



## Colombia: Vouchers for Sexual Reproductive Health (SRH) Services

<b>LOCATION</b>	Colombia (Pamplona, Norte de Santander, Bucaramanga, Santander)
<b>MODALITY &amp; SRHR OUTCOME</b>	Vouchers for SRH services; cash transfers for transport
<b>TIMELINE</b>	December 2020 – June 2021
<b>TARGET POPULATION</b>	Migrants and refugees in transit or staying in Colombia, and Colombian returnees and other vulnerable host community members with a focus on women, girls, and the Lesbian, Gay, Bisexual, Trans, Queer, Intersex (LGBTQI) community
<b>TRANSFER AMOUNT</b>	Up to 120 USD for SRH services and 30 USD for transport
<b>MONITORING</b>	Post-distribution monitoring (PDM)
<b>DELIVERY MECHANISMS</b>	Paper vouchers; remittance company
<b>REACH</b>	10,000 participants

## Background

*This study is part of a larger multi-country study by CARE entitled “Cash and Voucher Assistance for Sexual Reproductive Health and Rights Outcomes: Learnings from Colombia, Ecuador, Lebanon and Somalia.”*

As a result of Venezuela’s socioeconomic and political crisis, there have been massive migratory flows of people from Venezuela into Colombia.<sup>1</sup> According to the Interagency Coordination Platform for Refugees and Migrants, as of May 2020 over 1.76 million Venezuelans had fled to Colombia with many continuing to walk to and across the Southern Border with Ecuador as *caminantes*.<sup>2</sup> This situation is compounded by the collapse of the Venezuelan health system, which has resulted in many migrants and refugees arriving in Colombia with a range of unmet Sexual Reproductive Needs and Rights (SRHR) needs. Women and girls face sexual exploitation, and some engage in transactional sex during migration, particularly along border crossings and in major urban areas. Many Venezuelan migrants and refugees are subjected to other forms of exploitation, abuse, negative coping mechanisms, xenophobia, and various forms of violence, in particular Gender-Based Violence (GBV). More than 50% of refugees and migrants have irregular status and, therefore, have limited or no access to essential public services and the formal labor market.<sup>3,4</sup> The COVID-19 pandemic exacerbated the vulnerabilities of these populations, as the Colombian government’s mandatory quarantine and border closures further limited access to services and income-generating activities while increasing protection risks.

CARE Colombia began direct operations in the country in 2019, focusing primarily on the needs of Venezuelan refugees and migrants in Pamplona, Norte de Santander and, later, Bucaramanga, Santander. Cash and Voucher Assistance then (CVA) are primary modalities for CARE

Colombia, particularly for its SRHR and protection portfolio. Working with populations on the move as was the case in this program, together with high levels of unmet SRHR needs resulted in a unique operating environment for a voucher intervention supporting SRHR programming.

This case study focuses on the design of the programming only. Due to the timing of the review, no substantive data on the user experience of the vouchers or outcomes could be captured.

## Program Design

CARE Colombia had support from a variety of donors, including the Chubb Foundation, an anonymous donor, Abbott, and the Civil Protection and Humanitarian Aid Operations department of the European Union (ECHO), to provide this programming. Aspects of each of these projects aimed at addressing barriers to SRH services for migrants and refugees, especially those with lifesaving needs on the route of the *caminantes*, as well as vulnerable members of host communities.

### IDENTIFYING NEEDS

The program design was informed by various needs assessments and analyses, including CARE’s 2019<sup>5</sup> and 2020 RGAs<sup>6</sup>, a **Profamilia** evaluation<sup>7</sup> of the unmet SRHR needs of migrant communities, from other multipurpose cash transfer pilot programs, SRHR programming, and guidance from the Colombian CVA national working group. Consultations with migrants, building on CARE Colombia’s **Women Lead in Emergencies** program, were critical to identifying the overall gaps in SRHR needs for Venezuelan migrants in Colombia. These analyses were immediately applied to the planned CVA for SRHR programming launched in December 2020. Given CARE’s commitments to localization and health systems strengthening, CARE Colombia sought to identify

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- 1 The Regional Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela. (2020). R4V launches “One step closer” A campaign in solidarity with refugees and migrants in Latin America and the Caribbean. Radiografía Venezolanos en Colombia. 2020. Migración Colombia.
  - 2 Migrants on the move across Colombia in either direction.
  - 3 Dany Bahar, et al (2020). “**Venezuelan Migration, Crime, and Misperceptions A Review of Data from Colombia, Peru, and Chile**,” Brookings Institute.
  - 4 During the finalization of this report the Colombian Government announced a massive “regularization” for all irregular Venezuelan migrants residing in Colombia by end of January 2021.
  - 5 CARE. (2019). **Análisis rápido de género de CARE - América Latina y el Caribe: migrantes y refugiados venezolanos en Colombia (mayo de 2019)**
  - 6 CARE. (2020). **Una emergencia desigual: CARE Rapid Gender Analysis of the Refugee and Migrant Crisis in Colombia, Ecuador, Peru and Venezuela.**
  - 7 Profamilia. (2020). **Desigualdades en la utilización de los servicios de salud entre los migrantes y refugiados venezolanos y Colombia.**

local government health actors with whom to collaborate to improve access to SRHR. However, the process was fraught with challenges due to:

- the limited availability of health providers offering SRHR services in target locations and surrounding rural areas, especially in humanitarian corridors;<sup>8</sup>
- individuals with legal documentation being able to access services at only a few approved public health clinics with free services, where many faced xenophobic attitudes from providers. “Irregular migrants” without legal documentation avoid seeking services for a variety of reasons, including fear of deportation, lack of insurance coverage, and negative provider attitudes, including xenophobia; and
- the inability of public health facilities such as the public hospital in Pamplona to continue offering SRH services as a result of being overwhelmed by the COVID-19 pandemic further limited availability of SRH services.

Based on the identified barriers to access, CARE Colombia collaborated with a variety of actors through seven working groups to establish and strengthen four referral pathways to facilitate access to quality SRH services – particularly antenatal care, Sexually Transmitted Infections (STIs), family planning, and Clinical Management of Rape (CMR) – in project locations. Key actors included the Mayor’s Offices of Pamplona and Cúcuta in Norte de Santander and health organizations.<sup>9</sup> These consultations helped to map out potential goods and services for SRH in the target areas and contributed to the first level of market analysis for the intervention. CARE Colombia then launched a bidding process to identify service providers.

Based on capacity and in line with the partnership model of the program, CARE Colombia selected CEDMI in Pamplona and Profamilia in Bucaramanga as clinical service providers for the program. Based on Colombia’s current regulations, CARE developed a partnership with the local Health Directorate to meet SRHR needs for vulnerable populations through rights-based approaches. SRH services were provided at either fixed points of service delivery--two static health facilities in Pamplona and one in Bucaramanga) or through mobile brigades.



## TRANSFER VALUES AND MECHANISMS

The SRHR voucher intervention was designed to facilitate access to timely care for vulnerable individuals who lack access to lifesaving SRH services guided by the Inter-Agency Field Manual for Reproductive Health in Crisis-Settings (IAFM). Based on the needs analysis, participants could receive vouchers for a range of goods and services including:

- Antenatal care and follow-up;
- Postnatal care and follow-up;
- Family planning, counseling on contraceptive methods in line with WHO eligibility criteria and provision of contraception, including insertion and removal of IUDs (Intrauterine devices) and implants;
- Detection, diagnosis, treatment, and follow-up for STIs;
- Other general medical consultations including pregnancy testing;
- CMR and referrals for other services for survivors of sexual violence; and
- Prescription medications according to the list of medicines authorized by CARE.

CARE designed Standard Operating Procedures (SOPs) to guide the program. The programming was led by a monitoring framework that combined various projects and followed outcome, output, and process indicators for CVA and SRHR.

8 Areas where migrants are allowed passage.

9 Local Health Directorate, hospital, Colombian Red Cross, Halu Foundation, Legal Option, IOM, UNFPA, and Humanitarian Civil Network

Paper vouchers were selected as the modality and delivery mechanism because CARE could secure quality service and because of the agreements (e.g. prices, number of people attended in relation to capacity to serve). The transfer value for the vouchers was defined through the market assessment on the costs of goods and services by the private service providers. The voucher amount varied by service and depending on the partner. Typical voucher values were 100 USD for antenatal checkups (for two Antenatal care (ANC) visits including relevant tests), 60 USD for diagnosis and treatment of STIs, 89 USD for subdermal implants, and 25 USD for IUDs . The program participants could receive up to two vouchers depending on the services needed (e.g., antenatal checkups). In addition, as the Colombian government offers free delivery services including emergency obstetric and newborn care for complications in pregnancy, CARE supports transportation and referrals to facilitate access to these services at public health facilities.

Participants could qualify for cash transfers for transport to health services within Pamplona to Bucaramanga and rural parts of Pamplona to Pamplona town, valued at up to 30 USD. These transfers were made through **Efecty**, a remittance company. Participants with identification (ID) that met Know Your Customer requirements in Colombia could use their ID to retrieve the money. For the participants who lacked valid ID, CARE set up an agreement with the FSP where a unique code would be provided to the participant and could be used in lieu of ID to retrieve the payments. Furthermore, participants could also qualify for other support from CARE and partners (e.g. multipurpose cash transfers, service delivery) based on assessment by CARE and partners.

## TARGETING PARTICIPANTS

CARE nurses and CARE-trained community focal points led the identification and prioritization of project participants. Once the referral and voucher systems were established, CARE leveraged its existing programming with women's and adolescent groups, community leaders, cultural and grassroots associations, humanitarian groups, and LGBTQI networks and local partners to raise awareness of service availability through awareness raising campaigns, radio and social media messages, collaboration with local governments, and, most importantly, through CARE-trained community focal points and staff. Priority groups for support included:

- Venezuelan migrants and refugees including *caminantes*, *pendulares*,<sup>10</sup> asylum seekers and particularly “irregular” migrants, without access to health insurance;
- Colombian returnees and vulnerable members of host communities; and
- Populations disproportionately impacted by COVID-19, with an emphasis on women, girls, and LGBTQI communities.

## MONITORING

Although participants were referred to health clinics for specific services, health providers screened for additional needs and referred them to other services if required. After participants received care, an estimated randomly selected 10% would be targeted with PDMs by phone two weeks after the voucher was delivered. The PDM assessed quality, timeliness, relevance, and access through an electronic survey on Kobo toolbox, usually conducted via telephone immediately after care and again two weeks to one month after services were rendered.

## Facilitating Factors

In addition, despite being a relatively new CARE country office, CARE Colombia's in-house expertise on both SRHR and CVA enabled a strong integrated response. The integrated SRHR/ CVA programming also leveraged other ongoing programming that strongly emphasized gender and inclusion (such as the Women Lead in Emergencies project and other protection programming) and facilitated identification, targeting, and accompaniment of individuals in need of SRH services.

Community participation was critical in program design, especially for prioritization of needs, development of communication strategies, and identification of the urgent need to train community leaders as focal points on SRHR. Strong collaboration across government institutions including the Mayors' Offices, the Secretary of Health, Municipal Secretaries and key actors in health, humanitarian, and civil society networks was crucial to finding viable ways to enhance access to SRHR and complementary services. CARE Colombia linked its Women Lead in Emergencies project participants to this intervention, where women could act as focal points in their communities for SRH services through CARE and partners.

## Challenges

The outbreak of COVID-19 forced critical adaptations in the project. These adaptations diminished the team's ability to conduct in-person follow-up with participants. The aforementioned scarcity of service providers caused additional delays. Antagonism and xenophobia of some authorities and host communities toward migrants and refugees was exacerbated during the COVID-19 crisis. Moreover, challenges in targeting and reaching intended populations due to fears of deportation, further stigmatization, or discrimination were further compounded by quarantine measures.

## Lessons Learned

**Vouchers and complementary services can be critical at times of crisis when SRHR needs may be deprioritized.** At the time of the study, the program was only in the early stage of implementation; therefore, the learnings only speak to planning and design. As COVID-19 resulted in further

limitations on access to SRHR, vouchers enabled access to hard-to-reach and often deprioritized SRH services, including contraception and STI services. Demand in places like the *albergues*<sup>11</sup> in Pamplona and from *caminantes* was so high that it sparked CARE's partner in Bucaramanga to initiate service provision in Pamplona as well. This is particularly important for irregular migrants for whom legal status is a major barrier to access. Furthermore, addressing provider attitudes, including xenophobia, towards these groups is a critical complementary aspect of this programming.

**Providing access to a full range of services aligns with a rights-based approach.** One important takeaway is that although paper vouchers were provided for specific SRH services, CARE's program design ensured that individuals who arrived at facilities were first screened to identify and be referred for other relevant services, facilitating access to a full range of services. Although this was more complicated for CARE and the health providers, it was instrumental in ensuring a rights-based approach to SRH, allowing access to a full range of services according to participants' wishes.

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11 These are shelters where the migrants can stay.

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