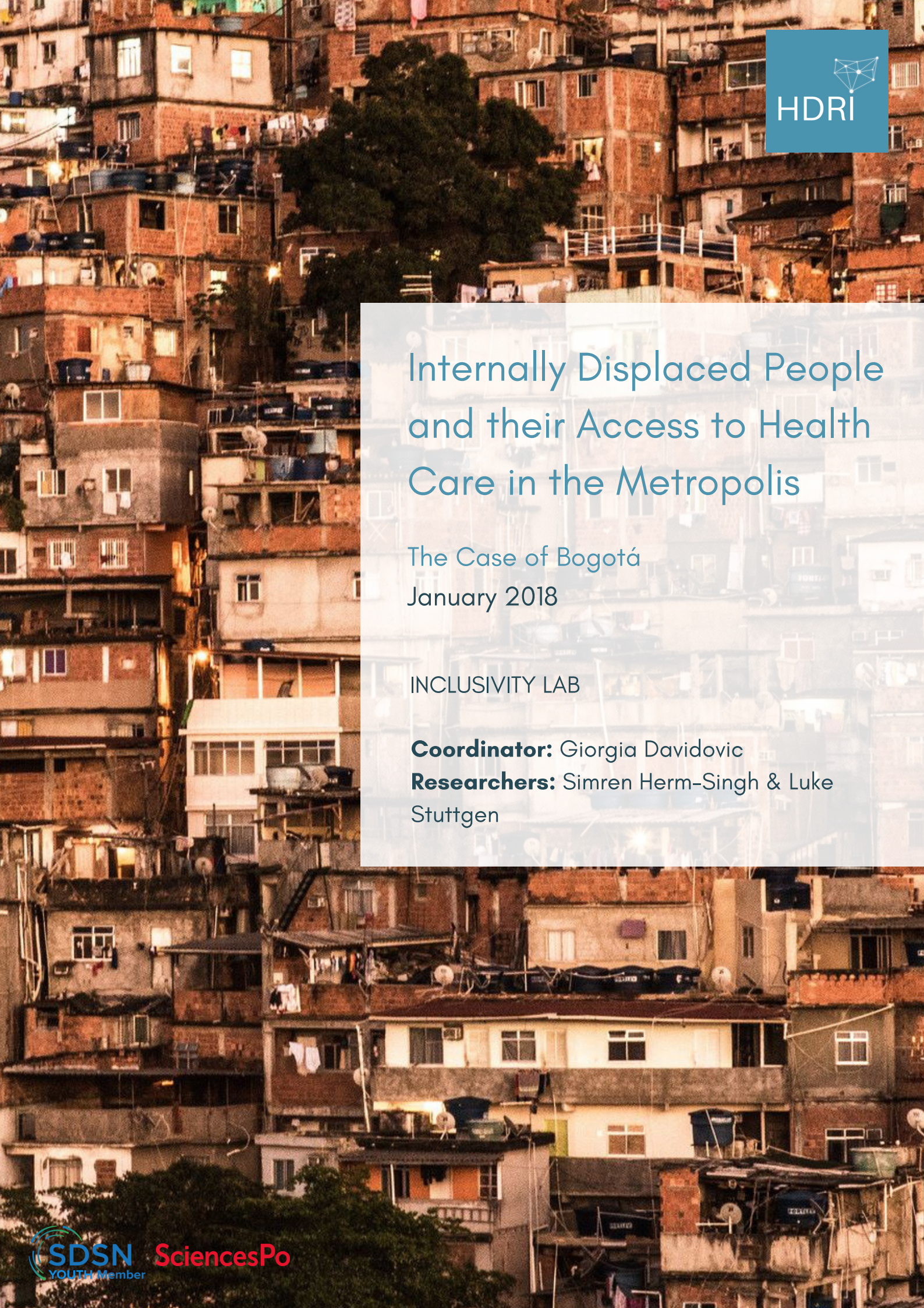


HDRI

Internally Displaced People and their Access to Health Care in the Metropolis

The Case of Bogotá

January 2018

INCLUSIVITY LAB

Coordinator: Giorgia Davidovic
Researchers: Simren Herm-Singh & Luke Stuttgen

SDSN YOUTH Member SciencesPo

The report **"Internally displaced people and their access to health care in the metropolis: The case of Bogotá"** was led by the **Inclusivity Lab team** from the Human Development Research Initiative.

26 January 2018

Published in 2018 by the Human Development Research Initiative (HDRI)

Layout by Lois Paatan
Photo cover from top left to bottom right: Chris Jones

EXECUTIVE SUMMARY

Internal displacement is the demographic process of forced migration without the crossing of national borders (OCHA, 1999). In Colombia internal displacement is largely the result of the nation's protracted armed conflict, which has primarily forced rural populations to flee to cities in search of safety and assistance. The predominant pattern of urban resettlement has produced serious demographic and humanitarian pressures on Colombia's capital, Bogotá, which has experienced rapid informal urbanization in the city's periphery with little to no urban development planning. The city's outskirts are characterized by widespread poverty, limited access to public services and precarious housing and sanitation conditions, which undermine underlying determinants of health. Forced relocation to informal urban settlements causes internally displaced people (IDP) to contend for public resources with Bogotá's host population, increasing their vulnerability to social stigmatization and further deteriorating their psychosocial and physical health. Providing access to health care for IDPs is of paramount importance within cities, as the circumstances of their displacement and living conditions increase their vulnerability to communicable and non-communicable diseases, violence and abuse. Ill health amongst IDPs can not only pose threats to public health for the city as a whole but, more importantly, generates adverse social and economic consequences for the individual, aggravating social inequalities. Improving IDPs' access to quality health care is thus a crucial step towards Bogotá's sustainable urban development, which is equitable and inclusive amongst all members in society. This brief provides an overview of the health situation experienced by IDPs in Bogotá and offers recommendations to inform municipal and national policies to improve health care access for IDPs. In many ways, these issues expand beyond the context of Bogotá and are applicable to other conflict-ridden countries burdened by internal displacement to urban centres.

RÉSUMÉ

Le déplacement interne désigne un processus de migration forcée sans franchissement des frontières nationales. Les déplacements internes en Colombie résultent de l'interminable conflit armé que connaît le pays depuis des années, et qui a très tôt forcé les populations rurales à fuir les campagnes pour chercher asile

et refuge dans les villes du pays. Le modèle prédominant de relocalisation des populations dans les espaces urbains a généré des pressions démographiques et humanitaires préoccupantes sur la capitale colombienne. Bogota a ainsi vu une croissance rapide de l'urbanisation informelle sur ses marges, dans le cadre d'une planification urbaine quasi inexistante. Les périphéries de la capitale se caractérisent aujourd'hui par une pauvreté endémique, un accès limité aux services publics et des conditions sanitaires et de logement extrêmement précaires, autant d'éléments qui minent les facteurs déterminants de la santé. Le déplacement forcé des populations, contraintes de vivre dans les secteurs d'habitat informel de la ville, génère une concurrence entre déplacés et population hôte de Bogota, obligés de se disputer un accès aux services publics déjà limité. Cette concurrence des publics accroît ainsi leur vulnérabilité à toutes formes de stigmatisations sociales et de détérioration de leur santé à la fois physique et psychologique. Assurer l'accès aux soins pour les déplacés revêt une importance capitale dans les villes, car les modalités de leur déplacement et les conditions de vie qui sont les leurs dans la ville d'arrivée renforcent l'exposition de ces populations aux maladies infectieuses et non-transmissibles, et à la violence. La mauvaise santé des déplacés ne menace pas uniquement la santé publique de la ville dans sa globalité, mais, plus important encore, cela génère des conséquences sociales et économiques négatives pour les individus, tout en accentuant les inégalités sociospatiales. Ainsi, améliorer l'accès des populations déplacées à des soins de qualité est une étape cruciale dans la mise en œuvre d'un développement urbain soutenable, équitable et inclusif. Ce policy brief propose un état des lieux et une analyse de la situation sanitaire des déplacés à Bogota, et formule des recommandations politiques à destination des décideurs municipaux et nationaux, dans l'optique d'améliorer l'accès aux soins pour les populations déplacées. Par bien des aspects, ces problématiques dépassent largement le contexte de Bogota et peuvent en réalité être appliquées à bien d'autres pays touchés par le conflit et les déplacements internes de populations vers les centres urbains.

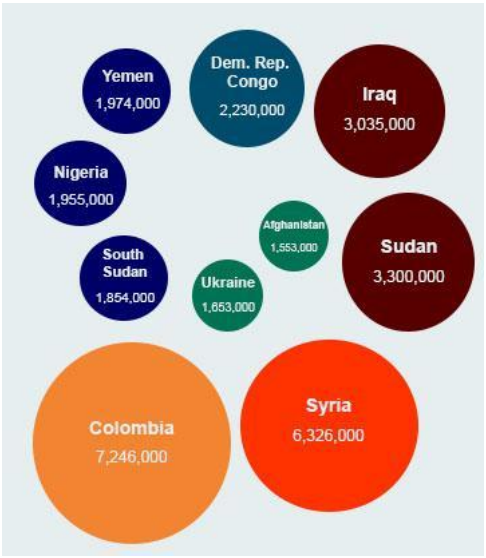
CONTENTS

Dimensions of internal displacement in Colombia

Drivers of displacement

Colombia's 50-year long civil war seemingly came to an end with the 2016 peace accords, which negotiated the disarmament and demobilization of the country's largest armed group - the FARC. Between 1985 and 2016, Colombia's protracted conflict caused the forcible displacement of over 7.1 million people (IDMC, 2017). However, internal displacement is not yet a phenomenon of the past.

Today forced displacement within Colombia continues as new insurgencies emerge in areas where former guerilla forces and paramilitary groups have been demobilized. While the state continues to struggle with the consolidation of territorial control in coastal and border regions, dissident groups thrive on the illicit business of the booming coca industry, illegal gold mines, contraband and extortion (ICG, 2017). Pressures to collaborate with armed groups, death threats, forced recruitment of children and sexual- and gender-based violence, as well as a renewed rise in insecurity, homicide rates and overall levels of violence force citizens to flee and relocate elsewhere (IDMC, 2017). Forced displacement is thus both a result of Colombia's armed conflict as well as a strategy for parties seeking to extend their control in rural power vacuums and profit from resource-rich lands. However, the structural drivers of forced displacement extend far beyond the continuation of armed conflict. The country's thriving drug industry, a recent outset of natural disasters and large-scale land acquisitions for development and mining projects further perpetuate internal displacement in contemporary Colombia (ICG, 2017). Between January and June, 2017, a further 79,000 new displacements have been recorded (IDMC, 2017).



Currently, policymakers face the challenge of managing this conflict-driven humanitarian crisis, which remains not only unresolved, but is intensifying and increasing in its complexity. As of 2016, Colombia overtook Syria as the country with the highest population of internally displaced people (IDPs). Today the nation is

estimated to host over 7.1 million IDPs, which has lead observers to label internal displacement as "Colombia's invisible crisis" (UNHCR, 2015).

Patterns of internal displacement

Displacement in Colombia is related to the acquisition of sparsely populated land, causing 92% of total displacements to originate from rural areas (Stirk, 2013). Consequently, indigenous peoples, Afro-Colombians and rural peasant landowners are disproportionately affected by displacement, as they often reside in remote, resource-rich regions that are targeted by armed groups (Beittel, 2012; IDMC, 2017). As a result, migration from rural to urban areas is Colombia's most predominant pattern of displacement (Bilak et al., 2014). Offering IDPs the security of anonymity as well as improved accessibility to public services, cities are the target destination for 80% of the country's IDP population (Bennett et al., 2017; Osorio & Brena, 2008).

The predominant pattern of urban relocation and subsequent difficulties for IDPs' wellbeing has produced a wide array of challenges to the sustainable and inclusive development of cities. Primarily, the influx of IDPs to cities has produced serious demographic pressures, with municipalities experiencing population increases of over 20% (Atehortúa et al., 2013). As Colombia does not have any displacement camps, IDPs tends to migrate to informal settlements in the outskirts of cities, intensifying the process of urbanization. Furthermore, informal urban resettlement has generated numerous sociological, economic and health-related challenges for IDP populations, as these districts are heavily burdened by extreme poverty, scarce employment opportunities, gender-based violence, inadequate infrastructure and insufficient access to public services. Today, over 63% of IDPs live below the poverty line and 33% live in extreme poverty (Bilak et al., 2015).

Relocating from rural, predominantly agricultural zones, many IDPs lack the skills to enter the labor market in an urban setting. Unable to secure stable employment, many IDPs are forced to encourage child labor or resort to criminal activities to secure a livelihood in urban spaces (Ramirez & Franco, 2016). In addition to entrapping IDPs in vicious cycles of poverty, such urban living conditions increase economic and social inequity within cities and can undermine public security. In larger cities, such as; Medellín, Bogotá and Cali, increased urban violence by parties of the armed conflict and organized criminal gangs has produced the phenomenon of intra-urban displacement, forcing repeated displacement within and between urban areas (Atehortúa et al., 2013). Moreover, considering the high proportion of indigenous and Afro-Colombian peoples amongst IDP populations, disparities

between IDPs and host communities can reinforce ethnic and social marginalization within the urban space. As the root causes of internal displacement in Colombia remain far from resolved, local authorities bear the responsibility of instituting policies to protect IDPs within cities and finding durable solutions for their integration, particularly for those living in peripheral urban zones. Failing to consider and address the needs of IDP populations as a priority within Colombian cities infringes their human rights and hampers the inclusive development of cities.

Colombia's legal framework for IDPs

Confronting the challenges of internal displacement for decades, Colombia has developed one of the most advanced legal frameworks for IDPs. In 1997 the state passed Law 387, officially recognizing the country's large internally displaced population, defining their rights and initiating a legal framework for their protection and assistance. Law 1190 in 2008 granted local authorities the responsibility to provide emergency assistance to IDPs (Atehortúa et al., 2013). In 2011 the government passed Law 1448 entitling IDPs to reparations, land restitution and humanitarian assistance (ibid.). The Victim's Law placed a particular focus on helping IDPs overcome socio-economic vulnerability through state assistance in the domains of food, education, documentation, family reunion, health (embracing psychosocial support), housing and livelihoods (including occupational support).

Despite its progressivity, Colombia's legal and policy framework experiences significant gaps for comprehensive implementation. As of September 2016, the courts had only ruled in 4,100 out of more than 93,000 claims received (Human Rights Watch, 2017). According to Harvard University's Carr Center, the government's capacity would require a sevenfold increase in order to achieve compensation targets by 2021 (Bennet et al., 2017). With more than 12% of Colombia's total population eligible for reparations and 4.9 million in need of humanitarian assistance, the Victim's Law has produced unprecedented challenges for state institutions and local authorities. Heavily overburdened, lacking sufficient funding and afflicted by endemic corruption, the capacity of municipal authorities remains weak in successfully providing for the plethora of IDP needs (Bennet et al., 2017). Bogotá has emerged as the city most affected by the sustained influx of IDPs. According to research conducted by Acción Social[1] in 2009, Bogota was hosting an estimated 244,184 IDPs, which made up 8.2% of the capital's total residents (Carillo, 2009). Receiving approximately 52 new families each day, the capital is challenged by a myriad of difficulties related to the integration and protection of almost 41% of Colombia's total IDP population (Ibáñez & Velásquez, 2009; Zeiderman, 2013).

[1] Acción Social is Colombia's Government Department for Social Prosperity

Barriers to accessing health care for IDPs in Bogotá

Access to health care for IDPs is of paramount importance within Bogotá, as the circumstances of displacement and living and working conditions of IDPs increase their vulnerability to disease, injuries, violence and abuse, and negatively impacts their mental and psychosocial well-being (Grover, 2013; Kontunen et al., 2014; Schultz, 2014). Mental health is of particular concern amongst the IDP population. The experience of displacement and exposure to exploitation, discrimination, violence, xenophobia or sexual violence during or subsequent to flight creates severe stress factors to psychological well-being (Bhugra & Jones, 2001). Today, an estimated 88% of Colombia's IDPs suffer from post-traumatic stress disorder (PTSD) (Ramirez & Franco, 2016). Moreover, IDP health is negatively impacted by the effects of poverty and resettlement in Bogotá's informal peripheries, such as the districts of *Las Americas*, *Bosa*, *Suba, Kennedy, San Cristóbal* and *Ciudad Bolívar* in the south-west and north of the city. Economic instability and inadequate living conditions cause the deterioration of virtually all underlying determinants of health, including nutrition, water, sanitation and housing. Ill health amongst Bogotá's IDP population not only poses a threat to public health for the city as a whole, but also generates adverse social and economic consequences for individuals and their families, exacerbating already difficult living conditions and aggravating inequalities throughout society. Improving IDP access to quality health care is thus a crucial step towards ensuring sustainable urban development in Bogotá that is equitable and inclusive for all members in society.

Although Colombia's legal framework for IDPs has established their *de jure* right to health care, which could help alleviate a multitude of negative factors for Bogotá's development, the reality for many IDPs is often quite different. IDPs continue to face numerous barriers to accessing effective health care, once resettled in Bogotá, in spite of the fact that Colombia has passed progressive legislation and possesses a theoretically universal health care system. A primary concern is financial affordability, as Colombia's nominally universal health care system lacks equal and universal access in practice. In the pluralistic health care system, established in 1993, there are three main classes of recipients: those in the *régimen contributivo* who pay for their insurance, those in the *régimen subsidiado* who have their care subsidized by the government due to low income, and the *vinculados* who have been identified as poor by the government but have not yet received membership certification in the *régimen subsidiado*. This category requires members to pay for 30% of the medical service costs (Bochenek, 2005). With 63% of Colombia's IDP population living in poverty, the majority of IDPs fall under the later category of *vinculados* and are unable to access subsidized care of the *régimen subsidiado*

(Bilak et al., 2015; Atehortúa et al., 2013). Falling in the lowest tier of health insurance severely impairs health care access for IDPs, as the majority lack the socio-economic capacity to meet out-of-pocket payments of 30%. Furthermore, the lack of sufficient medical facilities and workforce has generated inequalities in the quality of health care services and treatment amongst the three insurance categories. Consequently, structural flaws in Colombia's universal health care system have produced significant barriers for IDPs wanting to access quality services.

Even when affordability is ensured, the lack of proper documentation amongst IDPs produces additional barriers to accessing public services. Most directly, many IDPs lack the required identification and health records for inclusion in the system, which also limits the ability to procure accurate health data for Bogotá's IDP population and thus confounds the government's ability to craft effective policy responses (Schultz, 2014). In an interview, a Profamilia nurse in Bogotá[2] described the documentation requirements as "unrealistic," adding that "[t]hese people fled their homes...it's highly unlikely they stopped to bring all their documents with them," and noted the improbability that an IDP would be willing and able to return to their home region to acquire them (Walsh, 2012). This also implies that IDPs frequently lack the requisite medical records to demonstrate pre-existing conditions and pursue treatment, even if they are able to access health services. Despite the added legal protections in the 2011 Victim's Law, efforts to increase the registration of IDPs in Bogotá have been ineffective because this process requires the confirmation of identity from the IDPs' home municipality. This can put their lives and those of their family at risk of further violence and many IDPs understandably do not opt into the system (Immigration and Refugee Board of Canada, 2013). The Constitutional Court added to the protections of the Victim's Law in 2013, holding that IDPs were eligible for emergency medical services even without documentation. However, even after these measures, IDPs have reported being turned away for emergency services on the grounds of missing documentation (Human Rights Watch, 2005). These documentation issues are cyclical. Without access to health services, IDPs may be unable to receive important documentation such as birth and death certificates, which can further complicate their situation (Ibáñez & Velásquez, 2008).

There are also a number barriers to accessibility unrelated to documentation and the institutions at the national level. IDPs who are able to visit a health care professional have difficulty paying for medication due to lack of availability in public hospital pharmacies or the inability to wait in long lines. This latter concern is important given that time lost can significantly affect income for IDPs, who

[2] Profamilia is a non-profit organisation that promotes sexual and reproductive rights in Colombia

frequently rely on income from labor in the informal sector (Bochenek, 2005). Related to affordability is the limited access to transportation. Clinics (especially mental health facilities) are often clustered in urban centres, inaccessible to the majority of IDPs living in the city's outskirts. This limitation arises both from difficulties in paying fares as well as from the confusing nature of the public transportation system in Bogotá (Walsh, 2012). Finally, IDPs with the means to afford transportation and payment may still have issues securing sufficient time away from work or other familial obligations and may have limited access to a telephone with which to make an appointment in the first place (Walsh, 2012).

Barriers of affordability, availability, quality and both information and physical accessibility currently prevent Bogotá's IDP population from accessing quality health care in the metropolis. Cultural issues, information gaps and insufficient institutional capacity produce additional factors that obstruct IDPs from receiving the health care they so desperately need. These gaps are even more pronounced in the field of mental health. As mental health is not considered a medical problem in Colombian society and culturally men are expected to deal with their emotions in private, mental health problems are commonly under-diagnosed and patients resort to drug or alcohol abuse. Moreover, mental health services are subject to urban segregation and significant underinvestment in Bogotá (Tamayo-Agudelo & Bell, 2017). Although the Victim's Law acknowledged the importance of providing mental health to IDPs, significant gaps remain in the execution of the National Program for Social and Psychological Support for Victims of Armed Conflict (PAPSIVI), which was part of the 2011 reforms. Corruption, stalled reforms, insufficient workforce allocation, health system debts and closure of mental health hospitals and clinics are significant barriers to progress (Tamayo-Agudelo & Bell, 2017). Today, mental health is poorly integrated into Colombia's primary health care, inaccessible and of lower quality for IDPs (De Bernal & Soto, 2016).

Policy recommendations

As the root causes of Colombia's forced displacement continue, the socio-economic integration and protection of internally displaced people remains a significant social challenge that will require concerted and persistent effort by Colombian policymakers for years to come. Below is an array of policy recommendations with the aim of improving health outcomes for Bogotá's IDP population and moving towards a more inclusive and accessible Bogotá. These recommendations vary in their scopes and ease of implementation, but broadly fall into four categories: enhancing Colombian institutional capacity; enhancing Bogotá's municipal institutional capacity; improving underlying determinants of health; and increasing access to mental health services.

Enhancing Colombian institutional capacity

While Colombia's national government should be lauded for the steps that they have taken towards assisting IDPs, it has been shown that there remain limitations on the government's institutional capacity to effectively promote and implement these laws.

1. Engage civil society organizations and the media to publicize the national programs that already exist to assist IDPs. Information targeted to the IDP population could help to inform them of the existence of programs, such as; the registration process, preventative health recommendations and their eligibility for emergency medical services. Many such programs exist in the status quo, but information barriers diminish their effectiveness because there is not always adequate information available to IDPs.

2. Adopt a Health in All Policies strategy to guarantee sustained consideration of IDP needs in the future. This would involve the inclusion of experts on the IDP situation in several related policymaking sectors, such as health, labour and immigration, to ensure that the policy impact on migrant health and health care access are taken into account (Kontunen et al., 2014). Corburn et al. (2014) details this approach further in the context of Richmond, CA, US.

Enhancing Bogotá's municipal institutional capacity

Although many programs are national in nature, implementation is generally handled at the municipal level. This means that the institutional capacity of the Bogotá municipality is of paramount importance to the successful implementation of inclusive policies. However, the city has experienced funding shortfalls for several

of its programs. As such, an important precondition for several recommendations is to secure funding from the national government and Victim's Unit to account for its disproportionately high IDP population.

1. Conduct a thorough epidemiological investigation of the IDP population in order to identify medical needs. Currently, minimal data is collected and published on this population which makes it difficult for policymakers to craft legislation that responds to their specific medical needs (Walsh, 2012). Updating the epidemiological profile of the IDP population and making that data available to researchers, legislators, social workers and health industry professionals would allow the municipality and health care providers to target health projects and interventions more effectively.

2. Establish health outreach programs that give IDPs a channel to provide feedback to health care providers. This would allow health care professionals within Bogotá to gain a more thorough understanding of how the IDP population perceives the quality of health services they receive and allow policymakers to more effectively target the underlying factors that affect decisions to utilize or avoid health services. Therefore, increasing effectiveness and scope of health care delivery (Walsh, 2012).

3. Increase overall capacity of local registration units to both quicken and improve the quality of registration under the 2011 Victims Law. According to Hanson (2012, p. 3), "additional human resource capacity should be offered to unclog the declaration bottleneck and provide onsite training and quality control of the declaration process."

4. Improve the relationship between IDPs and the host community. This should be done via a participatory approach with civil society, the media and NGOs with the goals of reducing the level of social marginalization that IDPs experience in Bogotá's urban space and fostering public support for the IDP cause and thus generating political will for further reform (see Atehortúa et al., 2013). There are a number of possible ways in which the municipality could become involved, including social media campaigns and advocacy events.

5. Incorporate civil society organizations that can undertake budget oversight initiatives at the municipal level. With adequate training and funding, these local NGOs can provide quality control of programming for urban IDPs and ensure the funds included in mandated local action plans are spent effectively in support of displaced victims.

6. Increase availability of government health services in neighborhoods with a high concentration of IDPs — *Las Americas*, *Bosa*, *Suba*, *Kennedy*, *San Cristóbal* and *Ciudad Bolívar* — and ensure that health services are migrant-friendly. A migrant-friendly health system would incorporate a number of factors (see WHO, Government of Spain & IOM, 2010 and Fortier, 2010), but specifically would involve the hiring of IDPs as cultural support staff and community health workers in the new facilities. This would ameliorate the transportation issues that many IDPs while improving employment prospects for those living in the urban periphery.

Improving underlying determinants of health

In order to achieve durable results in the campaign for improving the health of IDP populations, it is necessary for Bogotá's municipality to deal directly with the root causes of the disparities in underlying determinants of health. While there are many recommendations in development and urban planning literature of how to improve health within cities, below are four recommendations to target the unique factors that affect the health of IDPs in Bogotá:

1. Engage in slum-upgrading in neighborhoods with significant IDP populations. Slum-upgrading is an urban renewal strategy that attempts to improve the living conditions of the inhabitants of underdeveloped urban areas. Improvements in water services, drainage systems, security lighting and shelter in Bogotá's peripheries will significantly enhance the underlying determinants of health and improve overall health outcomes amongst IDPs (WHO, 2005).[3]

2. Prioritize urban IDP integration as a key pillar of the implementation of the Victim's Law, and devise new, integrated programs that help displaced people in urban areas attain decent housing, formal employment, and self-sufficiency in

[3] For example, replacing dirt floors with cement in Mexico City significantly reduced the rates of parasitic protozoa infestations and diarrhea in children (Alirol et al., 2010).

their local communities. This is critical for the durability of the programs, as it will solve the root cause of the health issues of the IDP population.

3. Create programs that provide job opportunities for IDPs in order to sustainably improve population health. Increased efforts to improve IDP job security by investing in targeted employment programs and creating an enabling legal environment will support the socio-economic integration of IDPs and produce positive externalities on health outcomes.

4. Improve nutritional assistance programmes in IDP neighbourhoods. Ensuring that subsidized food items contain an appropriate mix of fruits, vegetables and protein is essential to a healthy and balanced diet, which will allow IDP children and adults to avoid health issues related to malnutrition.

Increasing access to mental health care

Ensuring access to adequate mental health care is of paramount importance for Bogotá's IDP health and protection strategy. While mental health is a critical part of any health care system, IDPs disproportionately face larger barriers to access and quality of care while simultaneously experiencing a significantly higher risk for mental health issues. Securing access to psychological and mental health care for IDPs, that is socially and culturally appropriate, is crucial to promote integration and normalization of daily life for IDPs.

1. Accelerate implementation of Colombia's already existent PAPSIVI and ensure that mental health remains a priority on the political agenda of improving overall health amongst urban IDPs.

2. Ensure that psychosocial assistance and basic services are available and mandatory for all IDPs on site at registration centers. Introduce an obligatory psychological interview during registration to identify any required level of need for further mental health and psychological support.

3. Ensure that registered IDPs can receive psychological assistance, independent of their insurance status. This can be achieved through the full execution of the PAPSIVI programme and increased mobilization of government funds into the area of mental health provision.

4. Reform health labor force policies and augment investment in education to increase the availability of workforce in the mental health sector. This can be accomplished in the following ways:

    i. Introduce a mandatory duty for Bogotá psychiatrists and clinical psychiatry residents to assist with IDP mental health services in facilities that support IDP populations.

    ii. Increase training for community health nurses to assist with the provision of mental health services in IDP settlements.

    iii. Increase the quantity of and investment in clinical psychology doctoral programs in universities to ensure that more psychologists are trained to treat IDPs with more complex mental health needs.

Conclusion

Overall, IDP populations in Bogotá face a number of socio-economic and psychosocial issues as they adjust to life in the country's largest urban centre. The experience of forced displacement and the living conditions that they experience once they have relocated negatively affects underlying determinants of both physical and mental wellbeing. While Colombia's government has taken many legislative steps towards the integration of this population, disparities persist in the quality and access to health care services. These barriers are varied and will require a coordinated response from a variety of stakeholders within Bogotá and the Colombian government. Specifically, HDRI's Inclusivity Lab has developed policy recommendations that are designed to enhance the institutional capacity of both the national and Bogotá municipal government, improve underlying determinants of health of displaced populations and increase access to quality mental health services. Given that durable and equitable solutions for IDPs are crucial to the inclusive development of Bogotá, it is necessary that Colombian policymakers take action to meet these goals and address the needs of this underserved and vulnerable population.

BIBLIOGRAPHY

Alirol, E. et al. (2010). *Urbanisation and infectious diseases in a globalised world.* The Lancet Infectious Diseases, 11(2):131–141.

Atehortúa, C. et al. (2013). Local government responses to internal displacement in urban areas: A study of Bogotá and Cali, Colombia. *Brookings-LSE Project On Internal Displacement*. Retrieved from http://www.brookings.edu/research/internally-displaced-outside-of-camps-and-the-role-of-local-authorities-in-colombia-a-comparative-study-of-bogot-dc-and-cali/.

Beittel, J. S. (2012). *Colombia: Background, US relations, and congressional interest* (pp. 7-5700). Congressional Research Service.

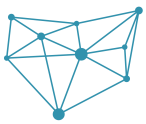
Bennett, K. et al. (2017). *2017 Global Report on Internal Displacement (GRID 2017)*. Internal Displacement Monitoring Centre (IDMC) - Norwegian Refugee Council.

Bhugra, D., & Jones, P. (2001). Migration and mental illness. *Advances in Psychiatric Treatment*, *7*(3), 216-222.

Bilak, A. et al. (2015). *2015 Global Overview 2015 - People Internally displaced by conflict and violence*. Internal Displacement Monitoring Centre (IDMC) - Norwegian Refugee Council.

Bochenek, M. (2005). *Displaced and Discarded: The Plight of Internally Displaced Persons in Bogotá and Cartagena* (Vol. 17, No. 4). Human Rights Watch.

Canada: Immigration and Refugee Board of Canada (2013) *Colombia: Internally Displaced Persons (IDPs), including relocation options available to IDPs; whether IDPs are issued documents that indicate their status, including requirements and procedures to obtain copies of these documents (2012-June 2013)*. Retrieved 28 November 2017 from http://www.refworld.org/docid/53733f054.html



Carrillo, A. C. (2009). Internal displacement in Colombia: humanitarian, economic and social consequences in urban settings and current challenges. *International Review of the Red Cross*, *91*(875), 527-546.

Chaskel, R., Gaviria, S. L., Espinel, Z., Taborda, E., Vanegas, R., & Shultz, J. M. (2015). Mental health in Colombia. *Mental health law profiles*, 95.

Corburn, J. et al. (2014). Health in All Urban Policy: City Services through the Prism of Health. *Journal of Urban Health.* August 2014, Volume 91, Issue 4, pp 623–636.

Fortier, J. (2010). *Migrant-sensitive health systems. In: Health of migrants - the way forward. Report of a global consultation*. (WHO, Government of Spain and IOM, eds.). WHO, Madrid.

Grover, A. (2014). UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*.

Hanson, M. (2012). *Colombia: Transformational change must include urban IDPs.* Refugees International Field Report.

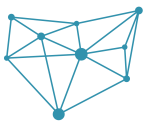
Højen, L. (2015). *Colombia's "Invisible Crisis": Internally Displaced Persons. Coha.org*. Retrieved 3 November 2017, from http://www.coha.org/colombias-invisible-crisis-internally-displaced-persons/

Human Rights Watch (2005). *Colombia: Displaced and Discarded The Plight of Internally Displaced Persons in Bogotá and Cartagena.* October 2005 Vol. 17, No. 4(B)

Ibáñez, A. M., & Velásquez, A. (2008). *Public policies to assist Internally Displaced Persons: the role of municipal authorities*. Brookings Institution-University of Bern Project on Internal Displacement.

International Crisis Group. (2017). *Colombia's Armed Groups Battle For The Spoils Of Peace*. Brussels. International Crisis Group.

Internal Displacement Monitoring Centre (IDMC) - Norwegian Refugee Council. (2017). *IDMC » Colombia country profile. Internal-displacement.org.*



Retrieved 3 November 2017, from http://www.internal-displacement.org/countries/colombia#link_concerns.

Kontunen, K., Rijks, B., Motus, N., Iodice, J., Schultz, C., & Mosca, D. (2014). Ensuring health equity of marginalized populations: experiences from mainstreaming the health of migrants. *Health promotion international*, *29*(suppl_1), i121-i129.

Osorio, P. F. E., & Brena, M. O. (October 30, 2008). Forced displacement among rural women in Colombia. Latin American Perspectives, 35, 6, 29-40.

OCHA, UN. (1999). Handbook for Applying the Guiding Principles on Internal Displacement. OCHA. *The Brookings Institution, Washington*.

Quintero, A. L., & Culler, T. A. (2009). IDP health in Colombia: needs and challenges. *Forced Migration Review*, (33), 70.

Ramirez, J. A. B., & Franco, H. D. (2016). The Effect of Conflict and Displacement on the Health of Internally Displaced People: The Colombian Crisis. *University of Ottawa Journal of Medicine*, *6*(2), 26-29.

Schultz, C. (2014). *Migration, Health and Cities - Migration, Health and Urbanization: Interrelated Challenges.*. International Organisation for Migration.

Shultz, J. M., Ceballos, Á. M. G., Espinel, Z., Oliveros, S. R., Fonseca, M. F., & Florez, L. J. H. (2014). Internal displacement in Colombia: fifteen distinguishing features. *Disaster Health*, *2*(1), 13-24.

Stirk, C. (2013). Resources for humanitarian response and poverty reduction. *Global Humanitarian Assistance*, *Apr*.

Tamayo-Agudelo, W., & Bell, V. (2017). Armed conflict and mental health in Colombia. *Open Science Framework*. http://dx.doi.org/10.17605/OSF.IO/3JZQM

World Health Organization (2005). *A Billion Voices: Listening and Responding to the Health Needs of Slum Dwellers and Informal Settlers in New Urban Settings.* WHO, Geneva.

World Health Organization, Government of Spain and International Organization for Migration (2010). *Health of Migrants – The Way Forward. Report of a global consultation. Madrid*. 3-5 March 2010.

Zeiderman, A. (2013). Living dangerously: Biopolitics and urban citizenship in Bogotá, Colombia. *American Ethnologist*, *40*(1), 71-87.