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Strengthening the Humanitarian Response to COVID-19 in Colombia

REPORT 1 OF 2

HELLER SCHOOL FOR SOCIAL POLICY, BRANDEIS & SCHOOL OF GOVERNEMNT, UNIVERSIDAD DE LOS ANDES

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Summary

This policy brief shares results of a study conducted July 2020 - February 2021, which examines adherence to public health and social distancing policies, health care utilization, and costs, among Venezuelan migrant refugees and Colombian citizens throughout the COVID crisis. Results cover 60 Colombian municipalities. Research is led by Brandeis University and Los Andes University. This brief is intended for two main audiences; applied academic researchers interested in the impact of COVID-19 in developing countries and policy makers who want to use data to make decisions about COVID-19 in Colombia. Results are summarized from four data sources: telephone surveys, COVID policies, heath care utilization, and cell phone mobility data.

The results show:

- Colombians have slightly higher knowledge of COVID-19, public health, and social distancing measures than Venezuelan migrants. However, Venezuelan migrants report slightly higher adherence to public health and social distancing among those in their communities.
- Colombians report having more difficulty accessing health care services and medicines during COVID than Venezuelan migrants.
- At the municipal level, there is considerable variation in both the implementation and intensity of public health and social distancing policies.
- Patterns of health care utilization show decreases in health care utilization by both Colombians and Venezuelan migrants during the pandemic. These decreases are likely due to the fear by both groups of catching COVID-19.
- Actual mobility captured through cell phone data shows much variation across municipalities in mobility since the start of the pandemic.

About the researchers: The Institute for Global Health and Development (IGHD) at the Heller School for Social Policy and Management, Brandeis University is comprised of health economists and health policy researchers analyzing important changes in the structure and delivery of health systems around the globe. The Alberto Lleras Camargo School of Government at Universidad de Los Andes aims at improving the quality of public policy and State administration by educating leaders in public and civil society organizations as well as conducting innovative academic research and consultancies that inform debates on current social, economic, and political issues in Colombia and Latin America.

Who are the Venezuelan Migrants?

As a result of various economic and political crises in Venezuela, over 4.5 million Venezuelans have left the country since 2014, with an average of 5,000 people leaving the country per day.[1] These demographic shifts have been felt globally and have been impacting migration patterns in South and Central America ever since.[2] More than half of all Venezuelan migrants have migrated across the border to the neighboring country of Colombia. As a result of this large number of incoming Venezuelans, Colombia has created the Special Permit of Permanence (PEP). Once enrolled in PEP, Venezuelan migrants receive a "regular" status, which provides residence for 90 days and can be extended for up to two years. It is currently estimated that more than 1.7 million Venezuelan migrants are currently residing in Colombia[3]; however less than 800,000 have become "regularized" immigrants through the PEP mechanism.[4] In addressing a pandemic such as COVID-19, in the context of a country, we must consider the behaviors and needs of large migrant groups like the Venezuelan migrants in Colombia.

Current COVID-19 Crisis in Colombia

Colombia announced the first confirmed COVID-19 case on March 6th, 2020.[5] Since then (and as of November 23rd, 2020), the country has reported more than 1.2 million confirmed COVID cases and more than 35,000 COVID-19 related deaths.[6] As with most countries at the start of the COVID-19 pandemic, Colombia closed its border on March 16, 2020[7] to help prevent the spread of COVID-19.

Colombia also implemented over 50 different types of policies/restrictions to reduce the spread of the virus and to protect the health system from collapsing. These policies include anything from shelter in place measures, restrictions on mobility and social gatherings, mask mandates, curfews, and restrictions on economic activity. Both the type of restrictions implemented, and the intensity of these restrictions vary across all municipalities within Colombia; especially after May 25th, when the nation-wide stay-at-home mandate was finalized, and a progressive reopening phase started.

The national lockdown and the closure of Colombia's borders have impacted both Colombian nationals and Venezuelan migrants in many ways. Examining the impact of COVID-19 on both populations within Colombia is important.

Colombia and Universal Health Coverage

Colombia has been providing universal health coverage since the passing of the "*Law 100*"[8] in 1993. This law states that regardless of an individual's ability to pay, all citizens are entitled to a comprehensive health care benefit package. The National Health System is composed of both private and public insurance schemes, known as Health Promoting Entities (EPS) that offer

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[1] Venezuela Humanitarian Crisis

[2] Venezuelan economic crisis: crossing Latin American and Caribbean borders

[3] Colombia-Latin America & the Caribbean Migration Portal

[4] Distribución Venezolanos en Colombia corte a 30 de Septiembre

[5] @MinSaludCol- Se confirma primer caso de coronavirus

[6] Instituto Nacional de Salud. Coronavirus Colombia. COVID-19 en Colombia

[7] Latest Measures taken by the Colombian government regarding COVID-19

[8] Colombia's Universal Health Insurance System

competitive health service packages to members and contract health services from health service provider institutions (IPS). EPS consists of four sub-schemes: (1) EPS- the contributory (EPS-C) regime, (2) the subsidized regime (EPS-S), (3) the "special regimes", and (4) for the "non-affiliated population". EPS-C is financed by an income tax for those in the formal work force; EPS-S is commonly used by lower-income individuals and those that do not participate in the formal workforce. EPS-S is financed entirely by the national government. Special regimes consist of groups such as armed forces, national police, public school teachers and public universities—each having their own financing mechanisms. The final sub-scheme "non-affiliated," is covered by each State and has historically received only emergent care or special health prevention services (such as vaccination campaigns).

In 2017, any foreigner obtaining benefits through the National Health System (SGSS) needed to become affiliated with either EPS-C or EPS-S first. As a result, any Venezuelan migrant who became enrolled in PEP was either included in the EPS-S scheme or the EPC-C when formally employed. Those who remain without PEP, remain in the "non-affiliated" sub-scheme- granting them access to emergent care or special health prevention services only.

Telephone Survey

The telephone surveys were conducted with individuals across 60 municipalities, reaching 70 Venezuelans and 50 Colombians in each municipality for a total of 8,130 telephone surveys. Surveys captured information from each respondent on demographics, work/economic activity, knowledge of COVID-19, one's own adherence and community adherence to public health and social distancing measures, symptoms of COVID-19, and access to and payment of health care services during COVID-19. As illustrated in Figure 1, 36.5% of our respondents were Colombian and 63.5% were Venezuelan. The average age of our respondents was 38 years (Colombian) and 33 years (Venezuelan). A smaller percent of Colombian respondents had higher education levels when compared to Venezuelans respondents (36% of Colombians had completed high school and 5% completed University, compared with 42% of Venezuelans completing high school and 13% completing University). Of those included in the telephone survey, 95% Colombians were affiliated with either the EPS subsidized or the contributory sub-schemes, compared with 25% of Venezuelans affiliated with the same. Notably, 75% of Venezuelans reported to not be affiliated with any EPS sub-scheme or not having health coverage.

Figure 1. Study Population
(n=8,130)

	Colombian	Venezuelan
Percentage of respondents	36.5%	63.5%
Mean Age	38 years	33 years
Highest Level of Education Completed	36% High school; 5% University	42% High School; 13% University
% Affiliated with Social Security Health Insurance	95% EPS- contributory-subsidized	25% EPS- contributory-subsidized

National Index Score

Figure 2 shows that among our 8,130 respondents, Colombians tend to have a slightly better knowledge of COVID-19, meaning they score higher on knowledge-based questions. Colombians also tend to score slightly higher in self-reported adherence, meaning Colombians tend to adhere more to *Social Distancing* and *Public Health* policies such as: maintaining a 2-meter distance from

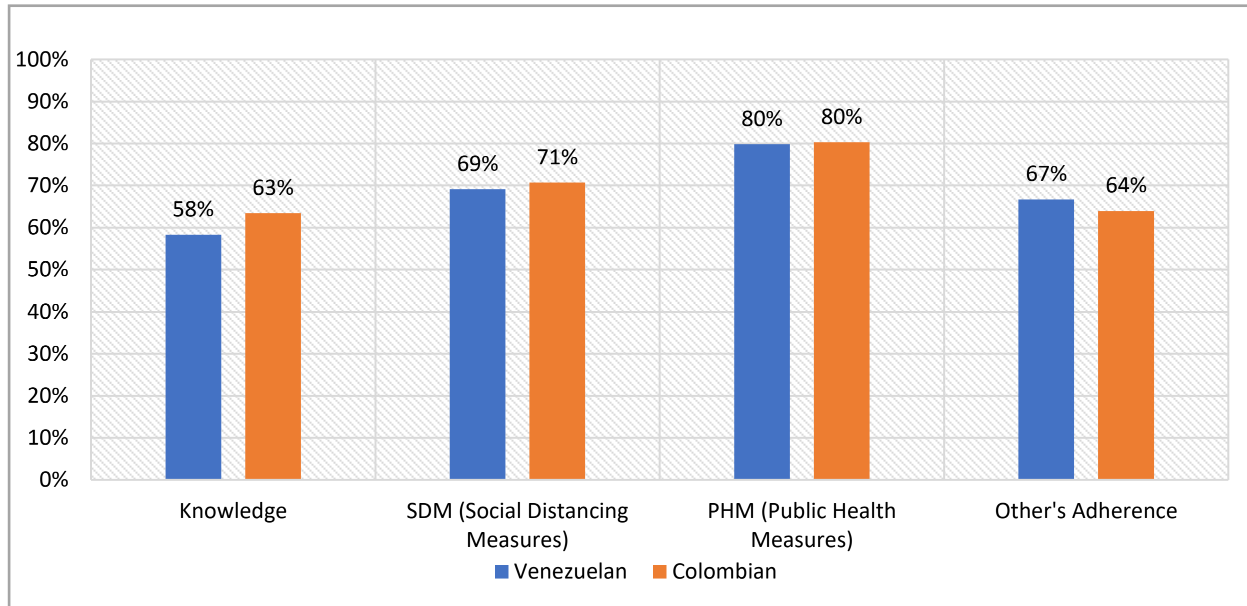

Figure 2. Average national index scores by nationality. Colombians were more likely to score higher in knowledge and adherence scores than Venezuelans.

others, staying home without receiving any visitors, avoiding social gatherings of more than 10 people, and using masks in public. However, when asked about their perception of the adherence to *Social Distancing* and *Public Health* policies of others in their community, Venezuelans tend to have a higher perception of other's adherence than Colombians.

Access to care during the COVID-19 pandemic

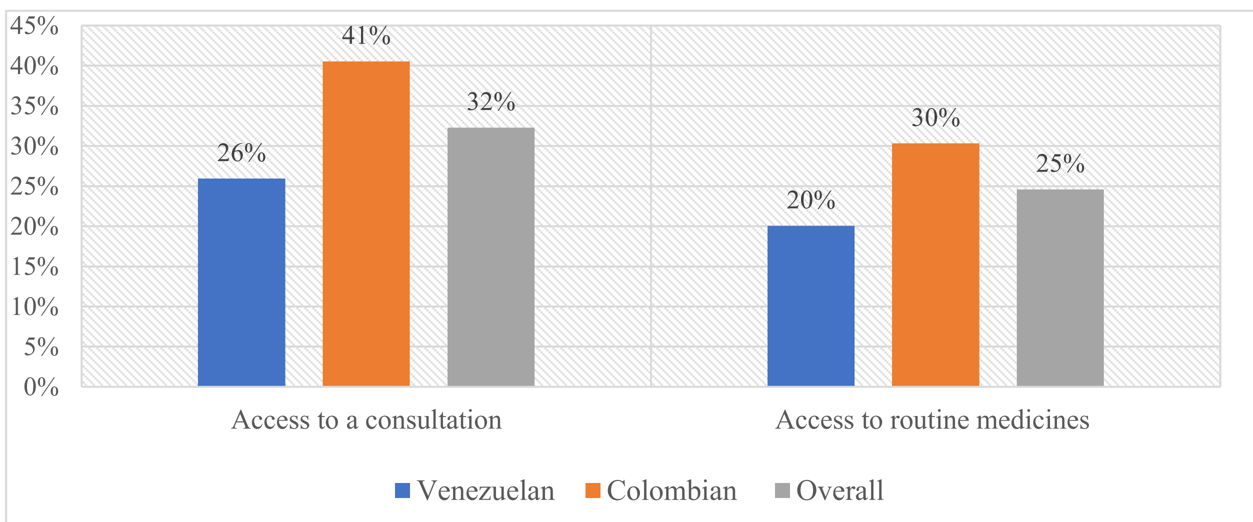

Figure 3. Percentage of respondents who reported more difficulty in accessing care during the COVID-19 pandemic compared to before the pandemic.

When asked about the difficulty in accessing care and essential medicines, Colombians report having more difficulty in accessing health care consultations (40%) and routine medications (30%) now compared to before the pandemic than their Venezuelan counterparts (See Figure 3). However, this increased difficulty in accessing healthcare during the pandemic for Colombians may also be due to the fact that it was already difficult for Venezuelan migrants to access health care before the pandemic, having fewer consultations than Colombians (See RIPS data below).

Policy Response Data

The Policy Response data collection was focused on policies and measures taken by each of the 60 municipalities as a response to COVID-19. This collection of this data was focused on the following areas: public health measures, social distancing, and social protection measures. This collection resulted in 34 different measures or areas of focus. The measures were contained in the following domains: physical isolation, social distancing, use of personal protection elements (such as masks, gloves, and eyewear), restrictions on economic activities, and biosecurity requirements for commercial activities. Figure 4 summarizes the results from the policy response analysis of policies and public health measures which were analyzed at the municipal level. The x-axis indicates the percentage of measures that each municipality implemented on average per week. This scale is calculated out of the 34 measures of our data set. The y-axis represents the intensity at which these measures were enforced, captured by the number of hours individuals can purchase groceries on average per week. As shown in Figure 4, there is no certain pattern of enforcement of the different restrictions across municipalities. However, in some municipalities, such as Jamundi and Rionegro, implementation reaches as high as 50% of the total possible measures and intensity is also very high; nearly 90% of purchasing hours were restricted. Whereas municipalities such as Puerto Inirida, Bello, and Pereira, were more lenient and enforced a much smaller percentage of measures and restricted fewer purchasing hours. Figure 5 illustrates the proportion of municipalities sampled that enforced COVID- restrictions each week. The greater number of municipalities that enforced measures from each of the four domains- ID restrictions, gender restrictions, curfew, and restrictions on gatherings the higher the bar. As shown, in the first weeks of the pandemic very few municipalities enforced COVID-19 related restrictions. However, as

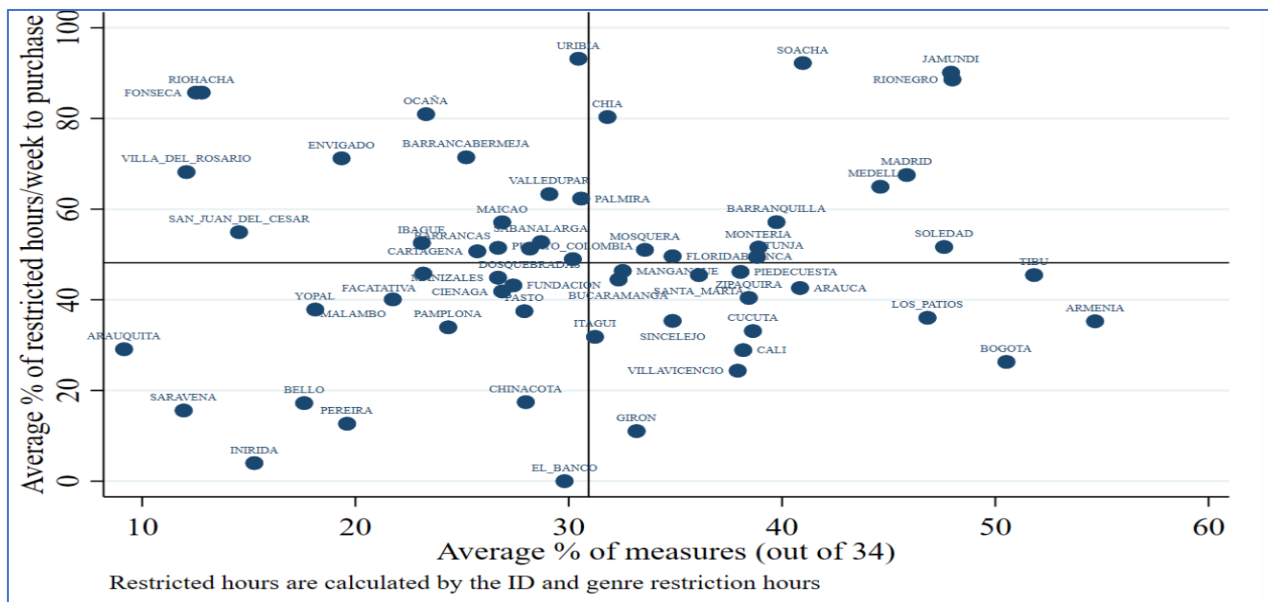

Figure 4. Distribution across relative use of measures and mobility restriction

time progressed more and more municipalities began enforcing each of these restrictions to prevent the spread of the virus.

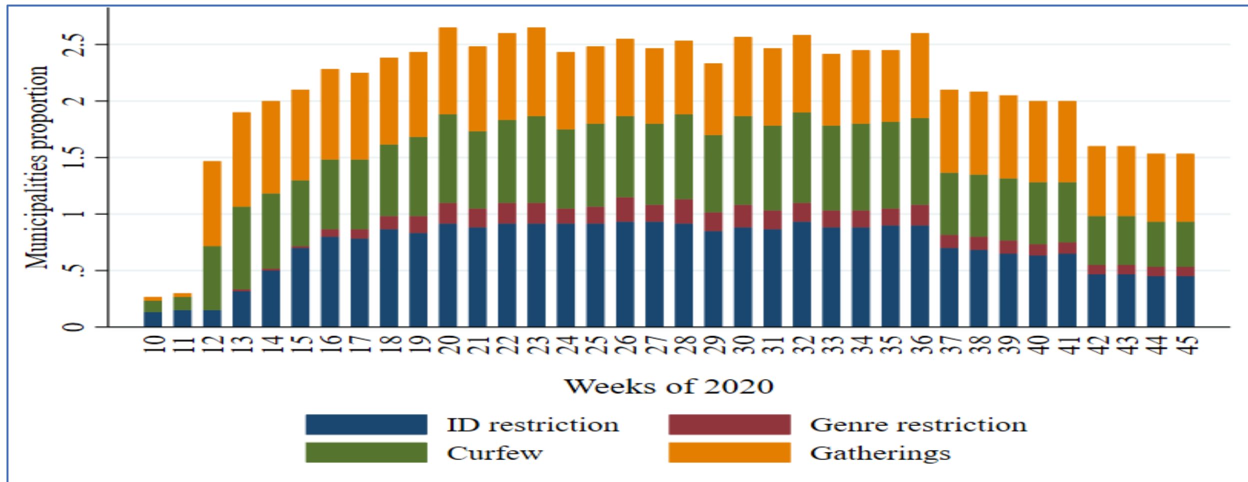

Figure 5. Proportion of municipalities sampled that enforced restrictions each week

Health Care Utilization Trend Data

The Colombia's health care utilization (*Registro Individual de Prestación de Servicios*, RIPS) data were used to understand how the use of health care services changed over time before and during the COVID-19 outbreak by Colombians and Venezuelans. Below, Figure 6 and Figure 7, represent the national consultation and hospitalization rates by nationality before (March-July 2019) and during (March – July 2020) the COVID-19 pandemic.

As shown in Figure 6, Venezuelans, had a lower rate of consultations than Colombians before the pandemic (March- July 2019). In 2019, Colombians utilized consultations 7.0 times (March- May) and 4.8 times (June-July) as much as Venezuelans, after adjusting for population and age. The rates of the Venezuelans in 2019 were lower than for Colombians probably their enrollment rate in EPS schemes was much lower, so their benefits package was more limited. Also, even those enrolled may not have been fully aware of their rights. Additionally, the UNHCR commented that some Venezuelans were concerned that they would not be treated with respect and feared they would risk potential legal sanctions. Furthermore, during the beginning of the pandemic (from March through July), the consultation rate across the 60 largest municipalities declined more for Colombians than Venezuelans (consultations by 58% for Colombians and 18% for Venezuelans, hospitalizations by 51% for Colombians and 24% by Venezuelans) according to a supplemental analysis comparing consultations in 2020 with the comparable months in 2019. It is likely that these declines occurred because both groups feared going to a clinic or hospital because of the possibility of contracting COVID-19.

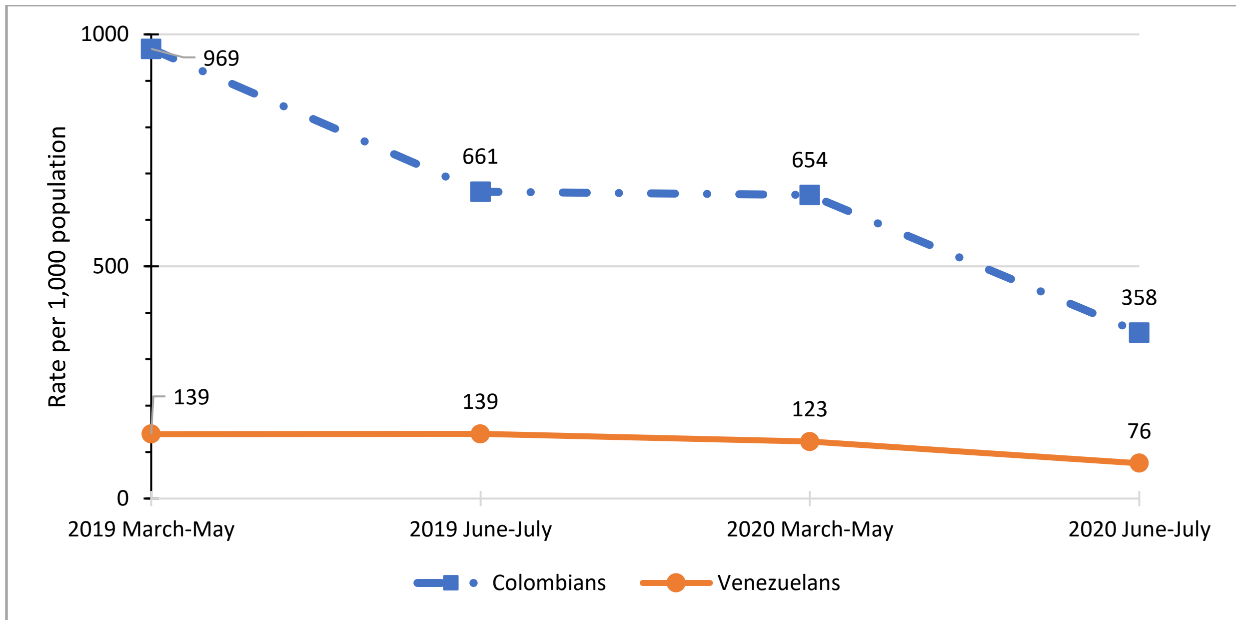

Figure 6. Consultation Rates of Colombians and Venezuelan

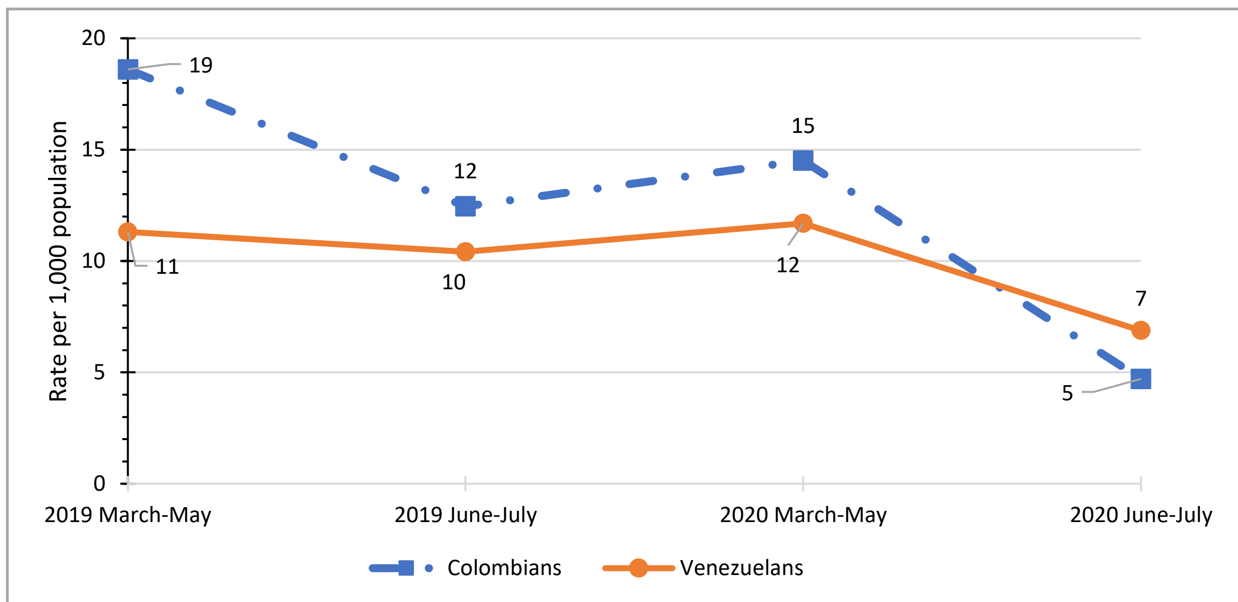

Figure 7. Hospitalization Rates of Colombians and Venezuelan

Mobility Data

Mobility data were obtained through a collaboration with the UNDP GRANDATA initiative. Anonymous mobility data have been used to measure actual movement of individuals across the 60 municipalities since the beginning of the pandemic, March 2, 2002. Figure 8 shows the actual mobility of residents in four municipalities over the period since the start of the pandemic (March 2, 2020) for four municipalities. All areas show reduced mobility compared to the level of mobility

on March 2, 2020. However, there is considerable variation, with some locations (Cucuta) showing increased mobility in comparison to March 2, 2020 on weeks 6-10, as restrictions were lifted.

*Weekly average mobility change is based on mobility captured at benchmark date (March 2nd, 2020). Weeks measured include March 2nd to August 31, 2020, based on current data available.

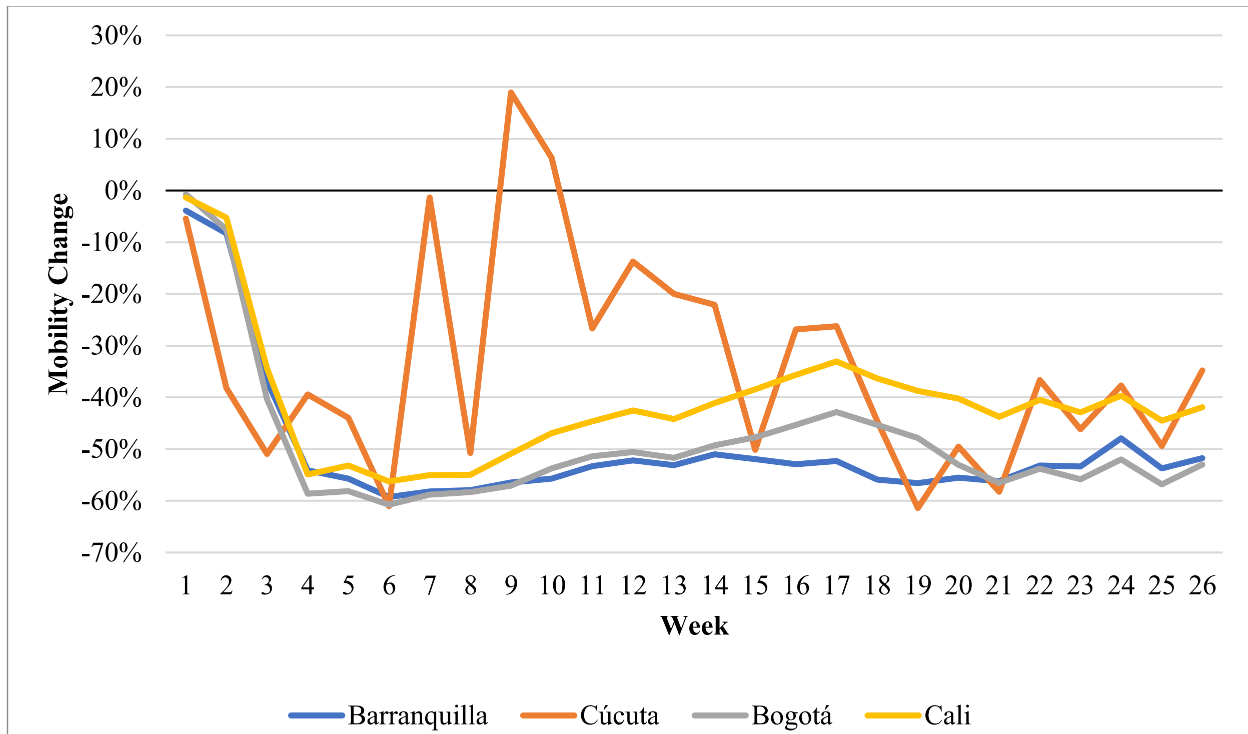

Figure 8. Weekly average change in mobility in four sample municipalities.

Conclusion

The data presented above for both Colombian nationals and Venezuelan migrants within Colombia, are unique in that they capture many aspects of the unfolding COVID-19 pandemic: reported behaviors (telephone survey), implemented policies (policy response), health care utilization (RIPS data) and actual mobility (mobility data). This policy brief summarizes some initial results from each data source. Next steps to the analysis will be combining all the data into a COVID dashboard to understand the "system" response to COVID-19 within Colombia.

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