review* 49

⁹⁰ Parent, Nicolas 'Falling short of Protection; Peru's new migration scheme for Venezuelans' *Forced Migration Review* (2017)

⁹¹ Yayboke, Erol 'Colombia Makes History by Offering Protective Status to Displaced Venezuelans' *Center for Strategic and International Studies* (2021)

⁹² Freier, Luisa Feline 'Understanding the Venezuelan Displacement Crisis' (2018)

⁹³ Fundación Arias para la Paz y el Progreso Humano 'la Represión al Exilio: Nicaragüenses en Costa Rica (San Jose, Costa Rica: Fundación Arias para la Paz y el Progreso Humano, 2019).

⁹⁴ Freier

under the Cartagena expanded definition of a refugee.⁹⁵ In theory, **Ecuador** provides a temporary residence for Venezuelans for two years through the UASUR visa scheme. Additionally, Venezuelans can gain temporary residence through the *2011 Estatuto Migratorio Ecuador-Venezuela*, provided they demonstrate the ability to support themselves financially. Access to such visas is costly at USD 50 for the visa application fee and USD 500 for the visa itself. More restrictive measures have been imposed by countries such as **Panama**, notably through Decree No. 473 (effective 1 October 2017) and Decree No. 269 (effective 31 May 2017), adding visa requirements for Venezuelan citizens and shortening the amount of time they may remain in the country. Countries that are politically aligned with the Maduro regime in Venezuela such as **Bolivia** and **Ecuador** deny the existence of a regional Venezuelan migration crisis and do not offer any special visas or assistance to displaced Venezuelans.⁹⁶

States wishing to adhere to their international legal obligations are struggling to manage an overwhelming number of asylum cases, putting a significant strain on various institutions. As such, asylum systems are ineffective for displaced Venezuelans to obtain permanent legal status, likely because of this high demand. However, the temporary status offered through the asylum application process and other mechanisms offer a shorter-term solution.⁹⁷

As a result of these measures, a little less than half of all displaced Venezuelans in the region had some form of legal status as of late 2019 and, as a result, had varying degrees of access to healthcare.

DISPLACED PERSONS' ACCESS TO HEALTHCARE AND HEALTHCARE NEEDS: COUNTRIES WITH UNIVERSAL HEALTHCARE POLICIES

Access to healthcare is a critical component to integrate displaced persons into host communities, and it serves the interests of both host communities and the displaced populations. Access to healthcare can prevent or mitigate new public health risks, especially during a global pandemic. Having access to healthcare supports the well-being of displaced persons to recover from their displacement journey and recover with the highest chance of success.

Argentina, Ecuador, Guyana, and Trinidad and Tobago have extended universal healthcare to all who need it. Practically speaking, their systems are overwhelmed and under-resourced, limiting the state's capacity to respond.

ARGENTINA

Argentina hosts the highest number of displaced Venezuelans in the Southern Cone subregion of South America, with approximately 281,000 Venezuelans living inside Argentina as of July 2021.⁹⁸ Argentina has faced a particularly acute and complex social and economic situation due to economic downturns exacerbated by the pandemic, resulting in over-burdened public institutions. There are challenges for the state to integrate displaced Venezuelans into public policies and systems.

HEALTHCARE ACCESS IN ARGENTINA FOR DISPLACED VENEZUELAN

⁹⁵ Ibid

⁹⁶ Ibid

⁹⁷ Selee, Bolter

⁹⁸ UNHCR 'Aspectos Claves Monitoreo de Protección -Venezolanos en Argentina- Julio-Diciembre 2019 (2019)

Argentina's healthcare system is divided into different levels – those with no health insurance, social security-funded care, and private care. The system is, again, overwhelmed and under-resourced. The Migration Policy Institute observes that when a universal system does not have the resources to cover everyone, host communities may perceive it as a scarce resource upon which migrants are encroaching.⁹⁹ In some contexts where universal healthcare is a national policy, local-level implementation of such policies is insufficient to meet needs. In Argentina, displaced persons may access all types of healthcare using an identity document from their home country. However, staff at healthcare centers often turn people with such 'foreign' documentation away, arguing that displaced persons are required to provide an Argentinian with an identity document to access healthcare. Similar denials of care due to perceived lack of appropriate documentation by local healthcare providers are also happening in Ecuador, even in emergencies.¹⁰⁰

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN ARGENTINA

Data on the health needs of displaced Venezuelans in Argentina and elsewhere in the Southern Cone is patchy, though a picture emerges of priority health needs. A 2019 UNHCR study interviewed 1,032 displaced Venezuelans in Argentina. It demonstrated that 8.9 percent live with critical chronic medical conditions, with 31.1 percent reporting health issues upon arrival to Argentina and 94.7 percent seeking medical care.¹⁰¹ This study also found that 9 percent of children suffered from medical conditions without identifying specific conditions. A separate 2019 study by UNHCRA interviewed 504 Venezuelans in Argentina. It noted that 13 percent of the participants suffered from a mental or physical disability, with 31 percent of women confirming a chronic mental health condition versus 13 percent of men. Most of these medical problems were related to ophthalmologic conditions, no statistics were reported, and no discussion on these pathologies.¹⁰²

Before the pandemic, Argentina was experiencing a surge in unemployment exacerbated by COVID-19 and is disproportionately affecting displaced Venezuelans without specific legal stay permissions.¹⁰³ Such a decline in livelihoods opportunities has resulted in more obstacles for displaced Venezuelans to access sustainable and suitable housing options, with many forced to live in poor conditions, including homelessness and lack of access to regular clean water, food, and other essentials that support a healthy and dignified life.¹⁰⁴

Food insecurity and associated harmful coping mechanisms facing displaced Venezuelans in Argentina affect their health and well-being. One study noted that the proportion of refugees and migrants who only had one meal a day or did not eat during the previous day increased 2.5 times compared to before the global pandemic.

¹⁰⁵

Physical distancing measures have increased the incidence of gender-based violence against women, girls, and LGBTQI+ people and have weakened child protection monitoring and response capacities. Domestic violence, sexual abuse, and labor exploitation are on the rise. Border closures and the increasing use of informal, more dangerous crossings force migrants to use smuggling networks,

⁹⁹ Selee, Bolter

¹⁰⁰ Ibid

¹⁰¹ <https://data2.unhcr.org/en/documents/details/73775>

¹⁰² UNHCR 'Aspectos Claves Monitoreo de Protección -Venezolanos en Argentina- Julio-Diciembre 2019

¹⁰³ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2021' (2021)

¹⁰⁴ Ibid

¹⁰⁵ Ibid

exposing Venezuelans attempting to reach Argentina to a range of additional vulnerabilities such as human trafficking, exploitation, and abuse.¹⁰⁶

The health crisis has also exposed Venezuelans in Argentina to immense stress due to prolonged isolation in overcrowded conditions and fear of the future, further exacerbated by limited access to psychosocial and mental health services.¹⁰⁷

The UN system in the Southern Cone countries, including Argentina, has identified that with weak public institutions, care for chronic conditions is inadequate, notably cancer requiring oncology treatments, infectious disease management for HIV/AIDS and other sexually transmitted infections (STIs), tuberculosis, diabetes, hypertension, and neurological illness.¹⁰⁸ In all four Southern Cone countries, Venezuelan women, children, and the elderly encounter significant delays in securing access to regular vaccines, controls, treatments, and medical examinations.¹⁰⁹

Sexual and reproductive health for women has also been identified as a particular concern by the UN and other actors. The pandemic and related lockdowns have prevented women from accessing needed pre-natal controls, medicines such as iron or folic acid, contraceptives including emergency contraceptives in cases of rape or incest, and access to professional counseling and other mental health support.¹¹⁰

CHILE

In 2020, Chile hosted the third-largest displaced Venezuelan population in the region; as of August 2020, according to the Chilean government, it is hosting 457,324 Venezuelans. Even though the country experienced social unrest throughout 2020, movement restrictions and secondary effects of COVID-19, Chile remains a destination for Venezuelans seeking a better future. The COVID-19 pandemic in Chile has severely impacted the economy, and these economic downturns and border closures have delayed regularization processes and negatively impacted livelihoods and income-generating opportunities for Venezuelans. As of November 2020, the unemployment rate in Chile reached its highest value in 10 years, leaving nearly 100,000 displaced Venezuelans without jobs. Vulnerabilities exponentially increase without an income, impacting mental and physical health, further exacerbated by a lack of documentation.

HEALTHCARE ACCESS IN CHILE FOR DISPLACED VENEZUELAN

Although Chilean law guarantees access to all levels of healthcare for the international migrant population based on a mechanism of the Public Health Insurance Fund (FONASA), the specific healthcare needs of refugees and asylum seekers are not adequately covered. Primary care and mental healthcare were the most requested services for displaced Venezuelans, yet they appear to be the most difficult to access. Barriers to social integration upon arrival, including access to healthcare, housing, education, and lengthy wait times for legal status, reduce effective healthcare provision. Healthcare workers and members of other organizations indicate the need for more information about refugees and

¹⁰⁶ UNHCR (June 2020), "Documento de políticas del Secretario General sobre la COVID-19 y las personas en movimiento".

¹⁰⁷ Ibid.

¹⁰⁸ PAHO 'Reseña sobre situaciones relacionadas con el acceso a la salud atendidas en CAREF en contexto de COVID-19' (Junio 2020).

¹⁰⁹ Ibid.

¹¹⁰ Gallo Marin B, Amaya A, Medina Perez G, Levine AC, Moretti K, Garbern SC. A scoping review of non-communicable diseases and maternal and child health needs of Venezuelan migrants in South America. *Journal of Global Health Reports*. 2

asylum-seeking populations, their rights, and conditions, as well as more effective and tailored healthcare interventions, particularly in emergency mental healthcare situations.¹¹¹

The lack of required Chilean civil status documentation to access public services and goods has had a reverberating effect on displaced Venezuelans' ability to secure appropriate healthcare, food, and housing. The UN has identified significant gaps in healthcare access information and rights for displaced Venezuelans. Hence, help for displaced Venezuelans to secure healthcare access documentation is a key challenge and opportunity.

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN CHILE

Like many countries in the region, border closures due to COVID-19 have increased irregular migration flows in Chile. Border authorities report that the smuggling of migrants increased by 53 percent between January and August 2020 compared to the same period in 2019. Economic downturns in Chile have also negatively impacted displaced Venezuelans, with the UN reporting an increase in Venezuelans selling their assets, sleeping on the streets, or resorting to begging. The more dangerous cross-border movements of irregular migration through arid and high-altitude regions of Arica, Parinacota, and Tarapaca result in the need for urgent medical care. Venezuelans frequently arrive without sufficient food and water, are exposed to extreme weather conditions day and night, and increased protection risks for women and children. Interestingly, the demographics of displaced Venezuelans entering Chile has diversified to include more unaccompanied and separated children, the elderly, people with chronic or critical diseases, people with disabilities, those living with HIV/AIDS, pregnant women, and members of the LGBTQI+ community.¹¹² Despite the government's vaccination campaign to include all foreigners. There are reports of displaced Venezuelans' documentation not being accepted for COVID-19 vaccines.¹¹³

Like Argentina and nearly every other country in the Americas, there is limited data on health, precisely the non-communicable health needs of displaced Venezuelans residing in Chile.

One in-depth study of children with Type 1 Diabetes indicates that medical care associated with improved knowledge on lifestyle management and access to medications significantly helped improve children's health. A UNHCR report from 2019 interviewed 769 displaced Venezuelans, with 11 percent reporting living with a disability, the most common relating to vision, followed by physical disabilities and hearing impairments. Eleven percent reported having a chronic medical illness, and 5 percent of children were found to have a medical condition without any specific pathologies identified.¹¹⁴

A survey from the National Institute of Statistics (INE) shows that many displaced Venezuelan patients have postponed medical treatments due to limited health facility capacity avoided facilities due to a fear of contracting COVID-19. Many cut back on healthcare costs due to income loss.¹¹⁵ In addition to chronic and other pre-existing conditions, many displaced Venezuelans in Chile faced increased health and protection risks working in dangerous situations.

The absence of health system mechanisms to deal with interculturality and tolerance are reported, and a lack of protocols for healthcare workers to understand and communicate the right of displaced

¹¹¹ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2021' (2021)

¹¹² Ibid

¹¹³ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹¹⁴ UNHCR 'Aspectos Claves Monitoreo de Protección -Venezolanos en Argentina- Julio-Diciembre 2019 (2019)

¹¹⁵ UNDP 'Encuesta de MDS-INE y PNUD revela impactos de la crisis en el desarrollo humano de los hogares Chilenos' (2020)

persons to access healthcare. This affects Venezuelans' health status and overall well-being, negatively impacting mental health.

In Chile, like many other contexts in the Americas region, there has been an increase in cases of women and children experiencing domestic violence and human trafficking, thus increasing health needs.

BRAZIL

Brazil hosts approximately 336,000 Venezuelans, the 6th overall largest displaced Venezuelan population in South America, following Colombia, Peru, Ecuador, Argentina, and Chile.¹¹⁶ As of March 2021, 144,996 Venezuelans have been granted temporary residence, 79,133 were seeking asylum, and 46,923 refugees were living in the country.¹¹⁷ Despite the border between Brazil and Venezuela remaining formally closed, the government eased entry restrictions for Venezuelans. The pandemic allowed for the regularization of those in vulnerable situations who had entered irregularly. However, processing temporary documentation has resulted in extreme administrative backlogs. The growing number of Venezuelans fleeing to Brazil contributes to regional public health concerns, notably the spread of infectious disease and increased burden on the health systems.¹¹⁸ Specific demographic subsets of displaced Venezuelans in Brazil have acute healthcare needs that are mainly going unaddressed due to weak public health institutions.

HEALTHCARE ACCESS IN BRAZIL FOR DISPLACED VENEZUELAN

In Brazil, primary healthcare is nominally available to Venezuelan refugees, asylum seekers, and Brazilian citizens alike through principles in the Federal Constitution and the law establishing the Brazilian Health System (Sistema Único de Saúde – SUS). The SUS, however, like many other health systems in the Americas, is under severe strain to meet the increased demand for care and is facing shortages in overall capacity, medicines, and supplies.¹¹⁹ Limited information exists on irregular migrants' ability to access healthcare under the SUS, but available data indicates it is doubtful, even for those with appropriate legal stay permissions.¹²⁰

Language barriers exist for displaced Venezuelan Spanish speakers within Brazil's official Portuguese-speaking administrative structures. If interpreters and materials are not available in the native language of the patient, access to healthcare at all levels is affected, from knowing how to make appointments to understanding medical information to adherence to treatments.¹²¹ Related cultural differences, socioeconomic barriers, xenophobia, and racism are also significant barriers in Brazil. People with disabilities face substantial physical, architectural, and ableist attitudinal barriers in healthcare services. These realities support the need for additional research on healthcare for disabled Venezuelans in Brazil.¹²²

¹¹⁶ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2021' (2021)

¹¹⁷ Ibid

¹¹⁸ Doocy S, Page KR, de la Hoz F, Spiegel P, Beyrer C. Venezuelan Migration and the Border Health Crisis in Colombia and Brazil. *Journal on Migration and Human Security*. 2019

¹¹⁹ Ibid

¹²⁰ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2021' (2021)

¹²¹ Serrano, Samantha; Martin, Denise 'Immigration, Disability and Healthcare Access in Brazil' *Disability Studies Quarterly* (Vol 41, No 2 – 2021)

¹²² Ibid

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN BRAZIL

According to the 2022 humanitarian health needs projections calculated by the UN-led health sector in Brazil, approximately 27 percent of households polled have members with chronic diseases. Of those, 43 percent could not access medical care. Twelve percent of households reported at least one person with a physical or mental disability, 38 percent of whom could not access care. Among households with sexual and reproductive health needs, 23 percent could not obtain contraceptives, 16 percent could not access sexually transmitted infection (STI) prevention/treatment services, and 19 percent of pregnant and lactating mothers received no prenatal care. Respiratory diseases including pneumonia, tuberculosis, and COVID-19 are among the leading causes of mortality in these communities.¹²³

Infectious diseases and the risk of further spread have been identified as a growing concern in the border regions. In a 2018 study, there were 10,274 cases confirmed along with 14 deaths, primarily linked to the border region.¹²⁴ The SINAN system in Brazil is a health-related system that tracks different health occurrences in the population and makes that data available to healthcare workers and policymakers for free. SINAN data from a 2015-2017 study evaluating the emergence of infectious diseases stemming from the Venezuelan displacement indicated that Sexually Transmitted Infections (STIs) were the most reported diseases.¹²⁵ HIV/Aids presented significantly higher in the Venezuelan population when compared to the Brazilian population ($p < 0.046$), as did leishmaniasis ($p < 0.049$) and malaria. Such an increase in infectious diseases and a lack of adequate disease management infrastructure is a significant concern for the health of both Brazilians and Venezuelans residing in Brazil.

There is limited data on people with disabilities, women, girls, unaccompanied children, and the elderly, indicating a need for more research. With immigration populations growing in Brazil and the arrival of displaced persons with disabilities, the probability of immigrants already in Brazil developing an impairment and the likelihood that immigrants have children with disabilities grows. There is also the possibility that certain immigrants develop or experience an increased impairment given the potentially precarious living and working conditions many displaced persons face due to lack of legal status, limited economic resources, and mental stress and strain.¹²⁶

While public education in Brazil is universal and accessible, including for refugee and migrant children regardless of immigration status, 22 percent of Venezuelan children and 27 percent of adolescents have not attended any school during the pandemic, meaning they have lost critical opportunities for meaningful engagement with peers, activities, and learning. Displaced Venezuelan children are more exposed to child labor, economic exploitation, early marriage, pregnancy, and forms of GBV. The increased vulnerabilities for children have relevance over their healthcare needs and overall well-being in Brazil, including mental health and psychosocial support.

¹²³ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹²⁴ Doocy S et al

¹²⁵ Mário Maciel de Lima Junior, Gabbrielle Almeida Rodrigues, Maysa Ruiz de Lima, Evaluation of emerging infectious disease and the importance of SINAN for epidemiological surveillance of Venezuelans immigrants in Brazil, The Brazilian Journal of Infectious Diseases, Volume 23, Issue 5, 2019

¹²⁶ Kempfer, M., & Martins, L. C. (2013). Trabalho escravo urbano contemporâneo: o trabalho de bolivianos nas oficinas de costura em São Paulo. *Revista Do Direito Público*, 8(3)

A qualitative study was conducted between November 2019 and February 2020 through 12 focus group discussions with 111 Venezuelan migrant women of reproductive age (18-49) at UNHCR-run shelters across the northwest border between Brazil and Venezuela to understand better the perspectives and views of displaced Venezuelan women related to their sexual and reproductive health. The following themes emerged in discussions with the women, focused on 1- healthcare for pregnant and postnatal women, 2- access to modern contraceptive methods, and 3- HIV and STI treatment. Researchers found general satisfaction regarding obstetric care, yet women reported challenges in language and understanding when it came to their first attempt to enter antenatal care, labor, delivery, and post-natal care. The women agreed that access to long-acting reversible contraceptives was difficult, which negatively impacted their ability to plan their reproductive lives, including mitigating against the risk of rape-induced pregnancy. This is worthy to note, considering the high rates of sexual and gender-based violence against displaced women transiting through informal border crossings, and is a key to supporting the sexual and reproductive health of displaced women.¹²⁷ Also noted was the predominance of 'traditional gender imbalances' in the relationships observed, as such attitudes are a barrier for displaced women to protect themselves against HIV/STIs.¹²⁸

Across Brazil, COVID-19 measures adopted to curb the spread of the pandemic have increased the economic vulnerabilities of displaced Venezuelans, as in every other country in the Americas. Overcrowded living and working facilities, poor water and sanitation, and the inability to acquire nutritious food have health repercussions for people, affecting those with pre-existing vulnerabilities and conditions. Pregnancy or lactation, the needs of infants and young children, people with disabilities, and chronic medical conditions are worsened in the migratory environment.¹²⁹ The UN has found that families with children and lactating mothers are particularly at risk of undernourishment and stunting, exposing them to illness and damaging their physical and cognitive development. There are also heightened instances of domestic violence, sexual exploitation and abuse, trafficking, and harmful coping mechanisms such as begging and survival sex.¹³⁰

Brazil is also experiencing a marked deterioration in food security which disproportionately affects those with fewer financial resources. Once considered an upper-middle-income country, Brazil was removed from the World Food Program's Hunger Map in 2014, a critical global tracker worldwide of food insecurity indicators. Less than seven years later, when faced with a mass influx of displaced persons from Venezuela and the economic downturns of COVID-19, more than half of Brazil's 212 million population is struggling with some degree of food insecurity, and nearly one in ten suffering from severe hunger. In June 2021, the WFP reported that more than 19 million people faced severe food insecurity in Brazil. This is the data demarcation for the infusion of significant resources and interventions to mitigate against the population falling into greater food insecurity levels akin to famine and starvation, which take time to manifest.¹³¹

ECUADOR

RMRP data for 2022 indicates that in Ecuador, the primary humanitarian needs of Venezuelans are access to food (87 percent), followed by employment/livelihoods (65 percent), accommodation/shelter

¹²⁷ Maria Y. Makuch, Maria Jose D. Osis, Cinthia Brasil, Helder S.F. de Amorim, Luis Bahamondes 'Reproductive health among Venezuelan migrant women at the northwestern border of Brazil: A qualitative study' *Journal of Migration and Health*, Volume 4 (2021)

¹²⁸ Ibid

¹²⁹ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2021' (2021)

¹³⁰ Ibid

¹³¹ Alves, Lise 'Pandemic puts Brazil back on the world hunger map' *The New Humanitarian* (2021) p

(53 percent), and access to health services (25 percent).¹³² The length of time spent in Ecuador correlates to increasing needs associated with education and documentation. Of the 46 percent of families with school-aged children, 32 percent reported children were not attending any school, and 5.3 percent of family groups including elderly members, 9.3 percent including people with disabilities, and 18.5 percent with chronic health conditions.

HEALTHCARE ACCESS IN ECUADOR FOR DISPLACED VENEZUELAN

According to UNHCR, as of April 2021, 29 percent of refugees and migrants from all countries of origin living in Ecuador do not have healthcare services.¹³³ While Ecuador allows access to public health services to all regardless of nationality or residency status through their 2008 Constitution, such access is inconsistent. Those with irregular status tend to shy away from accessing the formal health system due to fear and isolation. Xenophobia is also present in Ecuador and affects the ability of Venezuelans to access public institutions alongside Ecuadorians and others.

Ecuador has a robust information system to support migrant health access through a Ministry of Health-managed system, “Daily Automated Registry of Outpatient Consultations and Care” (RDACAA), which monitors migrants’ access to health services. This registry collects and stores information on the displaced person’s country of origin, visits to health service locations across Ecuador’s provinces, the types of services received, and the total number of displaced persons visiting each institution. Further, a Community Epidemiological Surveillance system tracks the analysis and interprets health data systematically and continuously.

In 2021 the Ecuadorian authorities announced a new regularization exercise to support the legalization/right to stay of displaced Venezuelans residing inside Ecuador. This is currently in the planning phase, with its launch scheduled for 2022. This is a promising development that will support the medium- and long-term health needs of those Venezuelans seeking to reside in Ecuador.

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN ECUADOR

Ecuador has had high rates of COVID-19 infections, significantly affecting the entire population. Like many other countries, the government issued a state of emergency to restrict movements and immigration. This meant that the only option for Venezuelans to access Ecuador was through informal crossings, exposing them to additional physical and mental vulnerabilities and risks. Hospitals and other medical facilities have been exceptionally overcrowded due to COVID-19, resulting in a reduction of care for non-COVID patients requiring regular treatment for chronic conditions and routine medical care, including vaccine access for preventable diseases such as tuberculosis.¹³⁴

Venezuelans in Ecuador experience poor living and working conditions because of their relatively poor economic status and the overall poor economic status of the country, compounding unfavorable healthcare outcomes. A 2019 survey of displaced Venezuelans conducted in Ecuador indicated that 10 percent of people surveyed suffered from chronic diseases, and 72 percent mentioned experiencing emotional distress during the year.¹³⁵ This suggests significant mental health and psychosocial needs across the Venezuelan population residing in Ecuador.

¹³² InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2021’ (2021)

¹³³ UNHCR ‘UNHCR Ecuador-Health’ (2021)

¹³⁴ International Association for Medical Assistance to Travelers ‘Ecuador’ (2022)

¹³⁵ InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2022’ (2022)

Food insecurity in Ecuador is rising due to COVID-19.¹³⁶ In 2022, the UN regional response plan estimates that over 73 percent of the displaced Venezuelan population in Ecuador do not have enough food and continue to lose jobs and livelihoods at an alarming rate.¹³⁷ Such food insecurity and harmful coping mechanisms such as missing meals can contribute to nutritional diseases and eventually starvation, disproportionately affecting those with pre-existing vulnerabilities, advanced aged, unaccompanied children and infants, female-headed households, pregnant and lactating mothers, and those with disabilities. During 2018-2019, UN partners working on the northern border carried out nutritional screenings of Venezuelan children on the move to identify the primary needs of children under five years old. Twenty percent of children under the age of two were stunted, and 3 percent were acutely malnourished. Thirty percent were found to have anemia, and only 63 percent of children under two years old were breastfed.¹³⁸

As of 2021, the UN estimates that 65 percent of women in Ecuador have experienced some type of violence throughout their lifetimes, and 32 percent over the last year. About half of the Venezuelans attempting to enter the country are female. Additionally, NGO assessment data demonstrated that 14.3 percent of the respondents were aware of incidents of GBV experienced by Venezuelans on their displacement journey; of the total respondents, 74 percent reported being aware of physical violence, 27.3 percent were aware of sexual violence, and 19.35 percent reported awareness of other types of violence.¹³⁹ Additional data demonstrates that 30 percent of women from Venezuela experience some violence themselves in host counties. Survivors avoid accessing public institutions for care and legal support for fear of potential discrimination/stigmatization and fear of reprisals.

CARIBBEAN

The Caribbean countries of Aruba, Curacao, the Dominican Republic, Guyana, Trinidad and Tobago host some of the highest concentrations of refugees and migrants per capita worldwide. For Venezuelans, the Caribbean is one of the farthest destinations for displaced Venezuelans absent the United States.

Such a lengthy journey exacerbates pre-existing health conditions and risks the imposition of new health risks.¹⁴⁰ According to the RMRP 2022, each of these five countries is expected to continue to receive new arrivals from Venezuela despite movement restrictions imposed by authorities to curb the spread of the COVID-19 pandemic and other entry restrictions.¹⁴¹ UN estimates are that by the end of 2022, the Caribbean will host approximately 225,500 Venezuelans.¹⁴² Joint humanitarian needs analysis for 2022 indicates that existing socio-economic and structural inequalities in the Caribbean region (and the broader Americas region) have significantly increased due to the COVID-19 pandemic and have negatively impacted the living conditions and overall health of refugees and migrants from Venezuela as well as their host communities. Business activity has markedly decreased, resulting in lost income and increased living costs in many Caribbean countries. Employment, medical care, and legal assistance for displaced persons from Venezuela manifested as acute needs throughout 2021, as food security and shelter emerged as a priority, leaving many families unable to meet basic human needs and facing

¹³⁶ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2020' (2020) ¹³⁷

InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022) ¹³⁸ Ibid

¹³⁹ CARE 'Análisis Rápido de Género- Ecuador' (2019)

¹⁴⁰ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹⁴¹ Ibid

¹⁴² Ibid

evictions.¹⁴³ Particularly affected populations include displaced Venezuelans living in rural areas alongside host Indigenous communities.¹⁴⁴

HEALTHCARE ACCESS IN THE CARIBBEAN SUB-REGION FOR DISPLACED VENEZUELAN

Caribbean countries hosting the most significant number of displaced Venezuelans include Aruba, Curacao, the Dominican Republic, Guyana, Trinidad and Tobago. Despite movement restrictions instituted by Caribbean states to manage and prevent the spread of COVID-19, Venezuelans continue to journey to the Caribbean in search of a better life, and most states are keeping their borders open to allow displaced Venezuelans seeking refuge a regular channel of entry and making available relevant stay permissions versus forcing them to take irregular, more dangerous routes.¹⁴⁵

All Caribbean countries are developing domestic legislation and policies related to refugees and migrants, including trafficking persons laws increasing legal protections for displaced Venezuelans in the sub-region. Obtaining the legal right to stay and associated work permits are challenges for Venezuelans in the Caribbean, affecting their access to healthcare. Insurance and other monetary requirements for healthcare are also becoming increasingly prohibitive.

Before the influx of Venezuelans, Caribbean countries already had strained public institutions inclusive of healthcare. The arrival of over 223,000 to the sub-region places additional burdens on the public health system.¹⁴⁶ Social elements impact displaced Venezuelans' health and well-being, such as cultural and language barriers with English, French, Portuguese, and Spanish spoken throughout the region. Xenophobia is particularly acute in the Caribbean due to misperceptions that displaced Venezuelans are 'stealing' public resources from local citizens, especially during the pandemic. Because most Venezuelans residing in the Caribbean are in an irregular migration status, lacking formal documentation from their host country, their needs are not captured in public health reporting and assessments, lessening or masking the actual conditions.

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN THE CARIBBEAN

The Caribbean's geography comprises small island nations with unique risk factors as Venezuelans seek safety in the sub-region. Displaced persons require boats to cross the Caribbean, compromising their safety with dangers such as human trafficking, an acute problem in the region. The ramifications for displaced Venezuelans' health and well-being include increased risks of sexual violence, child labor, economic exploitation by smugglers, and other criminal networks, potentially resulting in loss of resources and further injury or illness on these water journeys.¹⁴⁷ Government denial of entry or other non-admission of Venezuelans is documented in Curacao, Aruba, and Trinidad and Tobago.

Due to COVID-19 restrictions, many displaced Venezuelans residing in Caribbean countries have lost their livelihoods, like food insecurity, malnutrition, and safe shelter needs have increased. The UN system

¹⁴³ Ibid

¹⁴⁴ Ibid

¹⁴⁵ Ibid

¹⁴⁶ Ibid

¹⁴⁷ Ibid

has reported that Venezuelans are failing to meet basic needs and are facing eviction.¹⁴⁸ While some countries have established social relief packages to support vulnerable people during the pandemic, undocumented Venezuelans continue to be excluded and must depend on humanitarian assistance to survive.

Gender-based violence (GBV) and other risks to human rights infringement combined with increased mental distress have heightened the need for mental health and psychosocial support for displaced Venezuelans in the Caribbean region, as observers witness harmful coping mechanisms such as the use of survival sex to pay for a female-headed household's children's food as a means of last resort.¹⁴⁹

DISPLACED PERSONS' ACCESS TO HEALTHCARE AND HEALTHCARE NEEDS: COUNTRIES WITH INSURANCE SYSTEMS

Countries such as **Colombia, Peru, and Costa Rica** do not have universal health systems, although public insurance options are available, with some offering limited access for displaced persons.

COLOMBIA

HEALTHCARE ACCESS IN COLOMBIA FOR DISPLACED VENEZUELANES

As of August 2021, Colombia is hosting 1.84 million displaced Venezuelans, more than any other country in the region.¹⁵⁰ Displaced Venezuelans in Colombia face significant obstacles to accessing public services, including healthcare and earning livelihoods to meet their basic needs. These conditions are exacerbated by a lack of documentation and widespread irregularity of status.

Colombia has a public healthcare system available for free to everyone regardless of immigration status and an additional private system accessible through public insurance. Available services through the public healthcare system include vaccinations, prenatal care, emergency care, and community-driven, "collective interventions."¹⁵¹ The Colombian government's definition of emergency care is relatively extensive. However, it lacks resources to implement programs that meet the demand fully. To access other healthcare outside of what is available for free, people in Colombia have options to join the public health insurance system, purchase private insurance, or pay out-of-pocket for care. For Venezuelans to access care through insurance beyond what the state offers, they must have the legal right to stay in Colombia. This means that PEP holders, immigrants with regular status, and asylum seekers can access these added, paid benefits; however, women and children who have fled with nothing and require specialized care beyond state-provided free options may not access the care they need due to immigration status. UN estimates are that 77 percent of the

¹⁴⁸ Ibid

¹⁴⁹ Ibid

¹⁵⁰ Ibid

¹⁵¹ Measure Evaluation 'Collective Intervention Records, Module 11'

current displaced population is not affiliated with the national health insurance system, including the 26 percent of households with at least one member documented as having a chronic condition.

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN COLOMBIA

According to the National R4V Platform in Colombia conducted in June 2021, 77 percent of surveyed Venezuelan households in Colombia lacked access to healthcare, 26 percent of children lacked access to education of any kind, 24 percent of households faced food insecurity, 25 percent consumed poor quality water, 36 percent lived in overcrowded conditions and 31 percent were at risk of eviction due to the inability to pay rent and utilities.¹⁵² Inclusion of displaced Venezuelans in the government's national COVID-19 vaccination plan is currently a challenge. Despite the Colombian government offering Venezuelans access to vaccines regardless of their legal status, vaccination coverage for Venezuelans in Colombia remains very limited, with only an estimated 5.3 percent of the population having received at least one dose.¹⁵³

The high number of displaced Venezuelans residing in Colombia or seeking to transit through and the ongoing humanitarian responses associated with international coordination infrastructure makes this a more data-rich environment. Most studies in Colombia on the health needs of displaced Venezuelans focus on chronic diseases and obstetric health.¹⁵⁴ A 2018 cross-sectional study surveyed 175 Venezuelans living in Barranquilla, Colombia (a border region with Venezuela), revealing that 30.7 percent self-reported suffering from chronic pain, followed by 19.8 percent citing depression, 10.9 percent hypertension, and 8.5 percent asthma. A little over 4 percent reported cardiac pathologies and diabetes. None reported suffering from cancer, although 31.5 percent reported suffering from a medical emergency while living in Colombia.¹⁵⁵

Maternal and child health is a growing concern for displaced Venezuelans in Colombia. In 2019, the Colombian Ministry of Health reported that the number of Venezuelan migrant births has increased from 5,561 births in 2017 to 52,635 in 2019.¹⁵⁶ There is no analysis to explain this upward trend. However, it is logical to assume that as Venezuelans increased in Colombia, the birth rate would increase. Data indicates that a 215 percent increase in maternal morbidity occurred during this period, a 132 percent increase in perinatal mortality, and a 138 percent rise in maternal mortality. UNHCR further reported a 76 percent rise in low birth weight among Venezuelan infants born in Colombia between 2017 and 2019. The International Planned Parenthood Federation and *Profamilia* jointly reported in 2019 that half of all maternal deaths in Colombia were among Venezuelan migrants. Venezuelan migrants in Colombia are at heightened risk for diabetes, hypertension, asthma, epilepsy, and psychiatric conditions. Still, we find no discussion on prevalence, morbidity, and mortality for these conditions.¹⁵⁷ Similarly, 61 percent of pregnant Venezuelan women seeking care at a Save the Children emergency health clinic on the Colombian-Venezuelan border have presented with high risk

¹⁵² InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹⁵³ *Ibid*

¹⁵⁴ Gallo Marin B, Amaya A, Medina Perez G, Levine AC, Moretti K, Garbern SC. A scoping review of non-communicable diseases and maternal and child health needs of Venezuelan migrants in South America. *Journal of Global Health Reports*. 2021

¹⁵⁵ Fernández-Niño, Julián Alfredo et al 'Modos de vida y estado de salud de migrantes en un asentamiento de Barranquilla' *Revista de Salud Pública* (2018)

¹⁵⁶ International Planned Parenthood Federation 'Evaluación de las necesidades insatisfechas en salud sexual y salud reproductiva de la población migrante venezolana en cuatro ciudades de la frontera colombo-venezolana – Colombia'

¹⁵⁷ *Ibid*

pregnancies, with half of those women suffering from anemia linked to nutritional deficiencies.¹⁵⁸ Such statistics are consistent with a regional study of Venezuelans in the Caribbean region, finding that 51.3 percent of pregnant women suffered from iron-deficiency anemia and 32.1 percent from depression.¹⁵⁹

The forced displacement also leads to the importation of infectious diseases, recently reported. Malaria and other vector-borne diseases, tuberculosis, vaccine-preventable diseases, sexually transmitted diseases, and HIV infection. The most direct consequences in public health are to countries of the Americas, e.g., Colombia¹⁶⁰ which is receiving a massive influx of from Venezuela.

Colombia's role as a massive transit location for the onward movement of Venezuelans also poses increased protection risks such as violence, robberies, and threats to women, unaccompanied and separated children, and those with disabilities.

In 2022, food insecurity is a crucial challenge facing Venezuelans in Colombia, as it is for most of the displaced in the Americas region. According to the UN's joint needs assessment, 54 percent of displaced Venezuelans in Colombia are moderately or severely food insecure, have low capacities to obtain and consume quality food, and face periods of hunger. Twice as many households (or 59 percent) had only two meals a day or less in 2021 compared to pre-pandemic.¹⁶¹ Those in transit and households headed by a female or person with a disability are assessed to have the greatest needs, alongside pregnant women, children, and the elderly. Limited livelihood opportunities in agriculture and production are particularly jeopardizing the resilience and integration of displaced Venezuelans in Colombia.

PERU

Peru is the second major host country for displaced Venezuelans, with 1.45 million Venezuelans residing there in January 2022. UN estimates project that by the end of 2022, there will be approximately 1.57 million. The people in need are expected to grow from 1.01 million to 1.7 million by the year's close.¹⁶² In June 2019, Peru introduced a humanitarian visa which decreased the migration flow. However, while regular movement decreased, irregular activity increased due to the visa and COVID-19 movement restrictions. Peru's land borders officially closed in March of 2020 to curb COVID-19, and Venezuelans' access to Peruvian territory is only possible through irregular entry points. This has led to increased human trafficking, smuggling, and criminal activity, with acts of violence in the border regions. Many enter Peru as their destination, but some do continue--approximately 30 percent --onward to Chile or other countries in the region.¹⁶³ The government has introduced two alternative regularization processes, the Temporary Permanence Permit Card (CPP) and

¹⁵⁸ Save the Children International. Hundreds of heavily pregnant Venezuelan women seek treatment at Save the Children Colombian border clinic. (July 10, 2019)

¹⁵⁹ Fernández-Niño JA, Rojas-Botero ML. The health situation of Venezuelan pregnant migrants in the Colombian Caribbean: first report for a rapid response in Public Health. *Revista de la*. 2019.

¹⁶⁰ Mário Maciel de Lima Junior, Gabrielle Almeida Rodrigues, Maysa Ruiz de Lima, Evaluation of emerging infectious disease and the importance of SINAN for epidemiological surveillance of Venezuelans immigrants in Brazil, *The Brazilian Journal of Infectious Diseases*, Volume 23, Issue 5, 2019

¹⁶¹ InterAgency Coordination Platform for Refugees and Migrants from Venezuela 'GIFFM Colombia: Evaluación Conjunta de Necesidades (Junio 2021)

¹⁶² InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹⁶³ Ibid

the humanitarian residency permit, both directed toward asylum seekers, which on receipt can increase access to healthcare and other public institutions.¹⁶⁴

HEALTHCARE ACCESS IN PERU FOR DISPLACED VENEZUELAN

“All my family had COVID. My 4-month-old baby and my 4-year-old child, my 26-year-old husband, and myself. We overcame it alone, without medical support.” A 25-year-old woman in Arequipa (Peru)¹⁶⁵

In **Peru**, there are limited options for Venezuelans to access healthcare impaired in part by the lack of inclusion of refugees and migrants with insufficient documentation, legal status, and normative frameworks in the national healthcare system.¹⁶⁶ Likewise, 78 percent of displaced Venezuelans responding to a Mixed Migration Centre survey in March 2021 said they would not be able to access urgent health services ‘today.’¹⁶⁷

A survey conducted by the National Institute for Statistics and Information of Peru in 2018 found that 92 percent of Venezuelans lacked health insurance.¹⁶⁸ Once again, having the correct civil status documentation is a significant indicator of whether a displaced Venezuelan can access healthcare. Only people with identity documents issued by the Peruvian authorities to people with *regular* immigration status can access the Comprehensive Health System (Sistema Integral de Salud, or SIS). The UN estimates that less than 10 percent of displaced Venezuelans in Peru have access to SIS.¹⁶⁹ The system excludes those with no documentation and PTP as predicated on an irregular status. The government has taken some relatively creative measures to try and overcome some of these challenges to support better displaced Venezuelans’ access to the healthcare they require. However, such efforts are minimal, and there is no identified political will to expand such options to be more inclusive of displaced persons’ needs. All pregnant women and children under five can receive free healthcare through SIS without formal processes. Likewise, there are some exceptions for people with chronic conditions as well as human trafficking survivors.¹⁷⁰

HEALTHCARE NEEDS OF DISPLACED VENEZUELAN IN PERU

Between July and August 2021, the UN joint needs assessment provided evidence that access to regularization, documentation, and information is a pivotal need across all response sectors.¹⁷¹ According to 60 percent of the displaced Venezuelans surveyed, 60 percent reported lack of documentation as the main obstacle to access the Comprehensive Health Insurance (SIS). Further, 76 percent of Venezuelans reported a reduction in the quality and frequency of their food consumption in 2021, while 30 percent referenced having to beg to meet daily food needs.¹⁷² Acute malnutrition among displaced children from Venezuela under five increased from 3 to 5.4 percent between 2001 and 2011. Only 3.6 percent of Venezuelan children under five received health assistance between 2012 and July 2021. Almost 70 percent report that members of their communities had no

¹⁶⁴ Ibid

¹⁶⁵ Mixed Migration Center (MMC) Latin America ‘Access to Health Services for Venezuelans in Colombia and Peru during COVID-19 pandemic’ (March 2021)

¹⁶⁶ InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2022’ (2022)

¹⁶⁷ MMC

¹⁶⁸ Instituto Nacional de Estadística e Informática ‘Condiciones de Vida de Población Venezolano Que Reside in Peru’ (2018)

¹⁶⁹ InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2022’ (2022)

¹⁷⁰ Selee, Bolter

¹⁷¹ InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2022’ (2022)

¹⁷² InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2022’ (2022)

stable housing in the first half of 2021 and expect that challenge to increase. Less than half of the displaced report inadequate income to meet their basic human needs, exacerbated by economic downturns such as currency depreciation. Chronic conditions, malnutrition, mental health issues as well as conditions induced by precarious living conditions are related and are some of the most pressing health issues in Peru.¹⁷³

In a 2020 study, Save the Children interviewed 1,224 displaced Venezuelans living in Lima and Trujillo and reported that 40 percent of these individuals were visually impaired, 16 percent had a memory or concentration impairment, and 17 percent had difficulty walking.¹⁷⁴ Another study from 2019 examined data from a 3,611-household survey in Arequipa, Callao, Cusco, Lima, Trujillo, and Tumbes, indicating that 11 percent of Venezuelans self-reported living with chronic conditions. Thirty-nine percent reported asthma, 18.4 percent hypertension, 4.8 percent arthritis, 4.6 percent diabetes. A total of 3.4 percent of women reported living with cancer instead of .5 percent of men. Additionally, 44 percent reported experiencing an illness upon arrival to Peru, notably respiratory and gastrointestinal conditions in nature.¹⁷⁵ Another 2019 study of 212 displaced Venezuelans living in northern Peruvian cities indicates more than two-thirds of the participants live with depression or anxiety (68.9 percent).¹⁷⁶

COVID-19 significantly disrupted the provision of primary healthcare in Peru, impacting both emergency and routine sexual and reproductive health services for women and mental healthcare. At the start of the pandemic, for example, in Lima and Callao, more than half of families in need of medical treatment reported not having access to healthcare services.¹⁷⁷

¹⁷³ InterAgency Coordination Platform for Refugees and Migrants in Venezuela 'RMRP 2022' (2022)

¹⁷⁴ Save the Children 'Health needs in Lima and Trujillo, Peru' (March 2020)

¹⁷⁵ Mendoza W, Miranda JJ. La inmigración venezolana en el Perú: desafíos y oportunidades desde la perspectiva de la salud. *Rev Peru Med Exp Salud Publica*. 2019

¹⁷⁶ Figueroa-Quíñones J, Cjuno J, Ipanaqué-Neyra J, Ipanaqué-Zapata M, Taype-Rondan A. Calidad de vida de migrantes venezolanos en dos ciudades del norte del Perú. *Rev Peru Med Exp Salud Publica*. 2019

¹⁷⁷ InterAgency Coordination Platform for Refugees and Migrants in Venezuela ‘RMRP 2021’ (2021)

6. CONSIDERATIONS AND RECOMMENDATIONS FOR THE PHILANTHROPIC COMMUNITY

As this study demonstrates, the health needs of the displaced Venezuelan community living in the Americas region are varied and plentiful. There is an ongoing regional humanitarian response, with continuous associated international funding, structural support, and related diplomatic efforts. What is significantly lacking, however, is a targeted focus on health systems strengthening to include the host government providing appropriate legal status so that displaced persons may access public institutions and services spanning well beyond healthcare with a range of services that support not only physical health, but mental health, livelihood, and wellbeing. Displaced Venezuelans also have acute health needs that require immediate support.

This section provides considerations and recommendations to encourage the private philanthropic community to support displaced Venezuelans in the Americas region to improve their health and wellbeing, balancing fundamental human rights protection and practical needs. The first part outlines considerations of potential NGO partners and acute health needs of displaced Venezuelans requiring immediate funding. The second part outlines secondary, longer-term options for funders targeting system strengthening and systemic solutions to address longer-term needs.

CONSIDERATIONS REGARDING FUNDING LOCAL/NATIONAL AND INTERNATIONAL NON- GOVERNMENTAL ORGANIZATIONS

Local and national NGOs (L/NNGOs) have been working in the Americas region for centuries and are a critical component of a free and democratic society present in most Latin American countries. These organizations arise from and are a part of the communities they serve, primarily accepted by local and national authorities, and have deep historical, cultural, and language expertise that no international organization can replicate. Such organizations abide by humanitarian principles of humanity, impartiality, neutrality, and independence while centering all approaches around the concept of do-no-harm associated with the UN-led regional humanitarian response. Not all organizations – especially L/NNGOs – maintain an exclusive humanitarian focus. Hence, the majority of the L/NNGOs, as well as international NGOs, are considered ‘mixed-mandate,’ delivering both humanitarian aid through a principled approach while also delivering specific development activities that may be inherently governance or political in nature. As close as possible to the affected communities or originating in the affected population, the local and national NGOs should be targeted for additional funding. At times, L/NNGOs will partner with INGOs for further technical and structural support. Still, it is essential to monitor these partnership arrangements as, at times, the L/NNGO is perceived and treated negatively as a sub-grantee instead of leading the work on the frontline, closest to the affected population.

Partners to consider funding: as local as possible, as international as necessary; emphasizing those with the capacity to offer specialized care or targeted support based on the gaps identified in this study

- *Support local and national NGOs that have worked for centuries in the region and are best placed to provide support for displaced Venezuelans because they understand the culture, language, and context and can provide community-based support to augment public services offered by state institutions.*¹⁷⁸

¹⁷⁸ In the following report, we will recommend specific organizations to consider funding against the identified priority health needs.

- *Consider international funding organizations when local organizations lack technical expertise, such as endocrinology, to manage care for patients with diabetes and thyroid conditions. In these instances, the INGO partnership with L/NGOs should minimize an international footprint by empowering and supporting local organizations. Such partnerships may include the secondment of technical staff from an international organization to a local organization, with local capacity- building an integral part of the partnership agreement. Said another way, where skills can be taught, they leave L/NGOs at the forefront of relief support for displaced Venezuelans.*
- *Investigate the partnership practices of INGOs when they are necessary to serve as fiscal sponsors of local organizations. In these arrangements, INGOs are responsible for demonstrating accountability for expenditures and impacts, as are the local organizations. Good fiscal sponsorship practices include: supporting the sustainable capacity of local organizations, refraining from recruitment of local leaders away from their primary contexts, and respecting the voices of the affected communities in determining and prioritizing the programmatic activities of the local organization.*
- *Make multi-year operating support grants to identified L/NGOs, in keeping with [Trust Based Philanthropy/Council on Foundations](#) best practices.*
- *Look for organizations with deep connections to and trusted relationships with displaced Venezuelans and their host communities. Expect these organizations to be grounded in a rights-based approach with refugee law expertise.*
- *Identify organizations with specific technical expertise, such as those supporting people with visible and invisible disabilities, the LGBTQI+ community, women and girls, and the elderly, all represented within the displaced Venezuelan population.*
- *Scan organizations for commitments to diversity, equity, inclusion, and non-discrimination.*

ACUTE GAPS IN HEALTH CARE FOR DISPLACED VENEZUELAN, INTERVENTIONS TO CONSIDER FUNDING IN UNDER-RESOURCED AREAS

Prevention measures associated with healthcare can be cost-effective, provide value for money and give returns on investment in the short and longer term. Response measures to health emergencies tend to be more costly and less sustainable. Therefore, it is vital to prioritize prevention measures such as vaccines for children while also supplementing gaps in healthcare provision with patients presenting different medical conditions.

Women and Girls

Across all geographies, women and girls' health needs were acute and lacked adequate resources and support services, with significant deficits in support for Indigenous women and displaced adolescent girls. Here we have outlined the most urgent health needs for women and girls and associated funding recommendations.

PRIORITY HEALTH NEEDS AND POTENTIAL INTERVENTIONS

- *Support family planning, including access to long-acting contraceptives and emergency contraception for instances of rape and incest. While pervasive before the COVID-19 pandemic, gender-based violence has exponentially increased during it. Survival sex, and other extreme forms of harmful coping mechanisms that displaced women and girls implement as a last resort, have increased dramatically. The need for family planning services for displaced women and girls, including emergency and long-term contraception options, are needed. Possible interventions range from campaigns to promote family planning education and access to contraception to establishing specific clinics where a suite of services could be offered to women and girls such as family planning counseling, access to contraception, mental health and psychosocial support, and necessary childcare for women during appointments. Indigenous*

Women and girls are particularly in need of this type of support, particularly in the north of Brazil.

- *Support pregnancy/prenatal, childbirth, and postpartum/neonatal care for women and infants.* Displaced Venezuelans continue to build their families even while encountering COVID-19 strained health systems and challenges accessing public or private care. Preventable diseases such as hepatitis and diphtheria are growing problems in the Americas. Neonatal and infant pediatric care is sorely lacking for displaced Venezuelans. Interventions in this area could include funding maternal and neo-natal wards in established hospitals in urban areas and establishing local community-based clinics specializing in maternal and neonatal care in rural regions. It also could mean funding increased capacity in pre-existing medical facilities to bring more gynecological care for women.
- *Support the establishment of mobile clinics in rural areas, particularly at transit locations that offer a suite of services for women and children.* Considering the rural areas where this need is particularly acute, consider supporting the establishment of mobile clinics that provide a suite of culturally appropriate services for women that can serve a large catchment area.
- *Support increased vaccine access* in clinics/medical institutions serving displaced Venezuelans for the standard childhood vaccines recommended by the [World Health Organization](#).
- *Support childcare provision, particularly for female-headed households in the context of accessing healthcare.* This is an overlooked service with a potentially wide-reaching impact for women seeking medical care, mental health treatment, and psychosocial support, potentially adjacent to medical facilities. The benefits extend beyond healthcare to livelihoods.

Children

Displaced Venezuelan children, like women and girls, have unique health needs. The economic downturn of COVID-19 has disproportionately affected children's health with related impacts on food availability and quality nutrition, often presenting as stunting and other developmental conditions.

Further, domestic violence, including child abuse, has increased during COVID-19 quarantine requirements.

Unaccompanied and separated children and those with disabilities are particularly in need of healthcare and wellbeing support.

PRIORITY HEALTH NEEDS AND POTENTIAL INTERVENTIONS

- *Support the capacity building of state-run child protection services to support unaccompanied and separated children better access healthcare and other services necessary for their health and wellbeing.* Currently, state-run child protection institutions across the region are not well designed to target support for unaccompanied and separated children, including healthcare.
- *Support standard child immunization programs.* There is no national vaccine campaign or effective program in Venezuela, which is why in part, previously eradicated diseases like measles and diphtheria have returned in the Americas region.
- *Support nutrition, growth, and child development programs.* Poor nutrition and lack of access to quality food have propelled children onto the street to beg for food for themselves and their families. With inflation skyrocketing and economies struggling, even host communities are scrambling to access the quality food children require. For these reasons, we recommend funding specific mechanisms to support children's nutrition through school feeding programs, community center feeding programs, food banks and social schemes (c.f., US food stamps), local religious institutions, and clinical care settings. Vitamin A supplementation

for young children is also a specific area to fund and support through the mechanisms mentioned above.

Communicable Diseases

This research demonstrates an increase in communicable diseases across the region, particularly prevalent in the displaced population due to poor living conditions and lack of access to regular healthcare. Care options for those with STIs and HIV/AIDs were lacking in every geography, urban and rural. Displaced Venezuelans with legal and financial access had more success in urban areas with more health facilities and resources than those seeking care in rural areas or lacking legal status in their host country. The data supports focusing on transit sites, informal settlements, or rural communities lacking sufficient health infrastructure to establish clinics or mobile clinics specializing in STI and HIV/AIDS testing, care, and case management.

PRIORITY HEALTH NEEDS AND POTENTIAL INTERVENTIONS

- *Support care for those with Sexually Transmitted Infections (STIs), including HPV and HIV/AIDS.* The documented prevalence of STIs, including alarming rates of HPV and HIV/AIDs across the displaced Venezuelan population is extreme, with few care options. These conditions comprise the most dramatic gap in health service access and availability for displaced Venezuelans. Clinics and increased technical personnel are necessary for pre-existing and planned medical facilities. The high prevalence of rape and other forms of sexual violence, particularly in rural transit locations, suggests that the establishment or expansion of mobile health services that specialize in STI and HIV/AIDS testing, treatment, and care is advised.

Non-communicable and chronic diseases

Many Venezuelans have pre-existing conditions exacerbated by their lack of access to healthcare inside Venezuela and worsened by their journey and relatively poor living conditions in host communities.

Similarly, some conditions are exacerbated by poor nutrition and the inability to access regular, quality care. Increased capacity to treat non-communicable and chronic diseases for displaced Venezuelans is needed. In urban areas, expanding the ability of pre-established medical institutions to offer this type of care and ongoing treatment and establishing more community-based, mobile clinic options to service a relatively large catchment area are two options.

PRIORITY HEALTH NEEDS AND POTENTIAL INTERVENTIONS

- *Support activities on non-communicable disease prevention and self-management.* These could be community-based or clinic-based education to prevent the onset and reduce disease severity.
- *Support interventions to expand specialized medical services in hospitals and clinics.* Increase the number of physicians specializing in endocrinology, cardiology, and pulmonology alongside providing access to these medical sub-specialties in rural areas. Mobile clinics that regularly bring specialized medical staff to different locations are another approach to meeting this need, as is funding transport and childcare to allow for services in urban medical institutions.
- *Fund specialized care for diabetes and thyroid conditions cardiovascular and lung disease patients.* Many displaced Venezuelans have pre-existing conditions, primarily the endocrine system, heart, or lungs. These may require emergency interventions while in transit and access to specialized and regular care where they are currently residing. There are limited options for citizens in many countries to access quality care for non-communicable and chronic conditions. However, some of the best care is through costly private insurance options and

providers. So even in contexts with universal healthcare policies, the demand for medical care that addresses such conditions outweighs the current capacity of the medical system. Related, and a relatively low-cost option with potential for broad-reaching impacts is also funding educational programs around self-care to help patients manage their chronic conditions on their own as able. For example, diabetes patients may require information about what food they can consume based on what's available in the market and their financial constraints. Such educational programs could partner with medical facilities adjacent to patient care- in waiting rooms, facilities next to or inside hospitals, etc.

- *Fund support for cancer care.* Much like the preceding non-communicable yet chronic diseases, detection capacity and care for cancer patients are neglected. Many displaced Venezuelans may have had cancer before they left Venezuela, or their cancer has matured since they left, given their inability to access regular treatment and care. We recommend Interventions focused on providing cancer treatment such as chemotherapy and radiation through mobile clinic modalities servicing a wide catchment area or increasing capacity in established medical institutions and making access to those institutions possible for displaced Venezuelans lacking status, financial resources, or the ability to travel.

Mental health

Across all locations and all population demographics within the displaced Venezuelan community in the region, there was one commonality: the extreme prevalence of mental health conditions and the need for significant resources to be channeled into addressing the psychosocial needs of the displaced. This is a particularly acute need within displaced Venezuelan youth in the region whose mental health has been chronically underserved.

PRIORITY HEALTH NEEDS AND POTENTIAL INTERVENTIONS

- *Support access and provision of mental health services, particularly for youth,* through formal and informal mechanisms. This includes building out the capacity of traditional medical institutions and related mental health care facilities to have more trained medical staff, increased psychiatric drug availability, and community-based education and outreach to help displaced Venezuelans understand their care options and combat the stigma associated with mental health as well as mobile clinics. Encourage creative options such as digital counseling services that align with social distancing requirements and allow a broader range of providers to counsel and support displaced Venezuelans regardless of location.¹⁷⁹
- *Focus on addressing depression, prolonged grief disorders, and suicidal tendencies among the displaced.* Many Venezuelans have pre-existing mental health conditions such as depression and anxiety. Such conditions are exacerbated by a lack of consistent mental health care, including psychiatric (medication) and psychological (counseling and other forms of psychosocial support). Access to care for mental health is further challenged by the stigmatization of mental health conditions.
- *Also, prioritize treatment and care for PTSD and other reactions induced by the perpetration of domestic or sexual violence and child abuse.* The horrific circumstances, including violence and deprivation, high instances of sexual and gender-based violence, and child abuse, are traumatic disruptions in forced displacement.

¹⁷⁹ Remote counseling has proven effective in hard-to-reach areas of Syria, for example, and in the United States during COVID-19 through telemedicine options.

COVID-19

- *Support prevention and mitigation efforts to reduce infections.* COVID-19 has disproportionately impacted vulnerable populations, such as displaced Venezuelans in the Americas region. Their inclusion in vaccination programs varied country-by-country and town greatly. Likewise, vaccine availability and access were significantly lacking—for both citizens and displaced persons alike. Strengthening campaigns to reach Venezuelans through non-discriminatory vaccine distribution, provision of masks, sanitation supplies, and hygiene kits, and information is supplemental to assisting them in meeting minimum daily needs.
- *Support emergency interventions in the case of domestic violence, in cases of domestic violence, and for survivors of domestic violence, particularly in border regions/transit sites.* COVID -10 has exacerbated domestic and intimate partner violence worldwide. One area to consider funding is lifeline support for those at risk or experiencing abuse in their homes and emergency care in transit sites. This could be the form of establishing secure and safe call lines inked to confidential resources to support women and children and others with vulnerabilities who are trapped in a location experiencing abuse and unable to access help on their own. It could also include mobile clinics and emergency mental and physical care, and other resources in border regions if borders remain officially closed.

Areas for future research

The lack of comprehensive health data for displaced Venezuelans makes it challenging to identify the best support to improve health and wellbeing outcomes. Migration patterns and displaced locations are relatively well known, despite forced displacement from Venezuela continuing more dangerously due to border closures. More sustainable data collection systems must support ongoing programmatic interventions and development support. To complement those efforts, further disaggregated research on displaced Venezuelan populations with additional vulnerabilities is required, along with addressing other significant gaps in public knowledge.

Recommended areas for future research include:

- *Health and wellbeing needs of populations with additional vulnerabilities* such as the LGBTQI+ community, disabled (visible and invisible) persons, adolescents/youth, women and girls, Afro-Venezuelans, Indigenous and the elderly, as well as the barriers they face with regards to accessing quality healthcare to include mental health and psychosocial support.
- *Forecasted long-term health consequences and scenarios associated with COVID-19* to design better public health systems and approaches to mitigate future suffering.
- *A comprehensive review of the pathways to legalization* available to displaced Venezuelans in host countries includes the specific legal barriers and opportunities to secure appropriate documentation so the displaced may access public institutions and support such as healthcare.

7. CONCLUSION

This research finds that the health and wellbeing of displaced Venezuelans in the Americas region are not being met in accord with international law, nor are current programs and interventions practically sufficient to ameliorate the suffering of this population. While local and national NGOs are active across the region, they lack critical funding and support to meet the growing health needs of displaced Venezuelans. Quality data to diagnose the health needs of displaced Venezuelans in the Americas region and design effective interventions is also pivotal.

Access to healthcare is primarily linked to legal status, and for a variety of reasons, such status is challenging for displaced Venezuelans to obtain. The COVID-19 pandemic and its secondary effects have devastating consequences for those with pre-existing vulnerabilities and disproportionately affect the displaced Venezuelan population without legal status.

Women and girls face unprecedented sexual and gender-based violence levels, and related care is sorely lacking, particularly in rural and transit locations. Likewise, maternal health and neonatal care are identified as a significant need in all contexts examined. Indigenous women find it difficult to access necessary healthcare because interventions have not been catered to Indigenous people through culturally and linguistically appropriate outreach. They are often residing in highly rural areas.

Unaccompanied and separated displaced Venezuelan children are falling through the cracks of state-run child protection programs, as they are not designed to meet the needs of this demographic. As a result, children live in horrific conditions without access to quality health care, including mental health and psychosocial support. People with disabilities are also nearly invisible throughout the public data sets. However, this research found a high need related to quality health care access, as are the needs of the elderly and those with chronic conditions, including mental illness.

Therefore, it is critical for the philanthropic community to consider short-term funding interventions to meet displaced Venezuelans' emergency and current health needs, as identified in this report. Investments are also needed to strengthen public institutions to offer better, more systemic, and quality care. We hope that this research can improve the health outcomes of the displaced population and host communities and mitigate the spread of communicable diseases.

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APPENDIX 1

SECONDARY, LONGER-TERM OPTIONS FOR FUNDERS TO CONSIDER

Considerations with regards to public institution strengthening

The effects of the COVID-19 pandemic on people's health are broad and deep and encompass economic downturns and associated struggles governments have in maintaining functional public institutions that meet the needs of their residents. A substantial investment in public systems strengthening is necessary to include holistic livelihoods generation/economic stimulation and expanded access to legal status in host countries. This research demonstrates that while some contexts have the political will to support displaced Venezuelans, the state capacity is not strong enough to do so. This causes increased tension between host communities and displaced Venezuelans. Such investment in public institutions is inherently development instead of humanitarian in nature and requires significant, long-term funding and support to achieve real, systemic change.

Recommendations:

- *Support local, national, and international organizations providing legal support to displaced Venezuelans associated with accessing immigration pathways to stay in host countries and access public institutional support such as healthcare.*
- *Identify partners who can support public campaigning and awareness-raising exercises to generate additional public and political will toward legalizing status for displaced Venezuelans in host countries.*
- *Identify NGO partners and governments to improve the data collection and analysis of the needs of displaced Venezuelans in the region. The lack of comprehensive health data is stark. For systemic and widespread solutions to be implemented, more data—including disaggregated data based on gender, age, and location—is necessary to support emergency and longer-term interventions.*

Leveraging private sector influence to improve health outcomes for the displaced

The private sector, including the private philanthropic community, has a unique opportunity to leverage influence over governments and authorities in the Americas region to support better protection and health outcomes for displaced Venezuelans. We are identifying financial incentives and support for political allies and authorities to enact legalization programs for displaced Venezuelans, opening access to public health institutions and other forms of support.

Addressing the social dimension of displacement and healthcare access

Xenophobia and other forms of discrimination against the displaced Venezuelan population are rampant in select locations. Social tensions increase due to economic downturns, loss of livelihoods, lack of access to education, healthcare, and other public services. Xenophobia and other forms of discrimination toward displaced Venezuelans endanger safety and security, inhibiting the pursuit of health services, particularly if the health issue is associated with more 'sensitive' topics such as rape-induced pregnancy. Xenophobia and other forms of discrimination increase the prevalence of mental trauma and related PTSD, calling out the need for improved mental health and psychosocial support. The philanthropic community can identify organizations that specialize in social cohesion, anti-racism,

tolerance, and non-discrimination and support them in repairing and strengthening community relations between displaced Venezuelans and their host communities.

