



An Unequal Emergency: CARE Rapid Gender Analysis of the Refugee and Migrant Crisis in Colombia, Ecuador, Peru and Venezuela

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Abbreviations

ART	Antiretroviral Therapy
ARV	Antiretrovirals
FG	Focus Group
FGD	Focus Group Discussion
GBV	Gender Based Violence
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
INE	Instituto Nacional de Estadística
IOM	International Organization for Migration
IPV	Intimate Partner Violence
KII	Key Informant Interview
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex
MISP	Minimum Initial Service Package
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
RGA	Rapid Gender Analysis
RV4	Coordination Platform for Refugees and Migrants from Venezuela
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene



Executive Summary

This combined Rapid Gender Analysis (RGA) provides information and observations on the different needs, capacities and coping strategies of Venezuelan women, men, and LGBTIQ+ individuals in Venezuela, Colombia, Ecuador and Peru. It seeks to understand how gender roles and relations have changed as a result of the crisis and share recommendations for how the humanitarian community can more effectively consider these changing dynamics to better meet the different needs of each group. It is based on a combination of primary and secondary data collection and analysis from each of the the 4 contexts through RGAs held over a 12 month period (2019-2020) – including focus group discussions and key informant interviews (KIIs). It was then updated with secondary data related to the onset of the COVID-19 pandemic.

The crisis in Venezuela, and the resultant refugee and migrant crisis in the region, is characterized by highly gendered dynamics that have taken a significant toll on the health and welfare on all those affected, but particularly on women, girls and LGBTIQ+ people. Refugee and migrant women, girls, and LGBTIQ+ people face profound vulnerabilities as they leave Venezuela and traverse Colombia, Ecuador and Peru in search of temporary or permanent destinations. Some groups within this migratory flow face particular risks, including indigenous populations, adolescent girls, and pregnant and breastfeeding women, among others.

Venezuela, like many other countries in the region, is a society where traditional gender stereotypes persist. Men control most assets, resources and decision-making and are predominantly the primary breadwinners; women's principal roles are domestic including child-rearing with limited decision-making in the household. The gravity of the ongoing crisis in Venezuela, including food scarcity and loss of livelihoods, has expanded the roles and responsibilities of women, requiring them to develop solutions to feed their families in the face of hyperinflation and a collapsed health system while at the same time assuming income-generating roles. These social and economic changes are also challenging power dynamics within households, which can lead to increased rates of intimate partner violence (IPV). Given the traditional gender roles, men and boys have been most likely to leave the home for livelihood opportunities elsewhere or to join the opposition movement, further expanding the role of women, and adolescent girls, who often take on the roles of adults and caretakers in the absence of their mothers.

Key findings

- Venezuelans face a variety of protection risks, which increase significantly once they begin their migration journey. Many Venezuelan migrants and refugees travel through “irregular” means, and many face exploitation due to their lack of documentation.
- Women, girls and LGBTIQ+ individuals face elevated risks of gender-based violence (GBV), including by authorities. GBV survivors do not access necessary services, due to fear, shame, impunity, lack of knowledge of services, and mistrust in the system.
- Venezuelan migrants and refugees experience widespread xenophobia across Colombia, Ecuador and Peru. Xenophobia also limits access to basic services, including housing and employment. The hypersexualized perception of Venezuelan women and adolescent girls leaves them particularly vulnerable to sexual violence and exploitation.
- While the majority of Venezuelans interviewed live in a house that they own or that is owned by their partner, most Venezuelan migrants and refugees are living in rental accommodation, which is often overcrowded and unsanitary. Toilets and bathing facilities are generally communal and often unsafe, particularly for women and girls.
- Venezuelan women, men, girls and boys struggle to find income-generating opportunities that are sufficient to meet their basic needs. Women and girls particularly are exposed to unsafe and exploitative working conditions, while men and boys are at risk of recruitment into criminal groups.

Results from RGAs in each country show a normalization of GBV, including high levels of sexual violence. Transactional sex is a common-place coping strategy, with Venezuelans accounting for high rates of transactional sex workers, and women, girls and gender-diverse individuals facing significant risks of sexual exploitation and trafficking. Venezuelan migrant and refugee women, girls and gender-diverse individuals in Colombia, Ecuador and Peru, are at risk of trafficking, domestic and sex slavery and other forms of exploitation and abuse. Lack of documentation and/or limited awareness of their rights based on their current documentation status further exacerbates the potential for exploitation. Nonetheless, reporting rates of GBV remain low; survey and focus group discussion results show limited knowledge of appropriate services, and low levels of trust in those services. Migrant and refugee GBV survivors fear deportation and retaliation if they report incidents to the authorities.



Food shortages and hyperinflation, the crumbling of public services such as water and sanitation, and the collapsed health system in Venezuela – compounded by significant limitations on women and girls’ bodily autonomy such as limited access to sexual and reproductive health services – encourage pregnant women and girls, sexual minorities, Human Immunodeficiency Virus (HIV) positive individuals, and persons with disabilities and chronic disease to migrate to other countries in the region. Many migrants and refugees have no choice but to live on the streets or in informal settlements away from public services. Beyond the scale of the response, there are challenges related to inadequate participation of crisis-affected populations in decision- making and through feedback mechanisms.

Findings from the four countries highlight the importance of implementing or strengthening programs that meet the different needs of women, men, and LGBTIQ+ people across various sectoral areas, including livelihoods, food security, water, sanitation and hygiene, sexual and reproductive health, and protection, with an important focus on GBV within and across these sectors. It also highlights the fact that existing gender inequalities in each sector are being exacerbated by the COVID-19 pandemic as measures have disproportionate impacts on refugee and migrant populations. This report therefore outlines a summarized set of recommendations that have emerged as common across the four contexts. More detailed recommendations for different actors in each context can be found in the individual country RGA.

Key Recommendations

This combined report provides overarching recommendations that are common across the four contexts. These recommendations call on governments, humanitarian actors and donors to recognise and address gendered differences in needs, priorities and vulnerabilities within Venezuelan and among Venezuelan migrant and refugee communities in Colombia, Ecuador and Peru; especially in the current context of the COVID-19 pandemic. Key recommendations include:

- Mainstream key gender and protection approaches in line with GBV principles and risk mitigation measures across all response sectors including Sexual and Reproductive Health and Rights (SRHR), WASH, shelter, food, nutrition and livelihoods and assistance modalities;
- Ensure humanitarian action considers the unique needs of women, men, girls, boys, and LGBTQI+ people individuals facing multiple, intersecting vulnerabilities;
- Ensure meaningful participation of crisis-affected populations, particularly women, girls, and LGBTQI+ people by actively and including their existing leadership;
- Meet the urgent protection and GBV-related needs faced by women and adolescent girls, as well as LGBTQI+ people individuals;
- Strengthen the Sexual and Reproductive Health (SRH) response in line with the Minimum Initial Service Package (MISP) for SRH in Crisis Settings;
- Support cash and voucher assistance, income-generating activities and safe and dignified employment options, based on a gender-sensitive market and risk analysis;
- Ensure the availability of safe shelter and housing options, particularly for women and girls travelling alone, or with young children;
- Urgently address food security and nutrition concerns, with a particular focus on the needs and vulnerabilities of women and girls on the move.



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Introduction

Humanitarian Context

Background. Ongoing political and economic crises in Venezuela have led to hyperinflation, breakdowns in public services, and stark increases in poverty levels, food insecurity, GBV and other forms of violence since 2016. This has resulted in massive displacement both within Venezuela and to other countries in the region, causing one of the single, largest human mobility crises in the world. According to the Coordination Platform for Refugees and Migrants from Venezuela (R4V), there were almost 5.1 million Venezuela refugees and migrants around the world as of May 5, 2020; the majority of whom remain in the region and over 2.6 million of whom are located in Colombia and Peru alone.¹

Colombia. Colombia hosts more than 1.8 million Venezuelans² – including over 1 million with an irregular status, and who are therefore without proper documentation to facilitate access to basic rights and services including healthcare.³ Colombia, itself, is emerging from decades of armed conflict which displaced over 7 million people, most of whom are marginalized rural, indigenous and Afro-Colombians.⁴ There are 7 formal border crossings along the 2,219 kilometer long border between Colombia and Venezuela, but at least 130 illegal informal crossing points have been detected,⁵ indicating that official numbers of migrants and refugees are likely significantly lower than actual numbers. The main points of entry into Colombia are in the departments of La Guajira and Norte de Santander, bordering the Venezuelan states of Zulia and Táchira.

In La Guajira department, Paraguachón is the only official entry point along the 249 kms border between Colombia and Venezuela. Weak infrastructure in this area is evidenced by scarce water supply, lack of access to health and education services, resulting in poor health outcomes such as high rates of child

¹ <https://r4v.info/en/situations/platform> (using data from May 5, 2020). Data drawn from the website on May 07, 2020.

² <https://r4v.info/en/situations/platform> (using data from Feb 29, 2020). Data drawn from the website on May 07, 2020.

³ R4V. Regional Refugee and Migrant Response Plan 2020 – May 2020 Revision. Accessed May 11, 2020.

⁴ <https://r4v.info/es/documents/download/76210>

⁵ Ministerio de Relaciones Exteriores, 2018

⁵ At the time of writing the CARE Colombia RGA (2019)

mortality. It also has a long smuggling history, with local criminal structures and armed groups controlling the trafficking of people and contraband, including gasoline, illegal drugs and non-food items. The department of Norte de Santander is the main entry point from Venezuela to Colombia with a border extension of 421 kms. Mobility in the department is constrained by the presence of armed groups related to internal armed conflict in Colombia, which creates high levels of risks related to violence, child recruitment and GBV. The main metropolitan area of Cúcuta has a large portfolio of public services, but both pendular and transit migration in the area has created an economy based in remittances, unemployment and high inflation. Displaced persons are concentrated in peripheral areas, with no access to the sewage system or electricity. Pre-existing public service and space limitations make overcrowding a source of risk for women, men, girls and boys. There has been an increase in recruitment for armed groups' urban cells; vulnerable groups are specifically targeted for inclusion in illegal smuggling operations.

Ecuador. Ecuador has gradually become a destination for Venezuelan population rather than a transit route. As of end March, 363,018⁶ Venezuelans were officially registered as either staying in the country or in transit to other countries. However, it is widely believed by operational actors that this figure is likely 50% under-reported as many people are entering through informal border crossings, thus not registered in the system. On average, 200 people were arriving every day by regular crossings, while up to 5,000 people were arriving daily via irregular crossings. The Ecuadorian government imposed a series of migration measures to control the entrance of Venezuelan migrants in July 2019, after Chile and Peru put a visa requirement into effect for Venezuelans. Since then, at least 80% of new arrivals are reported to enter through illegal crossings, many of them controlled by illegal groups including guerrillas, drug traffickers, smuggler gangs, and organized crime networks. Ecuador is, itself, in the midst of an acute economic and political crisis, creating tensions between local host populations and migrants/refugees and leading to various conflicts over scarce resources and limited services.

Peru. By September 2019, Peru was officially hosting over 850,000, with the majority entering the country in 2018. The Peruvian government initially followed an open migration policy for the Venezuelan population; however, this policy framework gradually shifted over time – as public opinion and sentiments shifted to be less welcoming – to one that limits migration from Venezuela. This stricter policy environment imposes immigration requirements that are impossible for most Venezuelan migrants and refugees to meet, with the result that many Venezuelans are now travelling through irregular and informal channels. Upon arrival in the country, integration into Peruvian society is difficult and slow. Peru has high levels of informality (in trade and labour, among other areas)⁷, strong religious and conservative social groups,⁸ high levels of GBV,⁹ racism and social discrimination against vulnerable groups.

Venezuela. The crisis in Venezuela has led to stark declines in health, safety and quality of life for millions of Venezuelans. Poverty levels in the country increased from 41% of households in 2015 to 52% of in 2018. Various health and social indicators in the country reflect this decline: Maternal mortality rates increased from a relatively stable 68.66 deaths per 100,000 births in 2013 to 112.29 women by July 2016 (the most recent figures available)¹⁰ while infant increased by at least 30% since the beginning of the crisis.¹¹ By 2018, the percentage of 12 to 17 year-olds attending school decreased to 70%, and 94% of households surveyed were reporting that their income was insufficient to meet all their needs. 80% of households surveyed were reporting food insecurity.¹²

⁶ <https://r4v.info/en/situations/platform/location/7512>, from May 5, 2020 Coordination Platform for Venezuelan Refugees and Migrants (RV4) report, using data from March 31, 2020

⁷ INEI 2019

⁸ Revista Argumentos, No-1-Año-12-2018

⁹ ENDES 2018

¹⁰ Según el Informe del Ministerio del Poder Popular de la Salud, *Sala Situacional para la Erradicación de la Mortalidad Materna 2017*; Lopez, 2017.

¹¹ Según Amnistía Internacional (2018)

¹² UCAB, UCCV, USB, s.f.)

Many Venezuelans face significant challenges in meeting their basic needs while in transit to, or upon arrival in, their host countries. They often and have to contend with high levels of violence – GBV and trafficking – as well as generalized xenophobia, a lack of access to basic services and/or protection, and a denial of basic human rights. Protection risks such as trafficking (for labour and sexual exploitation), and other forms of GBV, are particularly stark for high numbers of unaccompanied children, women traveling alone with young children. Migrants and refugees also often face barriers to livelihoods opportunities in their host countries, leading to a flourishing transactional sex economy. Xenophobic discourse and attacks are also common.

COVID-19. The first COVID-19 cases in Latin America were found in Brazil in February, 2020. Venezuela declared its first cases on March 13, 2020. Venezuela is considered one of Latin America’s most vulnerable countries in the face of COVID-19, given the poor state of the country’s health system, and Ecuador and Peru are two of the hardest hit countries in the region with high infection rates per million inhabitants. As of the time of writing, sex disaggregated data was only available for Ecuador, Peru, and Colombia but, in each country, case fatalities and infection rates are following the global trend of being might higher for men than women.

Job losses as a result of COVID-19 related movement restrictions, and increasing costs of basic resources in host countries, mean many Venezuelans are now unable to afford accommodation, food, or other basic needs. As a result, April-May 2020, saw a spike in levels of evictions for Venezuelans in host countries and subsequent homelessness and destitution of refugees and migrants. Many Venezuelan refugees and migrants are therefore now unable to cover regular basic needs such as shelter, food, hygiene and healthcare needs, and are equally unable to comply with the quarantine measures and social distancing.¹³ This has led to an increase in spontaneous returns to Venezuela¹⁴ – as people are left with no other alternative – but has also exposed them to additional health and protection risks across the region such as increased trafficking, exploitation by smugglers, and pressure to engage in survival sex. Incidents of xenophobia and violence against Venezuelans by host communities perceiving them as potential “vectors of disease” have also been on the rise. Overstretched health systems, and continued uncontrolled movements across borders, as well as refugees’ and migrants limited capacity to socially isolate themselves or adhere to infection control measures such as handwashing in these conditions, are therefore increasing their exposure and vulnerability to COVID-19. As mobility restrictions ease up, it is unclear when – and how – Venezuelan migrants will be allowed to re-enter host country workforces and/or safely access income earning opportunities in either their home, or host, country. In short, COVID-19 has exacerbated all of the life-threatening health, economic, and protection challenges facing Venezuelan refugees and migrants across the region.

RGA Objectives

This RGA report has the following objectives:

- **To identify key trends, and differences, in the situation and vulnerabilities** facing the women, men, girls and boys affected by the Venezuelan crisis across 4 countries: Venezuela, Ecuador, Peru. Colombia;
- **To understand the impact of the Venezuelan crisis on gender dynamics for Venezuelans** across the region; and how the crisis may have led to changes in these relations;
- **To give a snapshot of Venezuelan women, men, boys’, girls’ common, urgent, protection needs** across home and host countries; and to highlight potential gaps in current humanitarian responses in Venezuela and/or Venezuelans’ home and host countries (as a result of these

¹³ Ibid

¹⁴ R4V. Flash Update: COVID-19 Update. April 17, 2020.

changes in gender relationships);

- **To analyze potential entry points (geographical and programmatic) and make concrete gender-focused recommendations** to humanitarian actors that can help improve humanitarian response across the region.

Methodology

Background. RGAs are progressively built up using a range of primary and secondary information to understand gender roles and relations and how strategies need to be in place to support the changing gender dynamics during a crisis. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls of different ages, abilities and other contextually relevant forms of diversity and to ensure we 'do no harm'. RGA uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterize humanitarian interventions. RGAs follow an iterative process; the data in this compiled document will be updated appropriately over time when new findings and recommendations are produced.

This Report. This RGA report is a consolidation of 4 country-specific RGAs carried out in Venezuela, Colombia, Ecuador, and Peru between May 2019 and January 2020.¹⁵ These reports were complemented with light secondary data research from the CARE LAC RGA for COVID-19 (April, 2020) and 2 key informant interviews with CARE Colombia staff conducting an RGA-Power exercise (May, 2020).

The information selected and presented in this report represents the key trends identified for Venezuelan women, men, boys, and girls, in the region over the course of all 6 RGA exercises carried out over the 12 month period. Information was selected and included in this report if:

- It represented a commonality for all Venezuelan men, women, boys, girls, LGBTQ people across all 4 countries.
- It represented a specific, or key difference, unique to Venezuelan' men, women, boys, girls,' LGBTQ people specific experience in 1 or 2 of the countries (and could, therefore, be significant for Venezuelans in others and should be further explored).

All other information, though important and rich in significance, was not selected for inclusion in this report but remains accessible in the individual RGA reports from each individual country.

Research Methods & Participants

The source RGAs included a mixture of both secondary, and primary, data collection and analysis, including through community mapping, surveys, KIIs, and focus group discussions. This included:

- **Community Mapping** with 917 individuals (607 women, 310 men) in Peru;
- **36 Focus Group Discussions (FGDs)** across all 4 countries, divided by sex, age, and some vulnerability factors, including pregnant and breastfeeding women;
- **95 Key Informant Interviews (KIIs)** across all 4 countries with: Venezuelan migrants and refugees, community leaders, representatives of government agencies, Non-governmental Organizations (NGOs) and other service providers
- **2,618 Surveys** with 1,682 women, 913 men, and 22 gender-diverse individuals across 3 of the 4 countries (Ecuador, Peru, and Venezuela)

¹⁵ Colombia: May 6-13, 2019 (some secondary data analysis was completed before and after this period), Ecuador: November 5-20, 2019, Peru: December 3, 2019 – January 9, 2020.

Breakdown of RGA Participants by age, sex and location		Colombia*	Ecuador			Peru			Venezuela***				Total
		Total	Total	12-17	18+	Total	12-17	18+	Total	12-19	20-50	60+	
Community Mapping	Total	0	0			917	77	840	0				917
	Female					607	41	566					
	Male					310	36	274					
	Gender-Diverse					0	0	0					
Focus Group Discussions	Total	4	12			5			15	3	8	4	36
	Female					2			9	2	6	1	
	Male					1			4	1	2	1	
	Gender-Diverse								0	0	0	0	
	Mixed					2			2	0	0	2	
Surveys	Total	0	782	56	726	902	77	825	934	216	617	101	2618
	Female		534	35	499	601	41	560	552	133	358	56	1687
	Male		238	20	218	301	36	265	370	83	246	45	909
	Gender-Diverse		10	1	9				12				22
KIIs**	Total	45	27			15			8				95

* NB. Colombia data does not include age breakdowns

** NB. Of 45 KIIs in Colombia, 15 are with Venezuelan migrants and refugees

*** NB. Breakdowns for Venezuela survey results are given by gender, where other countries are given by sex, due to discrepancies in data. Refer to the Venezuela report for details including by sex.

In each context, primary data collection was complemented by secondary data analysis, including from government, United Nations agencies and NGO sources.¹⁶

Geographic Focus

Locations for primary data collection were variously chosen across the 4 countries for their proximity to borders, high numbers of displaced individuals, known limitations in access to services and resources, and ease of accessing participants through existing CARE and partner projects.

Country	Location (State/Department/Province)
Colombia	Riohacha & Maicao (La Guajira Department); Cúcuta & Puerto Santander (Norte De Santander Department); Bogota.
Ecuador	El Oro Province (on the border with Peru), Pichincha, Azuay, Manabí, and Sucumbíos. ¹⁷
Peru	Callao, Lima, Piura, Tumbes & La Libertad
Venezuela	Focus Group Discussions (FGDs): Bolivar (Tachira State – Colombian border), Sucre (Miranda State) & Vargas (Guaira State). Interviews: Caracas.

¹⁶ For a full list, see the individual RGA reports from each country.

¹⁷ In Ecuador, data collection was carried out with the support of five organizations: Quimera Foundation and Plataforma Latinoamericana de Personas que realizan Trabajo Sexual (PLAPTERS), Alas de Colibrí Foundation, Diálogo Diverso, Nuevos Horizontes Foundation, and two professionals linked to women's organizations in the province of Sucumbíos.

Limitations

- **Safety:** Safety concerns and risks related to immigration status prevented some migrants, refugees and key informants from participating in the 3 host countries. Some participants did not want to discuss sensitive issues such as migratory regularization or xenophobia.
- **Participation:** In Colombia, a short primary data collection timeframe meant that geographic coverage was limited, and the RGA did not reach those in the informal settlements that are more distant from the border, and smaller Indigenous settlements. In Peru, the timing of data collection made it difficult to include adolescents due to school vacations. In Venezuela, interviews could not be held with national government officials. For this reason, the Venezuela analysis primarily uses government information from two sources: the Instituto Nacional de Estadística (INE) website and the Plan for the Homeland (*Plan para la Patria*) document. In Ecuador, many key informants delegated personnel under their supervision instead of participating themselves.
- **Representativity:** In Venezuela, a significantly higher proportion (50.45%) of households in the survey sample were headed by women, as compared to the recorded national average (39%), leading to an oversampling of this group. In Colombia, most respondents reported that they had been in the country for less than two months. This may be due to fear of deportation as many migrants are in Colombia on tourist visas that expire after 90 days. However, if this information is accurate, the survey may represent perspectives of only a sub-set of the migrant and refugee population.
- **Limited information on at-risk groups:** Limited information could be gathered on at-risk groups such as Indigenous and LGBTIQ+ populations. Some gender-diverse individuals did not want to identify themselves as such due to safety concerns. In Peru, contacting participants through activities planned by governments or other actors may have represented an obstacle to the identification of the most vulnerable populations, including individuals with physical or intellectual disabilities, chronic illnesses, or those in situations of extreme poverty.
- **Comparability of RGAs:** While identifying similar trends in some respects, the 4 country level RGAs are difficult to compare in many others, as they included different age and gender categories, different main sectoral focuses, different levels of depth in different thematic areas and, occasionally, different questions on the same topic. This report therefore tries to mine the wide variety of data presented to find common trends where possible, and signals when other pieces of information are likely to be repeated as trends across different countries even if current RGA data did not include it; thereby suggesting that they be explored in future RGAs.
- **COVID-19:** The RGAs in all 4 countries were conducted before COVID-19¹⁸ emerged as a worldwide pandemic, and significantly prior to the first recorded cases in Latin America. The primary data collected in the different countries therefore does not address any gender-related changes connected to the disease or related mobility restrictions and public health measures; however, this RGA draws on secondary data sources to include a brief update in the context of COVID-19, given the consolidation occurred during and after the pandemic's emergence.

18 COVID-19: Corona Virus Disease 2019.

Demographic profile

Of the estimated 5.1 million Venezuelan migrants and refugees globally, more than 3 million are thought to be in the 3 host countries covered by this combined RGA. Colombia hosts an estimated 1.8 million Venezuelans, while more than 861,000 are registered in Peru, and 363,018 in Ecuador (in transit or staying in the country).¹⁹

While migratory flows from Venezuela early in the crisis consisted largely of men and professionals with the skills and funds to support themselves, this make-up has changed in recent years with more Venezuelan women and girls arriving in all 3 host countries. For example in 2019, 55% of registered Venezuelans who entered Ecuador were women: 29% were under 18 years of age, 65% were aged 18 to 55, and 4% were elderly.²⁰ This does not include individuals who entered the country through illegal border crossings, who are estimated to make up 80% of the migratory flow into Ecuador. Discussions with Colombian health officials at formal border crossings in the same year indicated that approximately half of all Venezuelan women crossing into Colombia were pregnant or with young children for whom they seek medical care. Some children cross into border towns in Colombia every day to go to school, because of disruptions of their education in Venezuela. See the section “Roles and Responsibilities” for more details.

Findings and analysis

Gender Roles and Responsibilities

Pre-Crisis Gender Roles

Historically in Venezuela, *machista* gender and social norms slot in men into traditional roles as primary breadwinners and decision makers, while women are primarily responsible for the child-rearing and domestic work in their households. These traditional, stereotypical views of gender roles were often found amongst the Venezuelan populations surveyed. For example, FGDs with male Venezuelan participants revealed a host of traditional beliefs along these lines including the belief that “cooking is women’s work,” “sometimes it is good to hit (your) woman,” and that “it is acceptable to sleep with other women (as a man, but) that women should “care” for themselves (to look nice and not have sex with others).” Interviews with Venezuelan women and men across Ecuador, Peru, Colombia confirmed these tendencies amongst Venezuelan communities.

Data from all 4 countries also demonstrate how these traditional roles were reflected in income and earning opportunities prior to the crisis – with men in heterosexual couples earning more than their wives, on average. The ENPOVE 2018 data from Peru showed that 65% of men, and 60% of women, surveyed declared that men earned more than their female partners, while only 20% of women and 12% of men surveyed declared that men earned less than their female partners. These gender dynamics led to male-dominated decision-making and access to resources amongst heterosexual couples in Venezuela prior to the crisis, regardless of socio-economic class, or the country interviewees had migrated to.

¹⁹ R4V Updated numbers as of May 7, 2020. Accessed: <https://r4v.info/en/situations/platform/location/7416>

²⁰ Ecuador Ministry of Government, Migration Flow Reports 2016, 2017, 2018, 2019 (last update September 26, 2019). pg.1

Gender Roles and Migration

Data from all 4 countries show that the division of traditional gender roles also influenced migratory dynamics for the Venezuelan population. Initial migration flows Results showed that the first waves of migration were largely made up of men migrating to provide for their families (i.e. 59% men in Ecuador, 63% in Peru). However, subsequent migratory flows slowly moved towards being more female dominated as women, girls, boys and complete families moved to rejoin the family members who first moved to the new host country (i.e. 58% women in Peru).



This migratory pattern also led to both shifts in, and exacerbations of, traditional gender roles for Venezuelan women. In Venezuela itself, men's migration to find more lucrative job opportunities (and/or to escape the higher likelihood they would be imprisoned or placed under house-arrest given political deterioration), left women in mixed households on their own, with increased income-earning and decision-making responsibilities, on top of their existing roles as caretakers. This resulted in the majority of women surveyed (both in Venezuela and in host countries) becoming the active head of their household while still in Venezuela; responsible for young children and other dependents as both primary caregivers and primary providers. While this has led to a gender role shift that has increased decision-making and leadership for women in their households, it has also led to increased care burdens and workloads which, in turn, increased vulnerabilities for these women and their dependents.

Consultation data from all 4 countries show that these additional roles and responsibilities persisted for most women upon arrival in their host locations. For example, 52.4% of women surveyed in Peru maintained that they were still heads of their household in their host country because they remained as the main economic provider for their family; even in the new location. Several countries found that this role change for Venezuelan women brought increased self-esteem and a sense of agency, even as it also brought additional stress and new concerns.

As family reunification – and women's migration with dependents has increased – so has the care burden of those women who remained in Venezuela. In Peru, 1 out of every 5 migrant groups traveling with minors (21%) reported that they had left other minors in their families back in Venezuela, under relatives' or others' care. Traditional gender roles, and an analysis of migrants' age demographics, means children were likely being left with other women such as grandmothers, older aunts, or other female family members. In host countries, Venezuelan women and men reported that they largely organized childcare within their own family networks as well; leaning on aunts, grandmothers and other female family members for additional, unpaid care. In both Colombia and Peru, women and men clearly demonstrated that migrant families without these female-led care and support networks face more difficulties accessing resources and/or are more limited in the forms of employment they can access. While some countries, such as Peru, do offer access to childcare services, these services are often limited and insufficient. They are also often misaligned with the work hours and schedules needed by both host community and migrant/refugee populations. These dynamics mean women's unpaid care labour is being used as an essential element of households' migration and economic survival strategies; increasing women's domestic workload even further, as well as the barriers to accessing safe, dignified work.

Access to and Control of Resources

Most public services were made available by the government in Venezuela prior to the crisis. While the cost of services such as water, electricity and health were heavily subsidized and sometimes free, men were most likely to cover these costs or make decisions about these services. This resulted in the perception that men controlled these resources. In addition, before rapid hyperinflation, food, non-food items and other assets were primarily purchased by the male income to the household. However, with the changing economic, political and social climate over the past few years in Venezuela, the ongoing crisis resulted in a shortage of public services such as electricity, water and natural gas for cooking. This situation challenged male control over household needs and resulted in greater participation/ involvement of women in the control of resources.

Food was one area where traditionally women made decisions for the household. However, as the crisis unfolded, Venezuelan women surveyed were able to claim more control over non-food assets as many had to sell off these items (i.e. television, furniture or other assets) to secure the cash needed to buy food for the household; especially as male partners and traditional household decision-makers migrated out.

Gender roles have shifted in other traditional resource areas as well amongst migrant populations in host countries. For example, safety concerns for women and girls in informal settlements in Colombia meant that men and boys surveyed became primarily responsible for seeking out water sources for their households. When asked about safety, Venezuelan participants in Colombia responded that women and girls may support in these activities but are usually accompanied by a male to ensure safety.

Generally, gender roles show some interesting opportunities for change in the midst of this crisis – including women's increased agency and decision making in the household as well as men's increased foray into care work. However, overall, women and girls in all 4 countries noted that their increased role in preparing food, caring for the household, and ensuring household health – as well as the additional time they now devote to generating income and household resources – is increasing their workload astronomically compared to that of men in their households. It is therefore also negatively impacting their mental, physical, and emotional health in different ways to their male counterparts.

Impacts of COVID-19

COVID-19 and related public health measures are disproportionately impacting refugees and migrants in the region; especially women and girls. While specific data regarding gender roles and relationships is just starting to emerge, important trends include an exacerbation of women and girls' unpaid care work in the household. In the LAC region, women, spend on average, 3 times as long as men on unpaid domestic and care work each day in the region. Prior to the crisis, this translated to a total of 22 to 42 hours a week on unpaid domestic care work for women in Latin America.²¹ While there is no recent data for Venezuela, according to ECLAC, women in Peru spend approximately 39.9 hours a week on unpaid care work (more than 24 hours than Peruvian men), while women in Ecuador spend 37 hours (27 hours more than men), and Colombian women spend approximately 32.9 hours (almost 20 hours more than men) a week



²¹ Per countries where such data has been made available. CEPAL. "La pandemia del COVID-19 profundiza la crisis de los cuidados en América Latina y el Caribe". 2 April 2020. Pg 1. <https://repositorio.cepal.org/bitstream/handle/11362/45335/1/S2000261_es.pdf>

on unpaid care work. There is no reason to assume this trend is different for Venezuelan women and men, especially given limited access to childcare or other care provision services in their host countries. Women living in households with limited access to drinking water – such as refugee and migrant households living in crowded or insufficient conditions, also spend between 5 and 12 more hours per week on unpaid domestic and care work than women living in households without such privations.²² Quarantine measures and social distancing rules – such as school closures and limited transit – have combined with these pre-existing inequalities to astronomically increase women’s care giving burden in the face of the COVID-19 crisis; negatively impacting their physical and emotional health as well as their ability to access income generating opportunities.

Capacity and Coping Mechanisms

Livelihoods

Across all 4 countries, informal work and irregular immigration status combines with precarious employment to create high levels of vulnerability to exploitation and trafficking for both women and men; including labour-related exploitation such as lack of payment or unfair payment, and unsafe working conditions.

In Venezuela, the crisis has led to an increasingly precarious local labour market and more reliance on international remittances. This has been more significant for women, where 6.8% of women surveyed report receiving remittances, compared to 2.9% of men. Only 15% of female heads of households report that their income is sufficient to cover their needs, compared to 26% of male heads of households. Both men and women have seen decreases in regular and/or professional work opportunities, in favour of increases in informal trade and sales-related work. LGBTIQ+ individuals surveyed in Venezuela also report a need to rely on increased levels of in informal sales and bartering to obtain essential goods.

Displacement creates additional challenges in generating enough income to meet basic needs. For example in Colombia, migrants and refugees reported that they were robbed of their money, clothes and legal documents during their journey to the host country. Some men and boys reported traveling to Colombia for short periods of time to earn money to send back home – including through fixing trucks and carrying items across the borders (such as weapons, drugs and gasoline). At border areas, many women and girls reported selling their hair (for the production of wigs) to earn money.

Upon arrival in all 3 host countries, employment opportunities are limited, informal, and often risky. Though employment is universally hard to come by, there are important gender differences evidenced across all the surveyed locations: for example in Ecuador, 40% of women and 38% of LGBTIQ+ individuals surveyed report not having access to work, compared to only 29% of men. The situation is similar in Peru, where only 64% of women versus 73% of men interviewed reported some kind of income-generating activity. Across Colombia, Ecuador and Peru, many Venezuelans earn money in the informal sector through begging, garbage collection/recycling, and working as street vendors. Many women and girls engage in domestic work or work in bars. Women and girls, and LGBTIQ+ individuals, also reported engaging in transactional sex for survival. In Colombia, some respondents reported that girls are even encouraged to do so by their mothers. Some men and adolescent boys engage in construction work, and some are involved in smuggling of fuel, drugs and other contraband, a situation which increases vulnerability to recruitment into criminal gangs and armed groups.

Barriers to finding employment for Venezuelan women and men in all 3 host countries include their nationality and immigration status (for example, 15% of those without an income in Peru report being refused a job due to their nationality), and some report resigning due to lack of payment (7% of unemployment respondents in Peru). Women and girls face additional burdens including high childcare burdens that prevent them seeking work, as well as sexual harassment. Of those who are working, many are forced to work long hours to make

²² Ibid.

ends meet, no matter which country they find themselves in. For example, in Peru, 55% of respondents in one study reported working more than 60 hours a week, meaning up to 14 hours a day. This situation has an impact on the care roles of women and men, who are forced to redistribute tasks and household responsibilities,²³ and on the costs associated with pursuing income generating opportunities.

Impacts of COVID-19

Refugee and migrant populations are being especially hard hit by COVID-19 containment measures as mobility restrictions have essentially shut down the informal economy where many migrants/refugees worked. Over half of all Venezuelan households interviewed in Colombia for the RMRP COVID 19 Revision reported have problems complying with quarantine measures, mainly due to the need to generate income to cover their basic needs (43%) or access food (36%). In Ecuador, 63% of refugees, migrants and host communities surveyed mentioned not having a job during the lockdown.²⁴

While there is not much data as of yet regarding the specific, gendered impacts, of COVID-19 on male vs female migrants and refugees, it is possible to surmise that women will be disproportionately hit, for longer, than their male counterparts. Women and men's participation in the informal sector varies across the region, with 11.4% of working women in the region employed as paid domestic work; 77.5% of whom are in the informal sector.²⁵ This will increase women's specific vulnerabilities in the face of COVID-19 as increased demands for care for their employers fall on their shoulders (because of school closures, a devolution of health care to individual households, etc), but without the systemic tools needed to be able to push back. Women with irregular migration status will be further vulnerable to increased demands or pressure from employers as that can be used as a tool to trade housing and/or pay for additional care work. This leaves women with the impossible choice of refusing work, or exposing themselves (and their dependents) to increased risks of infection as they engage in care.

Additionally, a 2017 study in Peru²⁶ found that women with children participate in the labour market at lower rates than child-less counterparts (because of their care work) and are largely found in informal, vulnerable employment, without social protections. Given women's larger propensity to migrate with children and/or family reunification, it is safe to assume that this will add additional barriers to migrant and refugee women's reintegration into paid work as COVID-restrictions start to lift.

Women's Participation and Leadership

The political, social and economic crisis has had a disproportionate impact on Venezuelan women's participation and leadership across all 4 contexts. As a result of the crisis, women in Venezuela have seen an increase in reproductive burdens and care tasks in the household, as well as their freedom to organize and mobilize become increasingly restricted over time. Venezuelan women leaders who denounce human rights violations are harassed and persecuted.

Women and girls report that they have not been consulted in the humanitarian response, despite their ongoing role in leading local responses to community needs. For example, in Colombia, the scale and complexity of the crisis has led humanitarian organizations to focus on meeting life-saving needs, de-prioritizing the participation of migrants and refugees in the humanitarian response. As a result, women, men, boys and girls have few, or no, mechanisms to voice their views or concerns.

²³ Antonio Ruiz de Montoya University & Labour Ministry, Peru

²⁴ R4V. Regional Refugee and Migrant Response Plan 2020 – May 2020 Revision. Accessed May 11, 2020. <https://r4v.info/es/documents/download/76210>

²⁵ Per countries where such data has been made available. CEPAL. "La pandemia del COVID-19 profundiza la crisis de los cuidados en América Latina y el Caribe". 2 April 2020. Pg 1. <https://repositorio.cepal.org/bitstream/handle/11362/45335/1/S2000261_es.pdf>

²⁶ <https://www.cies.org.pe/es/investigaciones/empleo-genero-pobreza/penalizaciones-salariales-por-maternidad-el-costo-de-ser-madre>

Although the region is home to many long-standing civil society and women's organizations – including those that address the needs of those with diverse sexual orientations and gender identities – these organizations remain under-represented in the response and associated decision-making.

COVID-19. On-going CARE RGA-P activities in Colombia (April-May 2020) show evidence that migrant and refugees' participation are becoming even more restricted as a result of COVID-19 mobility restrictions. Whereas Venezuelan women reported that, prior to COVID-19 measures, they could at least "have a voice, even if not a vote," by attending municipal meetings and decision making spaces, these avenues have closed as a result of quarantine measures. They report being left out of both decision-making spaces and information flows that they previously had access to.

Protection²⁷

Venezuelans in all 4 contexts are faced with significant protection concerns, including widespread violence, GBV, trafficking, and a generalised lack of access to related Protection services and support. Venezuelan populations in Colombia, Ecuador and Peru also face risks related to immigration and legal status, as well as xenophobic attitudes and attacks.

In Venezuela, respondents reported their primary concern was being attacked by people or groups, with violence by authorities in second place (except among girls 18-19 years old, where the second-highest concern was lack of access to resources). Women and girls perceive higher risks for themselves across all 8 of the violence categories included in the analysis than men and boys did. Some individuals – especially adolescent girls and boys, and adult males – even reported concerns about participating in the RGA due to the risks this could cause them with military, government, or police authorities.

31% of all individuals surveyed in Venezuela reported that they knew someone who had experienced some form of violence in the past year. Where the person who experienced the violence was male, 41% of the population reported that the perpetrator of violence was unknown. Where the person who experienced violence was female, 34% of perpetrators were reported to be partners or ex-partners. Among LGBTIQ+ individuals, 30% of perpetrators were reported to be their neighbours. This is significant as it shows highly gendered patterns of violence that will follow migrants and refugees into their host countries; especially intimate partner violence against women. Several groups were recognised as particularly vulnerable, including pregnant women, adolescents and older (female) adults. Pregnant women reported not feeling safe in their own homes, where they fear state agents knocking down their doors. Adolescents reported concerns such as limited schooling, entry into the informal labour market, unmet sexual and reproductive health (SRH) needs, high pregnancy rates, and GBV, among others.

Protection risks are exacerbated by forced displacement. Many border areas between Venezuela and Colombia have pre-existing high risks related to armed groups, internal displacement, and natural disasters. These have been further exacerbated by militarized border actions since the onset of COVID-19 and national border closures. Prior to that, Venezuelan migrants travelling through these areas already faced heightened protection risks, including human trafficking and various forms of GBV such as sexual exploitation and slavery. Women and girls are the primary victims of such forms of violence, alongside some men and boys, and LGBTIQ+ individuals. Those who follow the migration route on foot ("*caminantes*") walk very long distances to the border on the Venezuelan side, without access to shelter, latrines and other forms of support. They are often forced to pay fees at informal border crossings or become indebted to those controlling them, and are very vulnerable to exploitation, harassment, sexual violence, recruitment into drug trafficking or other involvement with various armed groups throughout this

²⁷ Protection is defined as the context, and the environment, that enables people to respond to, and overcome, the different vulnerabilities they face. Across all four contexts, Venezuelans report high levels of protection risks.

process. These risks play out differently for male and female “*caminantes*” especially as female *caminantes* are more likely to be traveling with children and/or dependents.

Many of those who make the long journey to Colombia, Ecuador and Peru experience violence en route or after arrival, including xenophobic attacks, robberies, physical assault, psychological violence, sexual violence, and extortion. Women reported the highest levels of sexual violence, while men reported robberies and fights as the biggest safety concerns, including those based on xenophobic sentiments.

Risks Related to Immigration and Legal Status

Many Venezuelans arrive at their destination with minimal information and support networks, often without financial resources and unable to obtain appropriate visas. Borders are highly permeable with many irregular crossings. For example, in Ecuador, 5% of participants surveyed reported having entered the country through irregular means and 8% said they had to make some form of payment to enter. RGA data shows that authorities (including police, migration agents, smugglers, taxi drivers and others) exploit their position of power over migrants at border crossings to make money. Even where there is no exploitation, migration services are reported to be disrespectful and unsupportive of migrants, focusing on those who meet visa requirements while ignoring those in need of protection, including unaccompanied children and adolescents. Immigration officers do not inform migrants how to access asylum claims and refugee services, and the procedures for residence and accessing services are complex and often not shared at the border.

Once Venezuelans arrive in a host country, critical obstacles exist in terms of regularising their documentation, which therefore limits access to various services and support (e.g. work, health, education, credit, justice). In Peru for example, more women than men are travelling under irregular migratory status; 59% of women vs 41% of men.²⁸ Employers and service providers, including in transport and accommodation, take advantage of migrants’ irregularity and their lack of knowledge of the legal framework to abuse and exploit them.

Xenophobia

Mistreatment due to nationality is highly gendered across the region. Images of the Venezuelan population are strongly influenced by stereotypes communicated through the media – and especially social media – including that Venezuelans are flirtatious, overly concerned with their physical image. Venezuelan women are particularly hyper-sexualised, putting them at risk of additional sexual harassment and abuse in their host countries. Xenophobic attitudes and responses are also reported amongst authorities and service providers in all 4 contexts. Xenophobia towards migrants and refugees was reported in Colombia, Ecuador and Peru, with high levels of verbal violence towards migrants, including insults, threats, and shows of contempt.

Gender-Based Violence

Crisis-related social and economic shifts have led to changes in family dynamics, including in some cases men abandoning their families and in others an increase in intimate partner violence (IPV). RGA exercises in all 4 countries confirmed that GBV continues to be widely normalized and justified, with heightened GBV risks for migrants and refugees in particular.

Sexual violence and exploitation is common across all 4 populations. In Venezuela, it was noted that sexual violence is considered a standard form of fee-payment by many of those controlling informal border crossings. In Ecuador, FGDs recorded that the majority of women who entered the country through irregular routes have experienced sexual assault and other forms of GBV. Women in Colombia –

²⁸ Presencia de Inmigrantes en situación de vulnerabilidad en el Perú: Estudio preliminar realizado desde una perspectiva de género. Superintendencia Nacional de Migraciones. Lima, 2018. Pp.27

sometimes with their small children – were offered shelter by Colombian men, and thereby drawn into situations of domestic servitude, including sex slavery. In all 4 countries, Venezuelan women searching for employment reported encountering harassment or job offers that come with the expectation of sexual favors, and women working in bars and massage parlours are treated as sexual objects.

In Colombia, Ecuador and Peru, high numbers of Venezuelan migrants and refugees are forced or coerced to engage in transactional or survival sex. For example in Ocaña in Norte de Santander (Colombia), one survey showed that 90% of the sex workers were Venezuelan.²⁹ Those who engage in sex work – primarily women, girls and LGBTQI+ individuals – often lack documentation and are vulnerable to further exploitation and protection risks, including health risks due to the non-use of contraception. Women in FGDs in Venezuela also reported high levels of harassment by men in the street.

Trafficking

Human trafficking is one of the primary protection concerns across the region. Entry points to trafficking networks are abundant, and often disguised as employment opportunities along the migration route. Trafficking is often for purposes of sexual exploitation, to which women and girls are particularly vulnerable. Participants report that Venezuelan women are often offered only work in bars, which are known entry points for trafficking networks. Minors have also been reported to have been recruited into armed groups at border crossings from Venezuela to Colombia. In Ecuador, data shows that migrants without family or support networks along the route are particularly vulnerable, and the extreme violence used within trafficking networks means that survivors are left with long-term consequences.

Access to Services, Support & Protection

Across the 4 contexts, there is a generalised perception that public institutions and service providers are not adequate or supportive. Respondents suggested that officials in all 4 locations often ignore claims from refugees and migrants, or are themselves the source of harassment or violence. Many of those who experience violence do not report it to authorities due to fear of reprisals and/or arrest and deportation.

GBV service provision varies across the 4 countries: In Venezuela, services are limited and often not of high quality, a situation that has worsened with the crisis. In Ecuador, services are more widely available; however, health personnel are often not familiar with the latest guidelines for GBV-related care, and psychosocial personnel struggle to support complex cases. Both health and protection personnel reported that they lack tools to identify potential cases of GBV and trafficking. Peru has established care protocols for survivors of violence, GBV-related services provided by the Ministry of Women (including a 24/7/365 support hotline), emergency women's centres that provide legal assistance, and counselling to women and other family members, Urgent Care Centres, and Institutional Care Centres – whose services are also available to migrants and refugees - among others. However, information about these services is not shared widely with migrant and refugee populations.

Across all 4 contexts, few respondents reported knowing about GBV services and how to access them, and many reported a variety of barriers to access. In Venezuela, 63% of those surveyed (61% of women, 67% of men, 50% LGBTQI+) reported not having information about services and protection support for GBV cases. In Ecuador, 72% of men, 69% of women and 50% of LGBTQI+ people were unaware of how to report sexual violence. In Peru, statistics were similar when respondents were asked for their knowledge of services; however, they dropped dramatically when asked about access. Only 16.6% of women and 12.2% of men reported being able to access services. Across contexts, respondents reported barriers to access as fear, shame, lack of trust in the system, lack of adequate services or knowledge or knowledge of services.

²⁹ La Opinión. En Ocaña, el 90% de prostitutas es de Venezuela. 23 July 2018. <https://www.laopinion.com.co/ocana/en-ocana-el-90-de-prostitutas-es-de-venezuela-158787>

Impacts of COVID-19

COVID-19 and related mobility restrictions have led to an increase in all forms of violence and protection risks across the region. According to the RMRP Revision (May 2020), “movement restrictions, loss of income and subsequently unfulfilled basic needs, increased discrimination and xenophobia, increased risks of homelessness and unsafe living arrangements, isolation from support networks and heightened exposure to violent partners (for women and girls). This, coupled with pre-existing gender inequalities, has resulted in increased exposure to sexual violence, survival sex, and domestic violence, mainly intimate partner violence.” Reports of GBV increased by 50% since the onset of the pandemic, with the most vulnerable and least enfranchised – such as migrants and refugees – likely being the most impacted as they also likely have the least access to services (which have moved online in several of the countries included in this report) In Peru, reports from April 17, 2020³⁰ indicate that 5,418 women had called the Helpline to denounce incidents of GBV since the start of the emergency – 360 new cases per day of the pandemic. Given that national statistics indicate that 7 out of every 10 women in Peru have experienced violence by their partner, but only 30% of them have reported, it is possible to assume that GBV cases have increased even more significantly during the pandemic than we already believe. Positively, national authorities and service providers are making great strides in innovating different ways to provide GBV and Protection services remotely, even as they face challenges reaching survivors during quarantine measures. In this context, refugee and migrant women and girls are facing additional barriers to accessing essential information and services for their safety and recovery.

Violence against LGBTIQ+ people has also increased during COVID-19. Both Colombia and Peru instituted gender-based “pass” systems to manage movement during pandemic mobility restrictions – limiting people to moving during times when either “women” or “men” were authorized to move. This led to increased policing of, and attacks on, LGBTIQ+ people when they left their homes, especially in cases where authorities deemed LGBTIQ+ people’s gender to be different than individuals’ actual gender identity. Given 63% of LGBTIQ+ people surveyed in Peru reported experience some form of discrimination or violence prior to COVID – principally in public spaces (65.6%) it is highly likely that marginalized migrant and refugee populations are even more at risk than before.

Needs and Aspirations

Expressed needs varied widely across the different contexts. In Venezuela, food was identified as the common highest priority need across all sex and age groups. This is followed by medicine, healthcare, employment and housing, with the order of priority similar for men and women. However, among the LGBTIQ+ population, employment is ranked higher than medicine and healthcare. Those over 60 years old prioritised medicine and healthcare; while 12-17 year-olds identified medicine, healthcare and education as the highest priorities.

In Colombia, interviews showed the desire for education. Most young people were forced to interrupt their education when they left Venezuela, and many pregnant adolescent girls expressed their desire to return to school after giving birth. Women, girls, men and boys all identified challenges in accessing education including differences in the school systems between Venezuela and Colombia, and lack of appropriate legal documentation.

In Peru, four priority needs were identified the most frequently: food, employment, healthcare, and migratory regularization, with similarity in percentages across the categories (women ranked employment four percent lower than men). Data from Peru shows that 8% of surveyed women in Tumbes were pregnant, 13% were breastfeeding, and 21% were mothers travelling alone with children.³¹ Each of these groups reported particular care needs for themselves or for those in their care.

³⁰ CARE Peru COVID-19 RGA document review (unpublished). May 2020.

³¹ Ronda 6 del DTM-OIM, en Tumbes



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Sector Programming

Health, Including Sexual and Reproductive Health

Health

The crisis in Venezuela has a wide variety of negative health impacts. Survey results showed that 46% of respondents in Venezuela had received some kind of medical care in the previous year. Of this group, 55% were happy with the care they received, while 45% reported that their care was only adequate or insufficient. This lack of satisfaction was due to a lack of medication, supplies for medical exams or personnel, deteriorated infrastructure, or the need to visit multiple health structures to find treatment. Respondents moreover showed a generalized concern about the vulnerability of pregnant women, reporting that infrastructure is rundown, there are not enough machines for testing, the cost of pregnancy supplements are very high, and most women do not take them.³²

For Venezuelan migrants and refugees in host countries, health access is highly gendered, and variable. In Ecuador, 69% of women, 75% of LGBTIQ+ individuals, and 45% of men surveyed reported needing healthcare. Among those who needed healthcare, 88% of women, 66% of LGBTIQ+ individuals and 80% of men did not receive the care they needed. Conversely in Peru, 47% of women had sought medical care in the last year, compared to 31.6% of men. Of those who sought care, 92% of women managed to access the services they needed compared to 87% of men.

Among those who needed healthcare in Peru and Ecuador, but did not receive it, men and women reported barriers to access included: lack of money to cover costs or buy medicines, discrimination (including

³² Sistematización GF-ME-1

healthcare personnel refusing to provide services) lack of documentation, and lack of information on how to access medical services. Men in Ecuador particularly reported choosing not to seek medical care in order to avoid xenophobic behaviour by service providers; however, it is likely that this choice also reflects traditional gender stereotypes which discourage men from showing vulnerability and seeking help. In Peru, women also reported challenges related to the opening hours of health services; where women are forced to work up to 14 hours a day while health services are only open during regular work hours. Many women struggle to access services. This is further complicated by their high burdens of domestic and care tasks.

According to the World Health Organization, populations on the move face increased health risks due to the conditions in which displacement takes place, with the most frequent disorders affecting reproductive health, mental health and nutritional status, among others.³³ Mental health issues may be exacerbated by the stress and uncertainty related to forced displacement. For example, in Colombia, 8 out of 10 Venezuelans surveyed confirmed that they themselves, or someone they know, had experienced long periods of sadness, or constant stress and worry. Half of those surveyed had experienced chronic anxiety or fear.³⁴

Sexual and Reproductive Health

Access to SRH services is limited in Venezuela, and for Venezuelan migrants and refugees in host countries. An increase in unplanned pregnancies (including among adolescent girls) and an increase in Sexually Transmitted Infections (STIs) have severely affected women and girls in the country. For example, The number of new HIV infections is estimated to have increased in the country by 24% from 2010 to 2016, and data on HIV infection is not available from 2017 onwards. Venezuela is the only country where many who were previously on Antiretroviral Therapy (ART), no longer have access to Antiretrovirals (ARVs). Survey results showed that of persons known to have HIV or other STIs in the last two years, 34% did not receive treatment, while 66% did receive some type of treatment.

Family planning services have been largely unavailable since the beginning of the crisis, with the cost of contraceptives increasing by 25 times. Public healthcare structures face a shortage of most contraceptive methods, and for many the only method available is surgical sterilization for women. This limits family planning options and has led to an increase in unplanned and unwanted pregnancies.³⁵ Indeed, FGD participants in Venezuela reported that most pregnancies were not planned. In one FGD, 0 out of the 17 women participants had free access to SRH services. The UNHCR reported that the adolescent pregnancy rate has increased by 65% since 2015. This has direct negative impacts on schooling among adolescent girls for whom pregnancy is the primary reason given for school drop-out.³⁶ OCHA reported in November 2019 that many pregnant adolescents are deficient in essential nutrients for the development of their fetus, due to difficulties in accessing appropriate food.

Many pregnant Venezuelan women and adolescent girls are not able to access any antenatal care or delivery services. 81% of the 97 pregnant women interviewed reported that they had received a prenatal checkup. Of this group, 77% received the checkup in the first trimester but only 20% received a checkup in the first month of pregnancy. Among the 19% who did not receive prenatal support, the reasons reported were: not having resources to pay (52%), not having time (29%), and difficulties in access from their homes due to distance or transport needs (10%). Maternal mortality rates have increased since 2015 due to the deteriorating public health system, lack of personnel, supplies, medication, diagnostic tests, and basic services. For many Venezuelan women, lack of healthcare has been part of their motivation for migrating to other countries. For example, many pregnant women and girls travel to Colombia for antenatal care, with

³³ Citado por ENPOVE, Lima, 2018.

³⁴ PADF, IDEHPUCP. Estudio sobre el perfil socio económico de la población venezolana y sus comunidades de acogida: una mirada hacia la inclusión. Cecile Blouin. Lima. Agosto 2019.

<https://www.researchgate.net/publication/335327990> Estudio sobre el perfil socio economico de la poblacion venezolana y sus comunidades de acogida una mirada hacia la inclusion

³⁵ Mujeres al Límite. Equivalencias en Acción. 2019. https://cepaz.org/wp-content/uploads/2019/09/WOMAN_LIMITE_web_compressed.pdf

³⁶ El informe cita a: UNFPA. "Maternal Health". www.unfpa.org/maternal-health

some even returning to Venezuela the same day.

SRH continues to be limited for Venezuelan migrants and refugees in host countries. In Colombia, humanitarian organizations are providing some life-saving services in line with the MISP for SRH in Crisis-Settings. However with the tremendous scale of SRHR needs, weak local coordination mechanisms, and lack of integration with HIV and GBV programming, those with intersecting vulnerabilities – such as pregnant adolescents, LGBTIQ+ individuals, and people with disabilities – are likely falling through the cracks; particularly in more remote informal settlements. Evidence from statistics shared by UNHCR / International Organization for Migration (IOM) figures show that in the year prior to the CARE RGA in Colombia, the number of births in Cúcuta increased by 150% and that, as a result of an already overburdened, health system, maternal morbidity had increased by 71% in 2019. In addition, due to poor access to food for pregnant women, newborns with low birth weight increased by 80% during the same period. In Peru, only 27% of Venezuelans surveyed (15 years and older) reported having received a sexual and/or reproductive health service in the past year. 67% did not receive any service, and 7% did not know about the services available. 51% of women accessing SRH services reported satisfaction with the services they received while 40% reported that it was adequate, and 9% reported that it was substandard. Some reported that terminology for different services varies from country to country, which causes communication problems between healthcare providers and patients.

Knowledge of STIs and Contraceptive Methods: Knowledge about STIs is high in Venezuela, with 80% of surveyed individuals reporting knowledge about HIV, and other infections including syphilis, gonorrhea, and human papilloma virus. This knowledge is similar across sexes. 82% of surveyed individuals report knowledge of the use of condoms to prevent pregnancy and STIs. 32% of people of reproductive age (12 to 39 years) reported using contraception, 62% know about contraceptive methods but do not use them, and 6% reported having no knowledge.

Surveys in host countries show similar, important, gaps between knowledge about, and use of, contraception – especially condoms. In Ecuador, there is widespread knowledge of contraceptive methods by women (95%), men (90%) and LGBTIQ+ individuals (100%). However, 55% of men surveyed, 58% of women, and 69% of LGBTIQ+ individuals reported not having access to contraceptive methods. In Peru, 94% of women and 85% of men reported knowledge of contraceptive methods. However, only 53% of women and 55% of men were able to access such methods. There is a high level of knowledge of the use of condoms to prevent STIs, reported by 85% of men and 90% of women. Generally speaking, almost all respondents surveyed in host countries knew about the male condom, but the female condom was virtually unknown. Women pointed out that they do not need to use a condom because they only have sex with their partner, or because they do not have a partner, while men avoided responding, or simply pointed out that they do not need it.

Institutional Violence

Some women and girls report discrimination, violence and refusal of service by healthcare providers. For example, in an FGD discussion in Ecuador it was reported that healthcare personnel refused to administer emergency contraception to a 14-year old girl who had been raped, due to their own personal position on the use of the method. Though anecdotal in nature, reports from FGs across the 4 countries indicate that negative attitudes towards, and stereotypes about, adolescent girls constitute an important limitation on their access to services.

Impacts of COVID-19

COVID-19 confirmed case numbers, and case fatality rates, in the 4 countries appear to bear out the global trend that more men contract the disease, and are more likely to die from it, than women.

Table 1 – Sex and Age Disaggregated COVID-19 data³⁷ for available countries

Country *	Confirmed Cases	Cases (% male)	Cases (% female)	Deaths	Deaths (% male)	Deaths (% female)	Deaths among confirmed cases (male)	Deaths in confirmed cases (female)	Deaths in confirmed cases (Male:female ratio)
Ecuador	20,622	56	44	2,127	69	31	12.8%	7.1%	1.8
Peru	68,822	60	40	1,961	72	28	3.4%	2.0%	1.7
Colombia	11,613	57	43	479	61	39	4.5%	3.7%	1.2

Ecuador rapidly became the epicenter of the outbreak in Latin America, with Colombia and Peru also hard hit. Venezuela has a ratio of hospital beds to patients that is less than 1 per 1,000, while the ratios in Colombia and Peru are less than two beds per 1,000 patients.³⁸ This limits infected patients' likelihood of being treated. For migrants and refugees in host countries, pre-pandemic xenophobia, barriers to accessing services (such as cost and access to medical equipment) increases the risk that they will be unable to access treatment or health services when they need it.

When states are unable to offer health care, families take charge of family members' health care, including: purchasing medicines, engaging services and providing direct care for sick people.³⁹ Gender roles and women's contribution to household care mean that the majority of this increased care load – and related costs – will be taken on by women and girls. As school closures require children to stay home, this can have the converse effect of leading families to de-prioritize girls' schooling in favour of their help with health care as family members become sick or household tasks take more time – such as food collection, income generation, and increased hygiene requirements for COVID-19 infection control in the home.

In Latin America, women represent 74% of the health and social workforce;⁴⁰ increasing their exposure to the disease and meaning they – and their households are further affected. While 75% of decision-making roles in the health sector are held by men, women are overrepresented in the most vulnerable, least protected roles such as health care personal attendants, cleaners, cooks, nurses, and other frontline jobs. Whether in Venezuela, or migrants/refugees in host countries, Venezuelan women and girls will likely be more impacted by COVID-19 as they take on these care tasks for both their paid jobs and their households. This is further exacerbated by the fact that, regionally, women's income in the health sector is generally 25% lower than that of men.⁴¹

Food Security⁴²

Venezuela is faced with high levels of food insecurity. 79% of respondent heads-of-household (60% of female-headed households, 39% of male-headed households, and 1% of households headed by LGBTIQ+ individuals) in Venezuela report that their income is not sufficient to buy food. This difference may be

³⁷ The reporting dates in each case are: 10.05.20 (Ecuador) and 11.05.20 (Peru, Colombia)

³⁸ World Bank. Hospital Beds (per 1,000 people). <<https://data.worldbank.org/indicator/sh.med.beds.zs>>

³⁹ https://repositorio.cepal.org/bitstream/handle/11362/45352/1/S2000260_en.pdf

⁴⁰ Delivered by women, led by men: A gender and equity analysis of the global health and social workforce. Geneva: World Health Organization; 2019 (Human Resources for Health Observer Series No. 24). Licence: CC BY-NC-SA 3.0 IGO.

<<https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf?ua=1>>

⁴¹ https://repositorio.cepal.org/bitstream/handle/11362/45352/1/S2000260_en.pdf

⁴² Information on Food Security is only available for Venezuela.

explained by the fact that among female-headed households there is a greater number of families where at least one family member has migrated.

Within households, distribution of food by gender and age is varied. For some families, participants reported shared and equal decision-making, others state that the decision is made by men, while still others report that the decision is made by women. Women, including older women, report that they prioritize food for children before eating themselves.

Faced with difficulties in finding food (prior to COVID-19), 35% of households had already reduced the quantity of food in each portion; 32% have reduced the variety of food; and 23% have reduced the number of meals per day. Though these statistics are similar across genders, it is likely that the impacts are higher on women – especially pregnant and breastfeeding women - and LGBTIQ+ individuals. Coping strategies vary by gender: children in female-headed households are often sent to other families (often their grandparents) who can help to support them; in male-headed households, it is more common to sell household goods as a means to access economic resources. Many Venezuelans of both genders are forced to sell their assets, change their family make-up, or displace themselves within or outside of the country to respond to the serious food insecurity they were facing.

COVID-19. Mobility restrictions and supply chain disruptions related to COVID-19 containment measures have increased food security for everyone in the region; with migrants and refugees particularly hard hit – especially those who were employed in the informal sector and/or living in informal settlements. According to the RMRP Revised (May 2020), up to 79% of refugees and migrants surveyed in Colombia reported facing considerable challenges in accessing adequate amounts of food; with over 80% only eating one to two times a day. In Ecuador, only 28% of refugees and migrants surveyed reported having sufficient food. Women tend to deprive themselves of meals in order to ensure sufficient quantities of food for their children and families; therefore it is safe to surmise that though the situation is dire for all people of all genders, refugee and migrant women are likely being disproportionately impacted compared to men as they limit their nutritional intake in favour of family coping mechanisms.

Safe Homes/Shelter

The housing situation is very different in Venezuela compared to Venezuelans on the move and in host countries. In Venezuela, the majority of respondents (57.3%) have their own home, though this rate is higher for men (63%) than for women (54%) and other genders (25%). 14% are renting (comparable for men and women, but much higher for other genders at 42%), 13% live with a relative (15% of women compared to 11% of men), and 7% live in borrowed accommodation. Policies and norms privilege men in terms of owning property in comparison to women; men are also more likely to have access to economic resources to purchase property than are women and LGBTIQ+ individuals.



Venezuelans in transit report facing significant challenges in terms of safe shelter. Almost half of those interviewed in Ecuador and Peru were forced to spend at least one night sleeping in the street during their journey from Venezuela (In Ecuador, 42% of women and 52% of men; in Peru, 41.8% of women and 49.1%

of men). While all those who sleep in the street are exposed to dangers, this is even more pronounced for women and minors, especially due to high levels of xenophobia.

Some temporary shelters are available along migration routes, where migrants and refugees can stay for short periods. Those housed in temporary shelters reported access to services such as safe water, food aid, and hygiene kits. Participants in Ecuador also reported the presence of safe spaces for women. However, these shelters are insufficient for all those needing accommodation, and do not exist in all cities. Some informal shelters also exist in several cities in Ecuador, some operated by civil society organisations and others by families. Conditions vary in such informal shelters, and the lack of security precautions and provision for privacy may represent risks, especially to women and LGBTIQ+ individuals. Such spaces have also been used as mechanisms of extortion and exploitation.

In Colombia, Ecuador, and Peru, the Venezuelan population is primarily living in rental accommodation. In Ecuador, 88% of men and women and 100% of LGBTIQ+ people surveyed are renting, while 4% of men and 6% of women are living with a host family. 3% of men and 2% of women are concerned about being forced to live on the street. Similarly in Peru, 89% of women and 86% of men surveyed are living in rented accommodation, while 4% of women and 3% of men live with host families. Rental accommodations were reported to be inadequate almost all across the board; most only have access to shared bathroom facilities. There are significant challenges to acquiring leases, with many Venezuelans reporting that they are denied them due to their nationality or sexual orientation. Even where migrants and refugees are able to find rental accommodation, they are often overcrowded and unsanitary, and lack privacy. For example in Peru, 62% of the Venezuelan population live in private residences with only one room, of which 56% house three people or more. All migrants and refugees in this situation are likely to experience some impact on their physical and mental health, and risks of violence and exploitation are particularly elevated for women and children.

Impacts of COVID-19

Inadequate, crowded shelters and/or housing make it virtually impossible for men, women, and LGBTIQ+ people or their families to maintain adequate social distancing or hygiene measures – such as washing hands, isolating sick family members, etc. Additionally, interrupted livelihoods, the stoppage of the informal economy as a result of quarantine measures, and increased costs of living, mean many Venezuelans at home and in host countries can no longer afford their rent. This has led to an increase in evictions and, consequently, increased levels of homelessness, exposure to health risks and, consequently, vulnerability to social and protection risks. “Authorities have been creating extraordinary legal measures to protect tenants unable to meet their financial commitments from eviction. However, these are often not applicable to refugees and migrants without formal tenancy agreements. The growing stigma towards refugees and migrants from Venezuela as people who are perceived to carry higher infection, due to their greater exposure to the virus under the vulnerable conditions in which many are living”,⁴³ exacerbates this situation. Temporary shelters and transit centers were also closed at the onset of the pandemic, as part of larger quarantine measures, but humanitarian and national actors have moved to re-open and operate them so they adhere to required public health measures, such as operating at reduced capacity to ensure physical distancing and appropriate hygiene.

While there is little data as of yet regarding the different gendered impacts of these situations on migrant and refugee women, girls, men, boys, and LGBTIQ+ people, it is safe to assume that women, girls, and LGBTIQ+ people will be more adversely affected. Women are more likely to have lost their employment as a result of COVID-19, less likely to hold their own tenancy agreements, and more likely to have dependents such as young children that they also need to house or ensure safe, healthy, care for. LGBTIQ+ people are more likely to have faced discrimination in securing safe adequate housing and are also less likely to

⁴³ <https://r4v.info/es/documents/download/76210>

therefore hold their own secured tenancy agreement. This means that the shelter spots available to them are likely to be less numerous as well, as shelters and transit centers operate at lower capacity levels.

Water, Sanitation and Hygiene

Access to safe water, sanitation and hygiene materials and services varies widely across the four contexts, but all show significant challenges, including particular WASH-related protection concerns for women and girls.

Access to Safe Water Sources: FGD participants report water scarcity in Venezuela, limiting their ability to maintain hygiene, flush toilets, take daily showers and wash dishes. Only 29% of respondents had access to water through the public network, while 29% supply themselves through water tankers, 18% through rain-water, 11% through well-water, and 11% from rivers. The water from the public network is not always safe and must often be boiled; 22% of women, who bear the main responsibilities for household resources, reported allocating some portion of their limited resources to acquire water (compared to 13% of men). In host countries, access to water varies. In Ecuador and Peru, the majority of respondents report access to the public water network (70% in Ecuador, 68.1% in Peru), while in Colombia, access to safe drinking water has deteriorated in recent years, especially in border areas where long-term structural challenges in water delivery, combined with contamination of water sources have all contributed to shortages. “Women living in households with limited access to drinking water spend between 5 and 12 more hours per week on unpaid domestic and care work than women living in households without” these limitations.⁴⁴

The lack of access to safe water inside the household can force people to travel to distant or unpopulated locations, increasing risks. In Venezuela, 18% of women, 16% of men, and 25% of LGBTIQ+ individuals surveyed reported risks in travelling to water sources. 81% of women who reported facing these risks also reported taking specific measures to mitigate them, such as travelling with others. Female FGD participants discussions report discrimination and incidents of violence in accessing water.⁴⁵ In Colombia, men and boys in informal settlements are usually responsible for collecting water for the household, due to safety concerns for women and girls. When women and girls do collect water they usually do so accompanied by men. In Ecuador, 13% of men and women, and 100% of LGBTIQ+ people report harassment risks when accessing the public water network.

Toilets, washbasins and showers: Over 90% of respondents across Venezuela, Ecuador and Peru report being able to access toilets and bathing facilities. However, toilets and bathing areas are often collective (used by several families), do not have electricity, and have inadequate hygiene conditions. Across all 4 contexts, those who report that they do not have access to toilets or a safe place to bathe also state they are concerned about the location of existing facilities – with most being outside and/or unsafe at night, lack separation between men and women, and lack locks on doors. In Colombia, migrants and refugees in informal settlements reported often using a hole dug in the ground, covered by cardboard, as a latrine, but with no waste disposal system. Limited economic resources, high costs of cleaning products and lack of water create unhealthy conditions, including limitations in terms of personal hygiene, household cleanliness and waste elimination. Added to the lack of water this already increased the risk of communicable diseases, even prior to the arrival of COVID-19.

Menstrual Hygiene Management: Menstrual hygiene is a significant concern identified by women and girls in all 4 contexts. In Ecuador, women in FGDs expressed concerns about the use of both reusable pads (because of difficulties in managing and washing them in overcrowded conditions and with limited access to water) and/or menstrual cups (which are seen to be uncomfortable, and difficult to wash and sterilise). Women describe being forced to pay for access to water and sanitary services and finding it difficult to pay for even basic menstrual hygiene needs. In Peru, 40.9% of women identified sanitary towels and pain

⁴⁴ https://repositorio.cepal.org/bitstream/handle/11362/45352/1/S2000260_en.pdf

⁴⁵ GF M-1

medication as their most urgent need during menstruation. Some Venezuelan adolescent girls in FGDs in Ecuador reported being scared at the onset of their menstruation due to a lack of information about the process. This lack of information combined with limited access to water and safe places to maintain their hygiene during their period can make them prone to disease and infection. Some of the women interviewed in Ecuador reported that during their menstrual period they may not have access to showers or places to bathe for up to 4 days.

COVID-19. Key infection control measures include hand washing and disinfecting contaminated surfaces, in addition to all of the social distancing measures to avoid human-to-human transmissions. The RMRP 2020 (Revised) notes that refugees and migrants, particularly in border areas, do not have access to the potable water, sanitary infrastructure, or the basic hygiene supplies needed to protect themselves from COVID-19 and adhere to these measures. Migrant and refugee populations – and host communities in these areas – are therefore highly exposed to risks. As primary care providers, and those most responsible for household hygiene, women and girls are being even further exposed to risks than their male counterparts. They will bear the brunt of ensuring constant disinfection and household care, even when WASH and living conditions make that difficult. This will have detrimental impacts on their time, ability to earn income once work and mobility restrictions are lifted, and their physical health. Menstrual hygiene products may also become more limited – because of supply disruptions and increased costs – leaving them more exposed to related social and health repercussions if they are unable to access the water, or products needed, to manage menstruation with dignity. Globally, lack of access to safe, dignified sanitation facilities and menstrual products (for caring for one’s self during menstruation) are one of the key reasons girls drop out of school. If menstrual products become out of reach of migrant/refugee/young women and girls’ means, this is a potential barrier to their re-insertion into education once COVID-19 restrictions are lifted.

Conclusions

The Venezuela crisis has worsened gender gaps, affecting the right to life and freedom from violence, access to SRH rights, and the well-being of all – but especially women, adolescent girls and LGBTIQ+ individuals.

The ongoing crisis has led to changes in gender roles and responsibilities in both Venezuela and host countries. While this has led to an increased burden on women and girls, who are often obliged to take on additional care tasks and perform the role of heads of households in the crisis context, it has also led to increased senses of agency and self worth amongst Venezuelan women.

Displaced women, men, boys and girls are further exposed to an alarming web of protection risks in transit and upon arrival in host countries. The migratory process confronts families with the possibility of a temporary or permanent separation of one or several family members. This indicates increased risks for adolescent girls – at minimum, many are unaccompanied, have seen their access to education interrupted, and struggle to earn enough money to cover basic needs, and many are vulnerable to early marriage and sexual exploitation.

Venezuelans in Colombia, Ecuador and Peru often lack the correct immigration documentation and are considered ‘irregular’. Irregular migration represents a vulnerability factor that can limit access to employment and services such as education, justice and health – for both women and men – as well as increasing the risk of being captured by criminal gangs for the purposes of sexual and labour trafficking, including of children.

Venezuelan migrants and refugees also face widespread xenophobic attitudes and attacks, with women and LGBTIQ+ individuals reporting particularly high levels of violence. Xenophobic violence is heavily gendered, especially in the context of prevailing stereotypes about Venezuelan women and adolescent girls, which consider them to be both attractive and sexually available. This has led to higher rates of

harassment and exploitation across the board. Other protection concerns are also abundant, including widespread violence (of which a major concern is GBV), trafficking, and a generalised lack of access to related services and support. However, most individuals surveyed in the region do not have sufficient information about, or access to, services for survivors; particularly for GBV. This particularly impacts women, girls and LGBTIQ+ individuals. Where services exist, they are often inadequate for migrant and refugee survivors because of specific face limitations and barriers to access related to their migratory or ethnic status (in host countries). In Venezuela, these barriers persist because of inadequate funding and infrastructure in the health system.

Women and girls face particular unmet needs in terms of SRH. High rates of maternal mortality, adolescent pregnancy and lack of access to testing and treatment are seen across the four countries. The LGBTIQ+ population is marginalised from SRH services and access to contraception.

Venezuelans in all four contexts have limited access to safe drinking water and bathing facilities. In Venezuela, these limitations are linked to inadequate and contaminated water distribution by public networks, while in Colombia they are exacerbated by ongoing insecurity in border areas. In all four countries, access to toilets and bathing facilities is inadequate, often limited by communal use of these spaces and lack of safety considerations.

Even prior to the arrival of COVID-19, the migrant and refugee community lived in conditions of extreme poverty, in overcrowded rental accommodation, without adequate access to health services. Most children and adolescents already had limited access to education, and most adolescents and adults are engaged in highly informal, precarious, and sometimes risky employment – including street sales, domestic work, smuggling, and transactional sex. Though many Venezuelan migrants and refugees have some form of professional qualification, this often does not translate into improved employment opportunities, as the qualifications may not be recognized, or they are negated by prevailing negative perceptions of Venezuelans. Precarious and exploitative working conditions pose particular risks to women and girls, and creates situations of dependence, even in the context of violence within the household.

With the advent of COVID-19, these issues – and related gender inequalities – are being exacerbated. While it is too soon to tell the extent to which women, men, and LGBTIQ+ people are being differently impacted (outside of GBV and infection rates), we know that they are. Protection and health risks in informal settlements, transit centers, and overcrowded areas have skyrocketed. Women and LGBTIQ+ people are facing astronomically high rates of violence; men are facing increased homelessness and evictions; women and men are both being pressured into being smuggled and/or trafficked in the hopes of arriving in ‘safer’ places – even home to Venezuela; and women are taking on the enormous burden of providing frontline health care for their families and employers, all while watching their incomes dwindle and their responsibilities grow. Despite this, women are also showing tremendous resilience and leadership in frontline response. GBV service providers and authorities are showing new, innovative ways of working and providing services. In other words, COVID-19 can easily exacerbate, and further entrench existing gender inequalities for Venezuelan women and men in the region. But it can also be a platform for new, innovative, ideas and leadership moving forward.



Recommendations

This RGA is focused on Venezuelan populations in Venezuela, Colombia, Ecuador and Peru. In all four contexts, there is an urgent and serious need for increased response and support; both prior to, and following, the advent of COVID-19.

Across all 4 countries, there is an urgent need for humanitarian assistance to consider the different needs and vulnerabilities of women, men, girls and boys. The particular needs and risks among at-risk groups such as pregnant and breastfeeding women, older women, girls travelling alone and LGBTIQ individuals must also be recognized and addressed. This is even more urgent in light of COVID-19 response plans and strategies.

Host countries should also recognize the potential richness of migratory inflows – such as cultural exchange, an influx of qualified professionals, and the potential for increased investments in host economies – and act to prevent and mitigate negative outcomes and hostile reactions from their own populations. Host countries have a responsibility to ensure the safety, dignity and access to basic services of Venezuelan migrants and refugees, and must address these concerns through a gender lens. This report focuses collates and focuses on those recommendations that are common for all 4 countries – for specific recommendations targeted to each context, please see each individual RGA report.

Overarching Recommendation

This RGA report should be updated and revised as the crisis unfolds and relief efforts continue.

Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, boys, girls, and LGBTIQ+ people. It is recommended that organisations continue to invest in gender analysis, that new reports are shared widely and that programming will be

adapted to the changing needs. This is particularly urgent in light of the evolving COVID-19 pandemic and its interrelated impacts with regional migration and related crises.

Targeted Recommendations

Public Sector:

1. **Review and adapt immigration regulations**, providing adequate responses to the protection needs of the Venezuelan population, especially those that are most vulnerable. Host countries should review restrictive migration policies and xenophobic practices from a gender lens, prioritizing strategies aimed at providing protection to vulnerable populations, especially women, girls, and LGBTIQ+ individuals.
2. **Train and support public officers involved in immigration services to perform their duties with sensitivity and respect towards the different and specific needs and vulnerabilities of women, men, boys, girls, and LGBTIQ+ people in migration/movement.** Public institutions – particularly those that operate migratory, social inclusion, education and health services – should ensure service providers have the skills and capacities needed to provide appropriate care to populations on the move, regardless of their nationality, gender, age, sexual orientation, ethnicity, health condition, or disability. This means emphasizing the provision of all services through trauma-informed, safe, effective, survivor-focused lenses.
3. **Increase information dissemination about the rights of, and public services available to, migrant populations.** Provide adequate, timely information to newly arrived populations about their rights, available services and support, and relevant legal frameworks. Build the capacity of border control personnel to inform new arrivals, reduce risks and refer migrants and refugees who need services or support. Ensure this provides specific services and information included through a gender lens, such as including GBV information for women and girls in all communication materials.
4. **Promote coordination between different sectors involved in employment education, health, migration and justice administration**, to ensure the protection of Venezuelan populations, especially in SRH, regularization of immigration status, and reporting of violence. This should lead to concrete, coordinated exercises to identify and address barriers for Venezuelans in accessing basic services, including health, education and employment services. This is particularly important for all Venezuelan migrant populations – male, female, and LGBTIQ+ - within the current pandemic to ensure a “do no harm” approach to new and existing Protection needs.

Humanitarian actors, including: Civil society, I/LNGOs, donors, and international agencies:

1. **Training and awareness-raising processes for all humanitarian personnel to help them recognize gender gaps** and address the need for assistance and differentiated protection of women, girls and LGBTIQ+ individuals in a given context. Ensure that this includes safeguarding and PSEA training and systems.
2. **Sensitize the Venezuelan population and host communities about their rights and obligations.** Build rights-based curriculums and education, as well as service information, into all humanitarian programs and interventions. Include actions such as updated service mapping and referrals systems for survivors of violence in as many communications as possible. Twin these messages with new, recent, COVID-19 messaging efforts so as to harness the potential of the new digital platforms.
3. **Provide sufficient funding for context appropriate Protection for Venezuelan women,**

children, and LGBTIQ + populations and host communities; especially in light of COVID-19 and increased protection risks of all kinds. Create regularization mechanisms and finance projects that promote the productive and dignified inclusion of marginalized populations. Focus specifically on paid/decent work for women and men – especially domestic workers or those resorting to survival sex – and those most vulnerable to trafficking and exploitation. Recognize that these vulnerabilities vary by gender, especially during the new COVID-19 pandemic, and resource them appropriately.

Gender Mainstreaming Recommendations

1. **Mainstream key gender and protection approaches in line with GBV principles and risk mitigation measures across all other technical sectors including SRHR, WASH, shelter, food, nutrition and livelihoods and assistance modalities** (cash and voucher assistance, in-kind and service delivery) both at the cluster level and across specific programs are essential. See CARE's *minimum commitments to gender and diversity for each emergency core sector and/or to CARE's Emergency Toolkit* for additional guidance.
2. **Ensure humanitarian action considers the unique needs of men, women, boys, girls, and LGBTIQ+ people facing multiple vulnerabilities within the humanitarian crisis.** *Build upon this gender analysis to gather additional data on the specific needs and overlapping vulnerabilities of specific groups including those in pendular migration, indigenous populations, individuals living with disabilities, and LGBTIQ+ individuals; especially how COVID-19 has impacted each of their specific situations. Increase and ensure investment in the specific needs of these different at-risk groups. Additionally, allocate specific resources to engage and strengthen local initiatives representing at-risk groups and support policy development, specifically, to address male, female and LGBTIQ+ migrants' specific needs.*
3. **Ensure meaningful participation of crisis-affected populations, particularly women and girls in all steps of response – especially in the COVID-19 pandemic given disproportionate impacts on women and girls.** It is critical to ensure that the voices of marginalized crisis-affected populations, particularly women, girls and LGBTIQ+ individuals, are not only heard but inform, and lead, the response efforts. To do this, ensure that their participation is meaningfully mainstreamed throughout assessment, design, proposals, implementation and feedback process. Promote and support the leadership of local civil-society organisations, including women's and LGBTIQ organisations as an urgent priority at each stage of humanitarian response.
4. **Urgently operationalize mechanisms to ensure accountability for rights violations** including GBV and sexual exploitation and abuse, through prevention, feedback mechanisms and robust response systems.

Gender-Specific Programming Recommendations

1. **Identify, fund, and respond to urgent Protection and GBV needs**
 - a. Strengthen and expand family reunification efforts that facilitate the entry and movement of those with irregular migration status.
 - b. Strengthen both prevention and response activities as well as referral systems. Ensure safe spaces are available to women, girls, and LGBTIQ+ people – especially in the context of COVID-19 and changes to shelter and transit center operations – thereby reducing risks of GBV and preventing harm for survivors.
 - c. Improve availability of and referrals between humanitarian actors on clinical management of

- rape, case management, legal services and other survivor-based care.
- d. Strengthen livelihood support for vulnerable and at-risk women, girls, boys and men. Should cash and voucher assistance be feasible and appropriate in the response, stakeholders should use the Cash & Voucher Assistance and GBV Compendium to implement promising practices into programming.
 - e. Coordinate with other actors to develop practical recommendations to address the scale of transactional sex, its complex dynamics including how it relates to diverse groups. Combine these efforts with economic supports, and CVA, for informal sector workers impacted by COVID-19 measures.
 - f. Promote the application of minimum standards in the prevention and response to GBV in emergencies, recognising and supporting the existing work and strength of women's organizations and activist, government services and the Protection Cluster. Work with them in partnership to design, support and implement activities that prevent and respond to violence, including through the establishment of safe spaces for Venezuelan migrants and refugees.
 - g. Address toxic masculinity as a cause of gender based violence by specifically working with men and boys to address violent behaviours.

2. Collaborate with other actors to strengthen the SRHR response in line with the MISP for SRH in Crisis Settings:

- a. **Scale-up life-saving SRH services** including voluntary contraception, safe abortion care, syndromic management of STIs and supporting access to ARTs for those previously on ARV, and strengthening of a 24/7 referral system for emergency obstetric and newborn care. Support this expansion in a way that is accessible to all, including at-risk groups. Ensure these are continued, without interruption, despite other COVID-19 health measures and funding requirements.
 - b. **Train health providers on providing rights-based, trauma-informed, approaches to service provision** – including for stigmatized groups such as sex workers, pregnant adolescents, LGBTQI+ populations, etc. Provide this training in ways that keep additional home and work place care burdens in mind in the current COVID-19 response context (to avoid further overloading health staff more than necessary).
 - c. **Build capacity of coordination mechanisms on the MISP** for SRHR in Crisis-Settings and on Adolescent SRHR in Humanitarian Settings.
 - d. **Support the public health system to accept and promote contraception options** to adolescents and others of reproductive age; Ensure these options are continued and provided either free of charge or at subsidized costs, especially in the context of COVID-19 supply disruptions and increasing GBV.
 - e. **Increase access to menstrual hygiene materials and provide support to access safe water supplies**, particularly for women and adolescent girls.
3. **Urgently support cash and voucher assistance, income-generating activities and safe and dignified employment options; especially in the context of COVID-19 work stoppages in the informal sector.** Ensure that these are based on gender-sensitive market analysis for market-based approaches and cash and voucher assistance; before implementing market-based and cash-based programming, seek to understand: who in the household should receive cash support; specific household and community risks that women, men, boys and girls face in receiving and spending the money or using vouchers; household decision-making dynamics; and mobility analysis, including access to markets. Support initiatives to identify technical and professional qualifications among Venezuelan women, and support them to translate these experiences into safe and stable employment opportunities in host countries. Address care burdens and related work by both encouraging men and boys to share the load and, also, accounting for women's unpaid care burden in both cash and work schemes.

4. **Offer safe shelter and housing programs and interventions** defined by Venezuelan populations who do not have access to their own housing, such as women with children, older women, and LGBTIQ+ populations. This may include access to shelters which are designated as safe spaces for women and girls, interventions to support access to rental accommodations, contracts with landlords in safe areas, or financial support through local banks or other financial actors. Ensure these follow safe infection control and physical distancing measures as required by COVID-19 IPC guidelines, but in ways that recognize rather than instrumentalize women's unpaid care labour in ensuring those guidelines are adhered to.

5. **Address food security and nutrition challenges for women and girls:** Immediately increase humanitarian action that promotes adequate nutrition, especially for pregnant women and adolescent girls. Combine this strategy with activities that allow girls – including pregnant girls - to stay in school. This may include: policies and financial support for young mothers, child-care, cash transfers to meet nutritional and medical needs, and income-generating or skills-building activities. Ensure that programs are **designed based on household composition**, rather than a standard idea of household size. For example, households headed by women, including older women, may be caring for more children and have higher nutritional needs. Look to innovative COVID-19 household support measures in different LAC countries for examples of how this has been done.

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CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water, basic healthcare and education and create opportunities for people to build a better future for themselves.

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We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 65 million people around the world.

