ReGHID

Redressing Gendered Health Inequalities of Displaced Women and Girls

Sexual and Reproductive Health of Migrant Venezuelan Women and Adolescent Girls in Brazil

Executive Summary

Ministério da Saúde

FIOCRUZ
Fundação Oswaldo Cruz

UFMA
Universidade Federal do Maranhão

UNIVERSITY OF Southampton

INTRODUCTION

Redressing Gendered Health Inequalities of Displaced Women and Girls in contexts of Protracted Crisis in Central and South America (ReGHID) is an international, interdisciplinary project, led by organizations and universities from the United Kingdom (UK), El Salvador, Honduras, Colombia, and Brazil, coordinated by the University of Southampton, UK. In Brazil, the study is coordinated by the Oswaldo Cruz Foundation and the Federal University of Maranhão. This project seeks to contribute to the construction of new knowledge and evidence concerning the challenges related to sexual and reproductive health rights faced by women and adolescent girls in situations of displacement in Central and South America. The study recognizes the importance of sexual and reproductive health as a core element for international development, and aims to reflect on the responsibilities of the States regarding the UN Sustainable Development Goals (SDGs), particularly those related to SDG3 to achieve universal health and wellbeing, and to ensure universal access to sexual and reproductive health care services; and SDG 5 on gender equality. As a result, proposes strategies based on rights as well as on international agreements and programs sensitive to gender equality so as to encourage the development of policies in response to Venezuelan migrant women and girls needs and rights. Based on this, ReGHID has the following objectives:

1 • Identify the sexual and reproductive health needs of Venezuelan migrant women and adolescents in Brazil;

2 • Analyze the challenges faced by migrant women and adolescents as concerns access to sexual and reproductive health services;

3 • Assess the impact of forced displacement on local health services, and the obligations of receiving and in-transit States in guaranteeing rights;

4 • Produce new research data on the needs and challenges faced by women and adolescents who migrate to Brazil as a consequence of the humanitarian crisis in Venezuela.

The aim of this document is to increase visibility of the situations that have come to light during the study and to enable a qualification process for care services, as well as the formulation of more appropriate and inclusive strategies and policies geared toward the needs of migrant women and adolescents.

CONTEXT

Venezuela is experiencing an unprecedented humanitarian crisis, including hunger and lack of access to health services. Since 2015, these factors have forced more than 7 million Venezuelans to leave their home country in search of a better life. This crisis does not affect all people equally. It has a disproportionate effect on women, as they are more likely to provide care. This is more pronounced in pregnant women, who, according to the UN High Commissioner for Human Rights (1), were particularly affected by the food crisis in Venezuela, which has led to high rates of undernourished pregnant women and an increase in maternal and child mortality in the country. This humanitarian crisis also affects sexual and reproductive health, with a rise in sexually transmitted diseases, such as HIV; higher rates of maternal mortality; a greater risk of an unwanted pregnancy, mainly among adolescents; and, consequently, high-risk abortions (2), limited access (or lack of access) to antenatal and post-partum follow-up. This plays out against a backdrop where stockpiles of medical supplies in Venezuela have fallen by 90% since 2005 (3) which makes it difficult to access contraception.

Under these conditions, it is not surprising that, since 2016,half of the Venezuelan migrant population consists of women and young girls who have been forced to migrate, mainly to neighboring countries, with Brazil being one of the most common destinations.

Up to January 2023, Brazil had received nearly 414,000 refugees and Venezuelan migrants.

In the states of Roraima and Amazonas, the consequent population increase placed significant pressure on local public services, especially in the health sector. In 2017, the Roraima state government declared a state of emergency.In 2018, Temporary Measure 820 (then Law 13,684/2018),established emergency care measures for the Venezuelan population in a situation of vulnerability, and in 2018, Decrees 9285 and 9286 (4) recognised the migrant population in Roraima as a vulnerable group

as well as providing formal recognition of the humanitarian and human rights crises in Venezuela; all of which became institutional benchmarks for ***Operation Welcome. Operation Welcome*** is an inter-institutional initiative organized at the Federal level, involving the Armed Forces, other governmental sectors and services, as well as non-governmental and international organizations, which provide support to local governments in receiving migrants and promoting order and control in border areas and most affected cities (5). It was officially set up to offer humanitarian support, by providing shelter, food, and health services, as well as a voluntary internal resettlement of Venezuelan migrants.

Currently, ***Operation Welcome*** runs 7 active shelters in Boa Vista and Pacaraima providing shelter to over 7,000 migrants, as well as temporary spaces for overnight stay for homeless migrants accessed at bus stations in Boa Vista and Manaus. Operation Welcome also provided access to health services, thereby upholding a constitutional right. Operation Welcome has had a positive impact in terms of local availability of services and in the access to basic socioeconomic rights for migrants. Nevertheless, the growing number of Venezuelan newcomers has challenged their capacity for shelter and revealed the limits of Operation Welcome, given the growth of nearly 200% homeless Venezuelans awaiting documentation, an unprecedented situation since 2017 (6). In addition, the health services in Roraima were also heavily impacted, both by the increase in the number of patients and by the severity of their conditions, including measles outbreak among non-vaccinated Venezuelans.

Although the Brazilian migratory regulatory framework has been recognized worldwide as progressive, the initial response to Venezuelan migration in Brazil was quite restrictive, including collective deportations. Brazil created temporary migration permits, which was a positive initiative, but was not sufficient to address irregular migrant status in general. Until 2019, Brazil did not recognize Venezuelans as refugees, however, and the closure of the Brazil-Venezuela border along with a hiatus in asylum processing and migrant regularisation due to the COVID pandemic blocked any regular route into the country for Venezuelan migrants. As a consequence, irregular routes were used instead, making the journey more difficult, expensive, and dangerous, especially for women and young girls. Even after the borders were opened, serious barriers to accessing sexual and reproductive health remained due to the social, cultural, institutional, and gender factors identified in this study.

The ReGHID project considers that gender and the migratory process are determinants of health, as can be seen in the Venezuela-Brazil migration corridor.

Consequently, this Executive Summary puts forward evidence that can be used to inform policy-making by addressing the factors that affect both general health needs and access to relevant services; and sexual and reproductive health needs and access to corresponding services, especially for women and adolescents across all points of the migratory journey - in the country of origin, during the migratory journey, and after their arrival in Brazil. Although young Venezuelan women and girls may commence their journey in search of safety, they are in fact faced with a variety of different risks due to their condition as migrant women.

METHOD

The study took place between 2020 and 2023 using qualitative and quantitative methodologies. Data was collected in Pacaraima (RR), Boa Vista (RR) and Manaus (AM), as these cities host the largest number of Venezuelan migrants in the country. Data was also collected in São Luis (MA) as the Northeastern migratory route saw a great deal of Warao Indian migrants.

In January 2020, exploratory visits to Boa Vista and Manaus were made with the aim of designing the quantitative and qualitative aspects of the study. Qualitative data collection targeted Venezuelan migrant women and adolescents, aged 15 to 49 years, who had come to Brazil between 2018 and 2021. Data from the qualitative study was obtained through semi-structured online or face-to-face interviews; focal groups; life stories; and observation of participants. 172 women and 74 managers, health professionals, and agents from governmental or non-governmental institutions involved in the migration and health sectors took part in the study across the four cities. The quantitative data, by contrast, was collected in two surveys, in Manaus and Boa Vista. In the first, 2,012 women were interviewed between July and September 2021. The "Respondent Driven Sampling" (RDS) method was used, which, after statistical corrections, made it possible to achieve a representative sample of the population of Venezuelan migrant women who arrived in Brazil between 2018 and 2021. This study aimed to gain a better understanding of the migration process and evaluate the impacts of forced migration on the sexual and reproductive health of the Venezuelan women. In the second, hospital-based survey, and according to findings from Nascer in Brazil (7), 575 Brazilian and 315 Venezuelan women who had given birth between June and November 2022. The aim of the study was to understand and compare the care provided during childbirth and the obstetric characteristics, as well as the clinical outcomes for post-partum Brazilian and Venezuelan women.

Ethical protocols were derived from the national guidelines governing ethics for research with human beings in Brazil, according to Resolution 466, from December 2012, set forth by the National Health Council, as well as the Economic and Social Council and that of the University of Southampton, both in the UK.

RESULTS

Reasons for migration from Venezuela to Brazil

The quantitative data indicates that women's main reasons for emigrating were a lack of food (54%), difficulty accessing healthcare (37.8%), violence and insecurity (27.3%), and a search for work (23.2%). These findings were also reflected in the narratives of women who participated in the qualitative study, with reports of the economic crisis in Venezuela, low wages, limited job opportunities, and restricted access to essential services such as water, food, and education, as well as inadequate healthcare. For some of the women interviewed, the free and universal access to the Brazilian health system was an important consideration when deciding to migrate. For those who migrated for health reasons, the specific need for access to medications, surgeries, and medical examinations were also taken into account. Reuniting with family members was also a common reason reported by women, both for those who already had family in Brazil and those who migrated, leaving their own children and parents behind in Venezuela.

Displacement

Nearly all Venezuelan women and adolescent girls crossed the land border through Pacaraima (RR), with the majority coming from the Bolívar, Anzoátegui, and Monaguas districts, which are the closest regions to Brazil geographically. They were often accompanied by their families (87%), especially their partners, and almost 8% of them were pregnant.

Various forms of displacement were identified, each posing unique risks at all points of the journey, especially when women migrated alone or in the company of other women and children. During the COVID-19 pandemic, when the borders were officially closed, crossings became even more dangerous, as they took place using irregular and hazardous trails known as "trochas." Under these circumstances, the risk of violence, especially sexual violence, perpetrated by "trocheiros" who led the crossing into Brazil, was constant. In some cases, they even demanded sexual favours as a form of additional and unexpected payment. Extortion, theft, adverse geographic conditions, long hikes, hunger, thirst, exhaustion, lack of access to bathrooms (especially during the menstrual period), were all reported as additional difficulties that created specific sexual and reproductive health risks.

In contrast, women who migrated when the borders were open reported greater ease in obtaining identification documents, less risk of theft, and reduced exposure to violence. However, they still had to endure waiting in long queues and often spent days living on the streets.

Arrival in Brazil

On arrival at the border, the language barrier created a significant issue for migrant women when dealing with Brazilian officials. Many of these migrant women were already showing signs of ill-health and were also emotionally vulnerable. Even those who enter legally faced days living on the streets, with no access to decent intimate hygiene facilities. The lack of shelter and the wait to obtain documentation further increase the risks to sexual and reproductive health and mental health.

Arrangement of space within the shelters is worthy of note, given that they are places where many people who are unknown to each other must co-exist. Access and exits are strictly controlled and life in the shelters is governed by well-defined rules and schedules. The “carpas” – as the allocated single-family spaces are known – are small and very uncomfortable.

For migrants who arrived illegally, obtaining information related to documentation and health is more difficult and drawn-out, and they expressed fear of being deported. Women with children find it even more challenging due to the lack of social or institutional support networks. As a result, many remain unemployed or in informal jobs, exposing themselves to even greater exploitation. These women left their home countries in search of a better quality of life, yet they continue to face insecure and poorly paid jobs; housing conditions which are inadequate and expensive; and unsafe transport.

PROFILE OF MIGRANT VENEZUELAN WOMEN

The majority of women who participated in the quantitative survey were young, between the ages of 24 and 35, with 14% of them being adolescents. Most had completed high school and identified as having brown skin (66%).

Most were in a relationship (61%) and reported being fertile. Almost all of them had access to personal documents, primarily the Social Security Number (CPF) (91%) and the Brazilian Unified Health Care (SUS) Card (72%). Most of the women were either seeking asylum or had temporary or permanent residency, while 13% were undocumented.

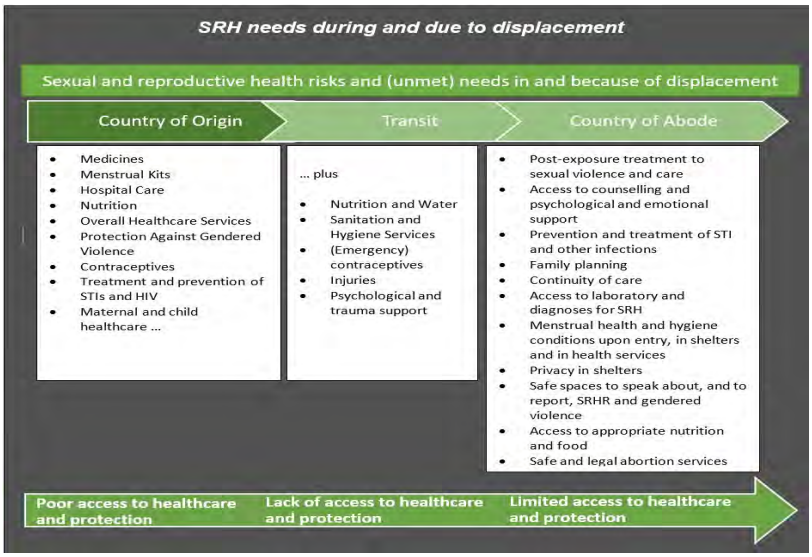
There were significant differences in socio-economic conditions between those residing in Manaus and Boa Vista. Lack of formal employment and high rates of insecure or informal employment were evident in both locations. In Manaus, the women had been in the city for a longer time than those in Boa Vista and had access to fewer shelters. As a result, most women lived in individual residences (74%), had a household income between one half and one full minimum monthly salary, and almost half of them had been in a paid job in the previous month. However, only 4% of these women had formal employment. 38% of the migrants received some type of financial support from the Brazilian government.

In contrast, 68% of the women in Boa Vista lived in shelters, and 66% reported no household income. Only 12% had been in a paid job in the month prior to the interview, and only 9% received governmental support, despite the high numbers of residents living in shelters. Only 3% of the women interviewed reported not having a place to live, although this percentage may be higher due to the difficulty in accessing women living on the streets.

PRIMARY SRH NEEDS AND ACCESS TO CORRESPONDING SERVICES

Women and adolescents, particularly those who are forced migrants, are especially vulnerable due to the risky conditions they face during displacement. The participants in this study encountered serious health challenges, such as the risk of rape, assault, harassment, and other threats, which were reported in the qualitative interviews. Contributing factors are poverty, stigma, social exclusion, and cultural differences, which exacerbate the inadequate access to healthcare services while in transit at the borders and in settlements.

These represent serious challenges to sexual and reproductive health, which had already been inadequate in their home country. The evidence produced by this study identified the following sexual and reproductive health needs during (and due to) the process of displacement from Venezuela to Brazil:



The participants made it clear through their narratives that their needs extended beyond just accessing and using condoms, treating sexually transmitted infections (STIs), and receiving antenatal care. They also highlighted the need for general information and more detailed information on family planning, as well as on the pros and cons of many contraceptive methods. In particular, the interviewed women showed interest in the use of an intrauterine device (IUD), tubal ligation, injections, and pills. They reported greater access to contraceptive methods in Brazil compared to Venezuela. In our study, 63% of sexually active women reported that their partners had not used any condom at all in the last 12 months. Only half of the women with an active sex life (53%) reported using some form of contraceptive, with the most common being the injectable anti-contraceptive (15%). This percentage is lower than that observed among Brazilian women (80%). Adolescent participants, who have not yet begun their sex life, primarily reported the need for competent professionals who provide accurate information, in a suitable space, without moral and religious biases.

Migrant women and adolescents indicated that they had been able to access some sexual and reproductive health services in the form of preventive exams provided through the Unified Health System (SUS), along with screening for STIs, which fulfilled some of their needs. Among the women who reported using services in the last two weeks at the time of the interview (32%), the main reasons included diseases (23%), routine check-up, or child care (19%), and vaccination (17%). A total of 69% had taken a Papanicolaou smear test within the last 3

years, and 40% of these had undergone the test in Brazil. Although more than 70% of Venezuelan women self-reported as being in good or very good health, the fact that their use of the health system was double the use of Brazilian women of the same age and region reflects a repressed demand in the home country, as well as new demands generated in the process of displacement. Women who suffered violence during migration or in Brazil, and who left their children in Venezuela, offered a worse evaluation of their state of health.

ACCESS TO HEALTHCARE - BARRIERS AND FACILITATORS

Brazil's progressive response to the crises through its migration policies and migrant and refugee protection has been a trailblazer in Latin America. The creation of Operation Shelter was essential for healthcare and the support of existing local health and social services, which had been overwhelmed with the increase in population in Roraima.

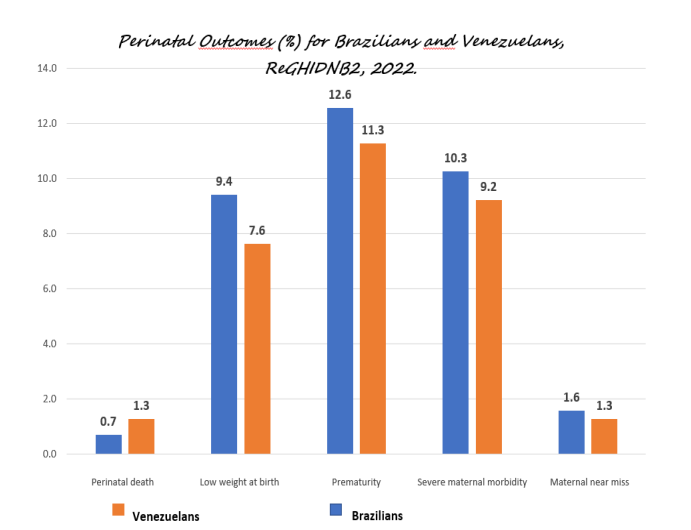
In Focus - Antenatal and Post-Partum Care

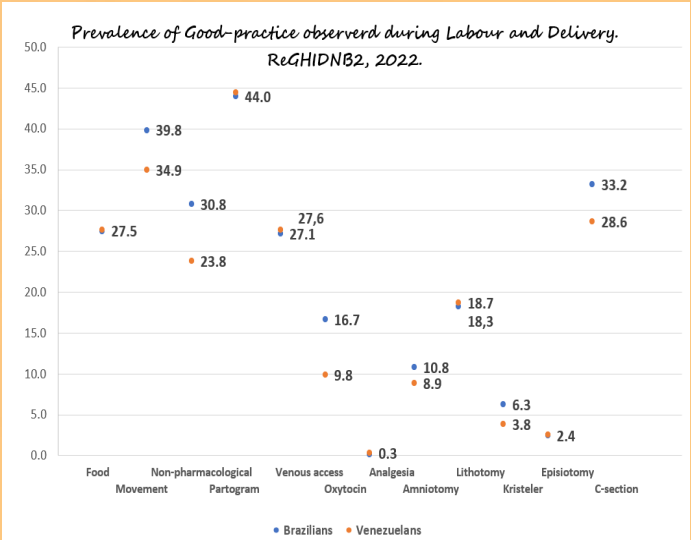
Hospital survey data showed that the clinical and obstetric characteristics of Brazilians and Venezuelans showed no differences regarding clinical history and the rate of previous Caesarean sections, but Venezuelan women reported less gestational diabetes. Brazilian and Venezuelan women had the same access to prenatal care, reaching more than 95% of the interviewed postpartum women. However, Venezuelan women began their antenatal care later and had fewer doctor's visits, which may be related to the arrival in Brazil of some women who were already pregnant or who did not receive information about their rights and how to access antenatal care soon enough.

Despite the favorable perception of antenatal care received in Brazil, one of the major difficulties faced was cultural differences. Due to the language barrier, Venezuelan women and adolescents often did not understand the recommendations made during their doctor's appointments, while others reported that a medical professional refused to provide care because they found it too difficult to understand migrant women. Unfamiliarity with the Brazilian healthcare system affected many migrants in their effort to access publicly available antenatal care, which obliged some to take recommendations from other migrant Venezuelan women and to seek out private health services despite their limited means with doctors who speak Spanish.

Of the women interviewed, none reported having received home visits from Family Health Strategy (FHS) staff, a situation most likely aggravated by their non-registration with a primary health unit. Venezuelan women had more natural childbirths than Brazilian women, and no difference was observed regarding the opinions towards the professionals attending to delivery and childbirth. Venezuelan women, however, had less access to certain aids, such as ambulances and non-pharmacological pain relief, most likely due to cultural and linguistic barriers between health professionals and the parturient. The frequency of unrecommended interventions in both groups of women proved to be low.

One out of every three Venezuelan women did not usually exercise the right to have a chaperone during delivery. This percentage was similar to that observed among Brazilian women. This element of good practice was remarked upon and appreciated by the migrant women, as it is not a guaranteed right in Venezuela. It is, however, part of Brazil's policy to make childbirth less daunting. No significant differences were observed in foetal and neonatal mortality rates. The weight at birth and term length of babies born to migrant women were comparable to those of Brazilian women, and both groups had a high prevalence of pre-term birth (12%) and early term birth (27%). Severe maternal morbidity occurred in 10% of women in both groups, and maternal near miss was observed in 1.4% of cases.





This was particularly evident in Pacaraima, a border region, where there are two primary health units, but no maternity ward; the closest is located nearly 200 km away in Boa Vista. The care provided in these units was seen by the users as lacking, due to the low number of health professionals. International organizations have contributed hygiene kits, basic food baskets, and even medical care provided by Doctors without Borders and the Adventist Development and Relief Agency (ADRA) in an attempt to meet the demand.

Although some women surveyed reported that they had been seen by a Doctor, they felt that the service did not meet their expectations and that a greater emphasis should have been placed on providing a more detailed physical examination rather than simply addressing the patient's complaint. Where sexual violence was concerned victims of rape and sexual assault were likely to turn down medical attention, even if legal and safe pregnancy interruption was required, due to fears that requests would be made of them that would result in embarrassment and shame.

Boa Vista itself has a public maternity ward that registers the highest number of childbirths in the country and has the only Neonatal ICU in the state. From the health professionals' perspective, the number of women towards the end of their pregnancy who have not had an antenatal doctor's appointment is high, as is the number of cases of HIV, hepatitis B and C, syphilis, and tuberculosis. Primary healthcare professionals complained of insufficient access to shelters in order to facilitate active tracking of tuberculosis. It was clear that a network of State, International Organizations, and NGOs had been established in order to address the needs of sexual and reproductive health among migrant women. This cooperation, which expanded healthcare services, also resulted in overlapping activities. The creation of a Health Center (NSA) in Roraima by Operation Welcome, exclusively for Venezuelan migrants, with the intention of reducing the burden on the Brazilian Unified Health System (SUS) actually decreased the flow of care to all.

In Manaus, the state and municipal secretariats set up links with international organizations, NGOs, and religious institutions to provide care to migrants and their families. The proximity of the primary health unit was highlighted as an advantage for access to doctor's appointments, vaccines, and tests. By contrast, in São Luís, migration was numerically much lower than in other locations, and is characterized mostly by the indigenous population of the Warao ethnicity. The Department of Human Rights and Popular Participation (SEDHIPOP, in Portuguese) worked to coordinate this action together with the population. Health care was guaranteed through state actions, called the State Health Force (FESMA, in Portuguese). The Reference Center for Social Assistance to Immigrants and Refugees (CRIR, in Portuguese) was created through a partnership between the Municipal Secretariat of Social Assistance (SEMCAS, in Portuguese) and the Black Culture Center (BCC) of Maranhão, a civil society organization, through the Ministry of Citizenship

Despite these strategies, Venezuelan migrants come up against barriers to their right to health and other basic human rights on a daily basis. These barriers are multiple and are linked to access to and use of transportation services, time and expenditure on food, poverty and discrimination, as well as cultural and language issues. They constitute the main barriers to accessing healthcare.

Although many interviewees positively highlighted access to a public, free, and universal healthcare service, they also drew attention to certain factors. They further expressed dissatisfaction with the recurring lack of clear and accurate information regarding the SUS card, the lack of which made it difficult to access healthcare services.

Of the healthcare professionals interviewed, many stated that the Venezuelan women were stigmatised as a consequence of having numerous children and a resistance to breastfeeding. These comments can be taken as revealing a level of institutional discrimination against Venezuelan migrant women and adolescents as well as a barrier to accessing healthcare in its own right.

Barriers to Access to Sexual & Reproductive Healthcare (SRH) for migrant Venezuelan women and adolescent girls and their consequences[9]

LANGUAGE
Difficulty accessing healthcare services and/or inaccessibility; Lack of understanding in healthcare treatments; Discrimination; Dependence; "Lack of voice."

POVERTY
Restricted choices; Homelessness; Sex in Exchange for survival; Labour and sexual exploitation; Trafficked women; Limited ability to perform caregiving tasks; Financial means to access healthcare (medication, transportation).

DISCRIMINATION
Impacts on behaviour when seeking healthcare services; Obstetric violence; Institutional and interpersonal violence; Stigmatization; Psychological stress.

CULTURAL INSENSITIVITY
Institutional and Obstetric Violence, Involuntary Family Separation; Lack of Traditional Remedies and Nutrition; Inadequate Maternal and Infant Health.

UNMET SEXUAL AND REPRODUCTIVE HEALTH NEEDS

INSTITUTIONAL BARRIERS
Inadequate Training of Healthcare Professionals insensitive to the needs of the Migrant Population; Discriminatory Practices; Lack of Support and Policies Sensitive to the Needs of the LGBT+ Migrant Population; Disruption of Physical and Psychological Treatments; Limited Facilities for Childcare; Lack of Availability of Menstrual Hygiene Products; Lack of Safe Spaces; Inadequate Mechanisms for Feedback; Bureaucracy.

LACK OF INFORMATION
Limited Access to Appropriate Healthcare Services; Contraceptives; Menstrual Health Products; Continuity of Treatment and Care in Sexual and Reproductive Health; Limited Ability to Seek and Access Healthcare Services and Documentation.

INFORMAL & DANGEROUS WORK
Gender-Based Violence; Gender and Sexuality-Based Insecurity; Harassment; Lack of Access to Services; Lack of Workplace Rights; Lack of Safety Net; Labour and Sexual Exploitation; Unemployment; Exhaustion and Mental and Physical Burnout.

SOLE CARER RESPONSIBILITY
Gender-Based Violence; Harassment; Abuse; Limited Time to Seek Healthcare Services; Reprioritization of Needs; Stigmatization.

DISPLACED / MIGRATORY STATUS
Discrimination; Stigmatization; Forced Return; Gender-Based Violence; Risks in Social Services; Unintended Pregnancy; Limited Access to Healthcare Services; Institutional Violence; Involuntary Separation of Families; Lack of Information on Sexual and Reproductive Health and corresponding services.

TRANS WOMEN[10]

On top of the situations experienced by all women, transgender women experience particular difficulties with the following: living their gender identities in Venezuela, where they experience a web of oppressions, often starting within their own families, culminating in social barriers such as unemployment, low education, economic difficulties, and challenges in personal relationships, among others. Upon arriving in Brazil, mostly unaccompanied, they seek greater personal freedom and better economic opportunities. Conditions in the shelters are challenging due to trans-phobia; there are numerous reports of violence perpetrated by other Venezuelans who also live in shelters.

This reality, often exacerbated by strict institutional rules, often result in transgender women finding themselves homeless, where they face the risk of further violence, whether from Brazilians or Venezuelans. Very few specific shelters for the LGBTQ+ population have been identified, despite the evident need.

Transgender women often face significant challenges in securing formal employment due to the compounded impact of their gender identity. Consequently, many find themselves unemployed, resorting to begging or engaging in sex work, which further exposes them to heightened risks in terms of their sexual health. The support from humanitarian organizations, although present, mainly consists of lectures on sexually transmitted infections, with few actions to facilitate access to protection and health services.

The provision of free care gives hope for accessing procedures for gender transition, hormone therapy, and breast prostheses, although they report lacking clarity around how to access certain services.

The competing tensions between life choices and migration are amplified by the limited coordination between migration and health policies, and the institutional and trans-phobic violence experienced on a daily basis. Despite the challenges faced, ranging from support to invisibility, a majority of trans women express a desire to remain in the country.

Indigenous Warao Women

In Brazil, indigenous migrants were treated merely as migrants and not as indigenous people, with the responsibility for their care, in general, including healthcare, falling under the purview of municipal authorities. The National Foundation for Indigenous Peoples (FUNAI) and the Special Secretariat for Indigenous Health (SESAI) acted in specific situations, understanding that these foreign indigenous individuals were outside their scope of operation.

As a characteristic of this population, displacement generally occurs in family and tribal groups. The main difficulties in accessing healthcare services and social integration, in general, arise due to socio-cultural differences, particularly in language, conceptions, and practices related to the body, health, disease, and nutrition, among others. These differences partly explain the reluctance to adhere to the concepts and therapies of the biomedical healthcare system. Health units lack the necessary linguistic and cultural mediation for this population. In addition to the difficulty of accessing services, there is a lack of connection between patients and healthcare professionals in terms of mutual understanding.

The demand for healthcare services, especially considering the prevalent malnutrition and overall weakness among the Warao population, is significant. The provision of healthcare services to meet the needs of these women is often insufficient.

According to professionals and managers, the main health problems include gastroenteritis, tuberculosis, malnutrition, diarrheal disease, parasitic infections, sexually transmitted infections (STIs), postpartum infections, acute respiratory diseases, skin diseases, fungal infections, ectoparasitic diseases, leprosy, diseases caused by ectoparasites, pyoderma, hypertension, oral health, suspected cancer, and collective alcoholism. These migrants are vaccinated every time they arrive in a new city, which may indicate an unnecessary sanitary barrier due to excessive concern for locals and discrimination against the Warao people.

In Focus

Vulnerability and Violence

The vulnerabilities of Venezuelan migrant women manifest in both strictly material terms and in symbolic terms. They face significant challenges in building a social life in the new country, especially considering the frequent discrimination they encounter as migrants, often related to their limited fluency in the Portuguese language and, primarily, being identified as individuals who take away job opportunities from Brazilians and are an additional burden on social and healthcare services, posing a risk to people's safety. Given the challenges of facing new cultural values, a new language, in a place far from their roots, and without a full understanding of the guarantees and protection from the State, many migrant women and adolescents reported feeling unwanted and that they were victims of xenophobia.

Violence against women is one of the most explicit manifestations of gender inequality. In the quantitative survey, 12% reported experiencing psychological violence, 3% physical violence, and 2% sexual violence. The main locations where these incidents occurred were their residence, followed by the workplace and public places. In qualitative interviews, migrants reported frequent street harassment by Brazilians with proposals related to sex, as these men believe that Venezuelan women come to Brazil to engage in prostitution, especially adolescent migrants. Many instances of physical and sexual violence, and psychological abuse, as well as human trafficking, are determined by conditions of vulnerability such as lack of housing and employment, informal work, hunger and poverty, lack of access to care and protection services, and irregular immigration status. Additionally, gender inequality imposes a series of restrictions on them, which are exacerbated when combined with other circumstances, such as adolescence and old age, being indigenous, having small children and/or children with special needs, mobility problems, or general health issues, among others.

POLICY & MANAGEMENT RECOMMENDATIONS

The results of the ReGHID survey indicate the need to improve care for migrant populations, respecting cultural, linguistic, ethnic-racial, and gender differences.

To achieve this, the involvement of managers, researchers, healthcare professionals, civil society, families, and migrant women and adolescents is necessary.

Guaranteeing socio-economic rights and social inclusion as determinants of health is crucial

- Create the conditions that permit migrant women access to formal employment with full labour rights and social security, free from sexual violence, exploitation and harrasment.
- Commit to offer creches to look after children under the responsibility of migrant women and adolescents, in order to ensure their continued employment and, in the case of adolescents, their participation in school.
- Facilitate access to education which caters for migrants and their children in the future.
- Promote awareness campaigns and education for society at large and professionals in migrant protection and rights services in the country, in order to prevent cultural and gender reductionism, discrimination, and xenophobia.
- Create and promote safe spaces for sheltering transgender women, preventing trans-phobic gender-based violence.
- Offer Portuguese language courses at convenient times for adult migrants, aiding in social integration.
- Monitor internally relocated migrants to create long-term support policies that take into account their needs.
- Promote the revalidation of diplomas for women with higher education degrees from Venezuela to prevent underemployment.
- Guarantee migrants' right to healthcare.
- Strengthen the SUS and improve relationships between federal, state, and municipal levels of management to optimize the care provided to migrants.
- Build partnerships with the National Foundation for Indigenous Peoples (FUNAI) and the Special Indigenous Health Secretariat (SESAI) to address the healthcare needs of indigenous migrants.
- Include country of birth and migrant status fields in all Health Information Systems (HIS) and Social Management systems to obtain reliable data for monitoring the health condition, social support, and employment of this population.
- Ensure that all authorities and healthcare institutions have standardized criteria and protocols to provide access to quality and appropriate healthcare (taking into account age, gender, and ethnic-cultural characteristics) for migrants.
- Establish monitoring systems to enforce compliance with these criteria and protocols.
- Develop specific training and continuous professional development courses for all healthcare service providers regarding the mentioned criteria and protocols, with a gender and culturally sensitive approach.
- Encourage and expand research funding on migrant populations to support targeted public policies.

Policies for sexual and reproductive health care

- Ensure respectful and considerate care for all migrants, in line with public health protocols and guidelines
- Promote sexual and reproductive health care practices with gender perspectives and attention to socio-cultural differences, including mechanisms and spaces for migrant women and adolescents to report institutional, interpersonal, and domestic violence.
- Create gender-responsive mechanisms for newly-arrived migrants in border regions, with special attention to psychosocial support.
- Ensure conditions and products for management of menstrual hygiene at border checkpoints, shelters, and health centers.
- Mitigate cultural and language barriers to facilitate access to SRH services among the migrant population, including translation services and the use of interpreters (rather than relying on other healthcare professionals or family members).
- Encourage the creation of support networks for self-care and collective and community care among migrant women and adolescents, including pregnant women and postpartum mothers, led by facilitators sensitive to gender challenges.
- Promote access to rapid STI tests, including HIV and antiretroviral medication when needed.
- Promote and ensure informed access to family planning to reduce the inequities faced by women and adolescents based on their different needs; provide women with their choice of contraceptives and adequate information about different methods (including long-acting methods such as IUDs and injectables, which reduce continuity insecurity).
- Conduct campaigns to promote the use of contraceptives, with an emphasis on condom use to prevent sexually transmitted infections (STIs).
- Establish protocols and mechanisms for identifying gender-based violence and accessing specialized services.
- Implement mental health programs for all forms of sexual and gender-based violence experienced by migrant women and adolescents, based on information, listening, protection, and solidarity.

FOOTNOTES

(1) United Nations High Commissioner for Refugees - UNHCR. (2019). Human rights in the Bolivarian Republic of Venezuela: Report of the United Nations High (1) Commissioner for Human Rights on the situation of Human rights in the Bolivarian Republic of Venezuela. https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session41/Documents/A_HRC_41_18.docx

(2) Idem, p. 04.

(3) Albaladejo, A. (2018) 'Contraceptive shortages mean Venezuela's people face a sexual health emergency' BMJ, [online] Available from: https://doi.org/10.1136/bmj.k1197 [Accessed 10 July 2021]

(4) Conjointly with MP 820, these decrees formed the normative basis of Operation Welcome. Both were revoked and replaced by the current decree, nº 10.917/2021.

(5) Ramsey, Geoff., and Sánchez-Garzoli, Gimena. 2018. "Responding to An Exodus: Venezuela's Migration and Refugee Crisis as Seen From the Colombian and Brazilian Borders" WOLA.

(6) Mello, P.C. (2021). 'Number of Homeless Venezuelan Refugees Explodes on Brazilian Border'. Folha de S.Paulo. [Online]. Available from: https://www1.folha.uol.com.br/internacional/en/world/2021/09/number-of-homeless-venezuelan-refugees-explodes-on-brazilian-border.shtml [Accessed 10 March 2022]

(7) https://nascerrcofi.psne.lisarbonuz.br/

(8) Cintra, N; Owen, D; Riggirozzi, P. (2023) Displacement, Human Rights and Sexual and Reproductive Health: Conceptualising Gender Protection Gaps in Latin America. Bristol: Bristol University Press.

(9) Modified graphic. For a complete version see: Riggirozzi, P., Curcio, B., Lines, T., Cintra, N., (2023) Moving Forward: Health, care and violence seen through the eyes of displaced Venezuelan women in Brazil. Rugby, UK: Practical Action Publishing and Latin America Bureau.

(10) The term 'trans women' as used in this document includes transgender women, transgender individuals, transvestites, and other terminologies and identities used.

CREDITS

ReGHID Project Management

Pía Riggirozzi - Co-Director of the Interdisciplinary Global Health and Policy Centre (GHaP), Department of International Relations, University of Southampton

ReGHID Project Coordination - Brazil

Maria do Carmo Leal – Escola Nacional de Saúde Pública / Fiocruz, Research Productivity Scholar CNPq
Zeni Carvalho Lamy - Universidade Federal do Maranhão / UFMA, Post-graduate Programme in Collective Health, Research Productivity Scholar CNPq

Executive Summary Authors

Zeni Carvalho Lamy - Universidade Federal do Maranhão
Maria do Carmo Leal – Escola Nacional de Saúde Pública / Fiocruz
Pía Riggirozzi - University of Southampton
Natalia Cintra- University of Southampton
Ruth Britto - Universidade Federal do Maranhão / UFMA
Thaiza Dutra Gomes de Carvalho - Escola Nacional de Saúde Pública / Fiocruz
Yammê Ramos Portella Santos - Escola Nacional de Saúde Pública / Fiocruz
Rita Suely Bacuri de Queiroz - ILMD / Fiocruz Amazônia
Cesar Carvalho - Universidade Federal do Maranhão / UFMA
Sara Fiterman Lima - Universidade Federal do Maranhão / UFMA
Liliana Yanet Gómez Aristizábal - Universidade Federal do Maranhão / UFMA
Leidy Janeth Erazo Chavez - Universidade Federal do Maranhão / UFMA

Field Work Coordinator

Rita Suely Bacuri de Queiroz - ILMD / Fiocruz Amazônia

Field Work Team

Adriana Mercedes Rodriguez Munguia
larbaC nadacoM afioS ablA
Cesar Francisco Roldan Ojeda
yarA opmeT anfiesoJ ramiloiD
Dorelis Maria Benitez Cequea
Egledimar Crespo
Eliana del Carmen Gomez Milano
omolaP onedeC anfiesoJ sylleinnE
Geisy Sulamita Barroso Rodríguez
Jani Sarai Exáez Ochoa
Leidi Leny Clavijo Pereira
Luisana Mercedes Diaz Garcia
Nixsa Maria Cabral
Oliennys Yamileth Santana Rondon
Orymar Dyleny Torres Orellana
Paula Andrea Morelli Fonseca
Zulay Ramona Martinez Aray
Zurima Cledy Hernandez Gonzalez

Other Researchers

Amos Channon - University of Southampton
David Owen - University of Southampton
Henry García - FLACSO El Salvador
Jean Grugel - University of York
Jovana Alexandra Ocampo Cañas - Universidad de los Andes
Marielos Cornejo - FLACSO El Salvador
Monica Linares - FLACSO El Salvador
Nádia Ethel Basanta Bracco - Universidade Federal do Maranhão / UFMA
Oscar Alberto Bernal Acevedo - Universidad de los Andes
Rodrigo Moreno Serra - University of York
Sarah Neal - University of Southampton
Sarahí Rueda Salazar - University of Southampton

Photographs

Bruna Curcio
Aline Fidelix
Rita Bacuri

Layout & Artwork

José E. Torres Filho

Funding

The RegHID project was financed by the United Kingdom Economic and Social Research Council (Project Nº 1/X14400T/SE). A side-project also received funding from the Maranhao Science and Technology Research Support Foundation (FAPEMA) via PPSUS n° 09/2020 and used research interns supported by CNPq and FAPEMA

For further information, please visit our website https://gcrf-reghid.com or scan the QR Code:

How to Cite this Text: Lamy, ZC; Leal, MC; Cintra, N; Carvalho, RHSBF; Carvalho, TDG; Ramos YS; Bacuri, R; Carvalho, C; Lima, S; Gómez, LA; Chavez, LE; Riggirozzi, P. ReGHID. Sexual and Reproductive Health of migrant Venezuelan Women and Adolescent Girls: Executive summary. Fiocruz and UFMA, 2023. Available here: https://doi.org/10.35078/3B7S4N

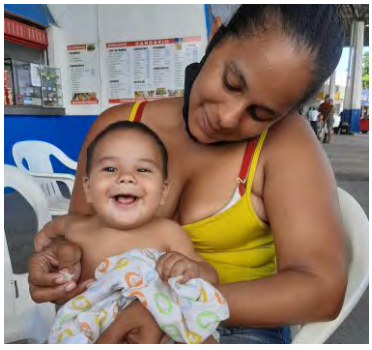
ACKNOWLEDGEMENTS

We would like to thank the NGOs Hermanitos (Manaus) and Mexendo a Panela (Boa Vista) for their hospitality during the data collection. We are grateful to all Venezuelan migrant women who shared their information and life experiences with us. We hope to reciprocate this trust by presenting the research findings and advocating for their transformation into public policies.







Redressing Gendered Health Inequalities of Displaced Women and Girls