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Access to health care for Venezuelan irregular migrants in Colombia: Between constitutional adjudication and human rights law

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Abstract

In the last six years, Colombia has received an exceptionally high number of incoming people on the move, fleeing from neighbouring Venezuela, including around 1 million Venezuelan nationals in an irregular situation.[1] Against this unique and challenging background, this article aims to ascertain the extent to which the jurisprudence of the Constitutional Court of Colombia and that of United Nations' human rights treaty bodies and InterAmerican institutions are synergetic and supportive of the idea that the right to health must be equitably accessible for irregular migrants and subgroups of the same. The case law of this social rights-friendly, transformative and relatively accessible Constitutional Court provides useful insights into both the difficulties of implementing 'beyond minimalist' approaches to the rights of irregular migrants in a middle-income country and the unusually influential but selective role of international human rights law and the comments of treaty bodies in its findings. For this case study, I also systematise applicable arguments of UN and InterAmerican human rights law (also here referred to as 'human rights law') and demonstrate that they are normative frameworks capable of pitching the right to health of irregular migrants beyond access to urgent treatment by integrating arguments based on core rights and vulnerability into a primary health care approach to public health that 'brings promotion and prevention, cure and care together'.[2]

KEYWORDS: right to health, primary health care, irregular migrants, children, women, international and InterAmerican human rights law, Colombia, Venezuela(n), constitutional law

1. Methodology, scope of the study and preliminary definitions

Approaching the multifaceted theme of the health of Venezuelan migrants in an irregular situation in Colombia is extremely complex because several public and private actors with different national and international mandates contribute to the normative and operational (health and social) frameworks for this disadvantaged population on the move, both before and in pandemic times.[3] The difficulty of providing a complete picture of the operationalisation of the right to health of migrants is exacerbated by the fact that Colombia is currently implementing a 'Temporary Protection Status for Venezuelans' (TPSV).[4] Presented as a pragmatic and human rights-based solution to the social and legal integration of Venezuelan migrants, this scheme aims to regularise the legal status of new immigrants, those whose permits are due to expire soon and around one million Venezuelans in irregular situation that were in Colombia on 31 January 2021. Once implemented, with the necessary technical and financial support from the international community, it will allow them to access the formal job market and mainstream social security system. Until that moment comes, however, divisions between irregular migrants and regularly resident populations in relation to accessing health and social benefits continues to be a highly controversial human rights issue. It has been the topic of particularly interesting examples of constitutional jurisprudence, which have played a central role in bringing domestic actors to account for human rights violations and striking a balance between particularism and universalism.[5]

This article reviews 14 judgments issued by the Constitutional Court of Colombia (CCC) between 2017 and 2020. All deal with the right to health care of irregular Venezuelan migrants and, by incorporating the contributions of several independent actors and statutory bodies, contain extensive references to human rights law and public policy considerations. The overall aim of this paper is to determine the extent to which the jurisprudence of the CCC and that of UN and InterAmerican human rights bodies are synergetic and supportive of the idea that the right to health care must be equitably accessible by people who are especially vulnerable because of their migration status, which is often compounded by economic deprivation, gender or age.

Using a conventional legal method for reading cases, this review outlines the facts, issues, decisions and reasons given in each case. Hence, it primarily comprises an 'expository' and 'evaluative' doctrinal legal analysis: normative standards are presented and assessed within the relevant legal frames of reference and in the light of relevant legal

principles, norms, case law, jurisprudence, scholarly analyses and metal-legal arguments and concepts.[6] This meta-legal material, which also serves as a set of analytical constructs, includes a conceptualisation of vulnerability that qualifies individual and group disadvantage as a catalyst for positive state actions targeting comparative power asymmetries[7] and the primary health care paradigm (an authoritative public health standard) to identify the levels and depth of health services that public (and private) authorities should not reasonably restrict on the ground of migratory legal status, including to avoid discriminatory practices in the enjoyment of core human rights. My approach, which combines these concepts, challenges common sovereigntist conceptualisations of human rights law and health policies, which reduce irregular migrant rights to bare minimal and emergency levels[8] and often disproportionally limit these people's right to health and their capability to be healthy vis-à-vis national and regularised communities.[9]

Furthermore, to deepen the human rights review of the CCC's judgments, in sections 4.5 and 5, these are screened for the number of occurrences of words and concepts that are key to the above-described legal analysis to help determine the existence of argumentative patterns[10] and their relationship(s) with and influence on judicial findings. I wish to test whether recurring references to 'vulnerability', 'international human rights law', 'state obligations vis-à-vis migrants' lead to decisions favouring an expansive conceptualisation of migrants' right to health and, conversely, whether repetitions in the text of judgments referring to 'migrant duties' and 'state sovereignty' have the opposite effect on the judicial findings. Therefore, it may be said that this paper also performs a modest 'content analysis' exercise,[11] aimed at complementing and supporting its legal or human rights review.

To avoid over-generalisations and make use of existing constitutional decisions, this article mainly addresses the matter of unequal or differentiated access to free health care services for poor, irregular migrants and subgroups of the same. This is only one dimension of the international right to health, which requires states to adopt measures targeting all the determinants of health and not only medical care.[12] The term 'irregular migrants' refers to foreign nationals who do not comply with immigration law requirements for entry and/or stay in a country and are, therefore, susceptible to deportation.[13] Considering the uninterrupted flow of people in a situation of human

mobility arriving from Venezuelan, this term is here employed to refer to all people of this nationality or Colombo-Venezuelans who have either entered Colombia irregularly and have not regularised their status or applied for asylum or have overstayed their expired residence permit.

As this research is not exclusively addressed to Colombian readers, the following section offers a birds-eye view of the research context, focusing on the Venezuelan diaspora and the Colombian legal system as receptive of human rights law. Section 3 demonstrates how the CCC has aligned the domestic conceptualisation of the right to health to international human rights obligations and overviews its case law regarding issues of denial or reduced access to necessary health care for Venezuelan irregular migrants, which has increased in the last few years. Section 4 examines these judgments against applicable UN human rights standards (also referred to as 'international human rights law' or 'IHRL' in this article) and Inter-American human rights law (also 'AHRL'), as receptive of authoritative public health material on the realisation of key elements of the primary health care strategy, which is an essential approach of public health and human rights.[14] Particular attention is paid to 'motherhood and childhood [which] are entitled to special care and assistance' under human rights law.[15] Precise identification of the scope of international norms is essential because human or fundamental rights are more susceptible to discretionary judicial interpretation than other non-constitutional entitlements[16] and because constitutional adjudication in Colombia has widely employed international sources to define the normative content of fundamental rights, including the right to health.[17] The conclusions of this articles suggest that genuine incorporation of IHRL and AHRL into constitutional law would require enhanced judicial findings on migrant health that exceed an urgent- or emergency-based approach.

2. The context

2.1. The Venezuelan diaspora and the Colombian response

The severity of the ongoing Venezuelan crisis, which has led millions of people to emigrate, is arguably one of the most topical transnational issues in South America today. Venezuelan people have had to endure the consequences of a particularly severe economic, political and social crisis which has become especially intense in the last six years.[18] To give an indication of its scale, the figures for 2019 show that 96% of the Venezuelans live below the poverty line (79% in extreme poverty),[19] compared to around

25% in 2012.[20] International actors have observed the deterioration of human rights and the consistent pattern of severe violations revolving around hunger, punishment and fear in Venezuela.[21] The healthcare system has been collapsing under the weight of underfunding, shortages of essential drugs and medical devices, and the re-emergence of several infectious diseases that had been eradicated.[22]

Since 2015, many Venezuelans have begun to emigrate at an unprecedented rate, and their number is expected to exceed that of Syrian refugees by the end of 2021.[23] Colombia and other countries of the region did not generally resort to closing their borders,[24] but instead implemented a series of targeted immigration schemes, mostly short-term in nature.[25] Venezuelans in Colombia could, until recently, apply for a special 2-year permanence permit (PEP), although they had to have regularly entered the country with a passport or have regularised their legal status and could only apply when calls for applications were open.[26] They can also apply for a migrant visa, but the requirements are very difficult for unprivileged people fleeing poverty to meet. For jobseekers, these requirements include having a formal employment contract with certain additional requirements for employers.[27] People who do not have a passport – which can be difficult to obtain, pay for and renew given the critical Venezuelan situation – and do not comply with regularisation requirements can easily fall into irregularity. According to the official figures, more than half of the estimated 1.7 million Venezuelans in Colombia are irregular migrants and, hence, have very limited access to the mainstream social security system.[28] In early 2021, to address the human rights and social inclusion of Venezuelan populations and for pragmatic reasons of migration control, the government launched the above-mentioned general regularisation scheme for Venezuelan migrants, leading to the granting of a 10-year permit, including for people entering the country irregularly, and a comprehensive migration bill is under preparation in the Congress of Colombia at the time of writing.

2.2. Core features of the Colombian legal system and human rights protection

In accordance with its 1991 Constitution, Colombia is organised as a unitary democratic republic but also grants a certain degree of administrative autonomy to its 32 territorial departments.[29] The legislative power remains centralised,[30] and significantly for this analysis, ratified human rights treaties are a primary source of law: They are a standard

of interpretation for constitutional rights and have broad normative effects where there is no directly applicable provision in the constitutional order.[31] They direct law-making and adjudication and contribute to making non-compliant subordinate regulations null and void.[32] Furthermore, according to the 'conventionality control' doctrine, domestic implementation of human rights in law, policy making and practice should be implemented in accordance with the jurisprudence of the InterAmerican Court of Human Rights' (IACtHR),[33] although judicial practice in Colombia has not unequivocally supported this.[34] The CCC, whose applicable decisions are scrutinised in the next section, is, *inter alia*, responsible for the judicial review of statutes and acts as an appeal body in writs of amparo or 'tutela' claims.[35] By activating the latter procedure – which is common in Latin American countries − any person or their authorised representative can immediately claim an irreparable violation of their fundamental rights by public and private entities before any ordinary judge. Following a regional trend,[36] socio-economic rights are central entitlements in the Colombian legal system because of the constitutional mandate to 'promote the conditions whereby equality is real and effective' by offering special protection to marginalised groups and to people who are in a situation of 'economic, physical or mental' vulnerability.[37] Such attention to socio-economic vulnerability is complemented by the development of the right to enjoy material means of subsistence (or 'vital minimum').[38]

3. The right to health care of irregular migrants in Colombia

3.1. A progressively more inclusive right to health

Health care in Colombia is organised around government-defined health care benefits offered by regional private and public health insurers and providers to people registered with a contributory (employment-based) system and a subsidised system for people who are unemployed or in a situation of financial vulnerability.[39] Uninsured people are offered urgent care, the cost of which is covered by department funds. While it is a constitutional state duty to coordinate, manage and regulate the provision of health services according to the 'principles of efficiency, universality and solidarity',[40] the dysfunctions of this social insurance health system, which is dominated by private actors, have led to the filing of hundreds of thousands of 'tutela' claims by people seeking concrete access to required health care services and essential drugs as dimensions of the scope of key human rights.[41]

In this case law, the CCC began by protecting health rights via fully justiciable civil rights and developed the 'right to a vital minimum'.[42] Further, relying heavily on IHRL, the seminal T-760/2008 judgment recognised the right to health as a fundamental right worthy of direct constitutional adjudication. With this ruling, responding to several concerns that had been raised about the equity of the Colombian health system,[43] the CCC issued structural orders to public and private bodies and laid out a road map − for political powers to implement − to make the Colombian health care system more equitable and rights-oriented.[44] The implementation of these orders by the national norm-making bodies happened gradually. In 2012, the regulatory body for health made the decision to unify contributory and subsidised benefit plans.[45] Subsequently, the 2015 Health Act codified a right to health based on 14 principles: universality, pro homine, equity, continuity, promptness, age-sensitivity, progressive enhancement, free choice, sustainability, solidarity, efficiency, interculturalism, indigenous-sensitivity and protection of minorities.[46] Although the gap between formal and material coverage has not been completely bridged,[47] in just over two decades, personal health coverage has been significantly enhanced, accessible benefits have increased for everyone and essential medicines have generally been made affordable.[48] The new system clearly compels the state to ensure formal and substantial equality 'in accessing services for disease prevention and health promotion, diagnosis, treatment, rehabilitation and palliative care', thus reducing inequalities in the determinants of health to achieve equity in health.[49] Health legislation clearly established that health services, facilities and conditions must be available, accessible, acceptable and of good quality (AAAQ framework), which bears witness to the strong influence of IHRL.[50] As mentioned above, people must register with either the contributory system or the subsidised system to access the health system and obtain comprehensive care. Irregular migrants – who are denied affiliation to the subsidised system, as this requires either a Colombian ID or a regular residence permit or visa[51] – are, by virtue of their socioeconomic disadvantage, recognised as having a right to minimum health care vis-à-vis health care insurers, providers, the state and its territorial units.[52]

3.2. The chronicle of the constitutional findings on health care and irregular migration (2017–2020)

Since 2017, the CCC has periodically issued judgments elaborating on the right to health (care) of Venezuelan migrants without regular migratory status. They are extremely useful pieces of case law, also under an international and comparative law perspective, as they cover issues as broad as maternal care, children's health care, HIV and cancer treatment and immediate and progressive realisation rules and often grant normative relevance to human rights law.

Table 1. The CCC's cases under scrutiny

Case No.	Applicant(s)	Claim(s)
T-239/17	Male adult with cerebrovascular haemorrhages, lung infection and kidney failure	Access to urgent (post-emergency) treatment
SU677/17	Pregnant/lactating female adolescent	Access to prenatal check-ups, delivery assistance and child health care (of the mother and the child)
T-705/17	Parent on behalf of her child with a lymphoma	Access to diagnostic testing (CAT test)
T-210/18	Woman with post-surgical and oncological care needs (1); Child with giant scrotal hernia (2)	Access to necessary diagnostic testing and treatment
T-348/18	Male adult, HIV-positive	Access to necessary treatment
T-025/19	Male adult, HIV-positive	Access to necessary treatment
T-074/19	Pregnant/lactating, female	Access to necessary maternal care
T-178/19	Public servants on behalf of new-born child	Affiliation with the health care system to access necessary care
T-197/19	Male adult with skin cancer	Access to necessary care
T-403/19	Female adult with breast cancer	Access to necessary care
T-452/19	Female adult (1, 2, 3), one elderly (2); Child with cancer (4)	Access to necessary health care (1, 2), mental health care (3), and diagnostic testing (CAT test) (4)
T-246/20	Female adult, HIV-positive	Access to necessary treatment
T-275/20	Child with severe neurological issues	Right to have access and be transported to centres for specialised care and neurosurgery
T-436/20	Child with critical health needs (among other non-health related claims)	Right to have access and be transported to centres for specialised cardiological care (and claim for status regularisation of family member for the purpose of accessing to the social security system)

The first judgment of this saga, T-239/2017, set a very restrictive approach with marginal references to IHRL: while it recognised that the Constitution established the applicability of equality of treatment and non-discrimination between nationals and non-nationals,[53] it differentiated between registered *residents* who are entitled to comprehensive health benefits and *non-residents* such as irregular migrants who have a right to minimum free-of-charge care but only in case of exceptionally urgent need.[54] Urgent health care, which was the level of care identified in law and administrative norms for non-residents without affiliation to the health system, was interpreted as *life-saving treatment only*. On the merits, the CCC did not find any right violation where a person with irregularity of status – the person in question had arrived at the hospital with cerebrovascular haemorrhages, lung infection and kidney failure − did not have access to dialysis treatment after emergency care on the grounds that urgent treatment for non-residents did not include the *provision of essential drugs* or *post-emergency treatment*.[55]

Later in the same year, the CCC issued judgment S.U. 677/2017 on the matter of maternal health care, which to date remains one of the Court's most human rights-oriented judgments. The Court, elaborating on the constitutionally protected right to life in dignity, held that state authorities are 'obliged to provide *basic* and *urgent* health care to all people, regardless of their irregular immigration status, especially in the context of the humanitarian crisis of Venezuela, in relation to whom there is a qualified duty of solidarity'.[56] Thus, the Court ruled that the applicant should have received free prenatal check-ups and delivery assistance, which were qualified as 'urgent care' because pregnancy status, compounded by poverty and an irregular migration status, posed physical and psychological risks to the mother's life and health, as well as to those of the foetus and new-born.

The right to health of irregular migrant children was the main subject matter of the CCC's judgment T-705/2017. In this case, the applicant's mother complained that local health authorities did not authorise a cancer-related CAT test for her child on the grounds of his irregular status. The Court began its analysis by clarifying that the right to health of the child was 'reinforced' in both constitutional and international law.[57] Accordingly, the Court ordered the competent health unit to perform the CAT test on the child as a matter of 'urgent care',[58] while clarifying that urgent care did not include the

provision of other important determinants of health, such as housing, transport or food, to the minor or his mother.[59] This was later reversed by subsequent judgments

Arguably, the most instructive judgment in this area is T-210/2018, whereby the CCC clarified the extent of applicable immediate and progressive duties. With this ruling, the Court adjudicated the case of a woman who sought post-surgical and oncological care and that of a child who required clinical assessment and possible surgery for a giant scrotal hernia. The health authorities justified the denial of treatment on the grounds that the health needs of the irregular migrant applicants did not require any 'initial urgent treatment' (or emergency life-saving treatment), which, according to certain domestic norms, constituted the level of health care to which irregular migrants were prima facie entitled to, the cost of which could be recouped from the guarantee fund.[60] By contrast, the CCC, referring to a series of administrative acts of the Ministry of Health and applicable sources of law, clarified that urgent care is not only aimed at restoring vital functioning – which would correspond to 'initial urgent care' – but also included protecting life and preventing severe or long-term health consequences for physical and mental functioning.[61] The cost of this treatment, which was controversial, was held to be covered by the department and subsidiary by the state funds.[62] Furthermore, elaborating on a broad array of international treaty norms and non-binding jurisprudence, the CCC held that the required urgent care should be *immediately* provided and that the domestic legal framework, in consideration of the special socio-economic vulnerability of irregular migrants, should *progressively* move towards the recognition of health benefits *equal* to those of country nationals.[63] The CCC made clear that the rule of progressive realisation of socio-economic rights does not allow the state to excessively postpone the adoption of measures that extend such health care beyond urgent treatment.[64] Among the measures taken to implement this judgment, the government passed a decree on 25 July 2018 clarifying that 'urgent treatment' should be provided to everyone, including non-affiliated nationals and irregular non-nationals.[65]

Regarding access to antiretroviral drugs and HIV-related continuous care, judgment T-348/2018 embraced a minimalist take on urgent health needs and, thus, constituted a setback vis-à-vis the findings of T-210/18. While the CCC did recognise that the concept of urgency could exceed life-saving treatment – in exceptional cases and where a medical doctor qualified the treatment as urgently needed to preserve life and

health – being HIV-positive at stage 1 was not identified as a severe health condition worthy of care in the case of non-regularised migrants.[66] Case T-025/2019 soon reversed this approach because the ruling on the case stated that AIDS and cancer should be considered 'catastrophic diseases' to be treated with urgency from the first stages and that such treatment should include the prescription or provision of essential drugs to avoid health status deterioration, which would be incompatible with life in dignity.[67] The CCC also asserted that the concept of urgent care includes the adoption of collective public health-based interventions such as vaccinations campaigns and treatment of contagious diseases to prevent and protect the health of both the migrant and the national community.[68]

In judgment T-074/2019, the CCC restated that pregnant women should receive all necessary care and check-ups as such measures aim to preserve the life in dignity of the mother and the new-born. It ruled that full health services be provided to new-borns because of their special vulnerability to ill health.[69] Several obiter dicta also highlighted the barriers to migrant status regularisation and the state *duty* to seek international cooperation to manage the humanitarian emergency of people fleeing Venezuela.[70]

Judgment T-178/2019 concerned the case of a migrant *infant* who was denied affiliation with the subsidised health system because of her parents' irregular migration status. The Court, recalling authoritative international jurisprudence and interpreting domestic norms in the light of constitutional provisions inspired by the principles of the inherent vulnerability and the best interest of the child, held that state authorities could not raise such an objection and that *all necessary care* for the full development of the child must be accessible.[71] Furthermore, noting the lack of understanding among the defendants (public authorities and private bodies) regarding the procedures to guarantee the constitutional right to health of migrant children, the CCC ordered the competent ministries to disseminate operational guidelines to the territorial entities.[72]

The cases T-197/19 and T-403/19 further confirmed that degenerative or 'catastrophic' diseases, such as cancer, met an urgent care threshold, which included immediate provision of *specialised* care to people, such as the applicants, who decided to move to Colombia precisely to receive the necessary health care that the collapsing Venezuelan health system was unable to provide, regardless of migration status.[73] Judgment T-197/19 restated maxims adopted by the CCC in similar cases and held that

the applicant's health conditions and his (irregular) migratory status were factors that could cause unbearable and irreparable harm to his life (in dignity) and integrity.[74] With judgment T-403/19, the Court found a violation of the right to health and ordered redress in a case concerning a person – the applicant had actually managed to regularise her status but was not yet affiliated with the health system – who was prevented from accessing required health care because of a lack of coordination among health care providers in offering specialised oncological care.[75]

Judgment T-452/19 resolved four cases concerning, respectively, access to treatment for a lupus rash by an irregular migrant woman, access to necessary care for a series of chronic diseases by an elderly woman, access to mental health care for a migrant woman whose son had disappeared and access to a CAT test for cancer detection by an irregular migrant child. In the latter case, considering the precedents on the urgent nature of preventive and curative cancer care and the rights of the child, the Court restated that health authorities should provide the necessary care. All the other applications were rejected because they were deemed to require types of health care that exceeded the concept of urgency.[76] While the Court extensively recalled rights-based maxims on this subject matter,[77] procedural issues and deference to state sovereignty in migrant-related policies affected the outcomes on the merits of the first two cases to the extent that the Court did not even examine the severity of the mid- and long-term consequences of lupus rash or the special vulnerability of elderly people to risks to their health and life. Concerning the third case, the Court considered that psychiatric care beyond urgent once-off stabilising interventions was not included in the package of urgent care accessible to irregular migrants.

In 2020, the CCC produced some particularly interesting pieces of case law. Judgment T-246/20 developed the Court's HIV/AIDS-related jurisprudence by adding significant public health and budget-related considerations. In particular, the denial of antiretroviral drugs to HIV-positive irregular migrants was deemed to constitute a violation of the individual right to urgent care to preserve life and health and the collective right to prevent the transmission of a virus in the interest of migrant and hosting communities and especially vulnerable people in the society.[78] With T-275/20, the Court clarified, with reference to numerous precedents and international and InterAmerican binding and soft law instruments,[79] that migrant children have a reinforced right to health,

which is interdependent with their harmonic development. Their vulnerability, particularly that of children with severe medical needs, justifies access to comprehensive care, which *includes* state authorities' duties to fund transportation to and accommodation near specialised health care facilities for the children and their carers.[80] Finally, in T-436/20, the CCC once again adjudicated on a case involving the urgent heath needs of a child, as well as the rejected claims for regularisation of other family members. The Court rested its jurisprudence on the right of the child, adding a few obiter dicta on the social matrix of the right to health, and ordered migration authorities to consider how migrant regularisation of the family could be achieved in that particular case, vis-à-vis the existence of formal criteria that applicants could not meet.[81]

4. Discussion: an exploration of UN human rights standards and InterAmerican law as normative sources for the CCC and beyond

Recent observations of international human rights monitoring on Colombia have attracted both praises and concerns in relation to rights implementation for Venezuelan migrants. A number of right-based policies relating to border management and the recent decision to grant Colombian nationality to the children of Venezuelan migrants who are born in the Colombian territory were praised.[82] However, the rise in xenophobic discourse against Venezuelan migrants[83] and the obstacles this group faces in gaining access to documentation and health care, in particular sexual and reproductive care, were issues of concern.[84] This section thematically recalls authoritative human rights obligations and soft law material relating to the matter at hand, against which it examines the findings of the CCC for which these are either binding or authoritative sources of law.[85]

4.1. Core and progressive international obligations regarding levels of accessible health care[86]

Discussing health as a human right raises ongoing theoretical disagreements on the nature of state obligations arising out of socio-economic rights and their operationalisation as intimately related to sensitive issues of public resource allocation and national decisions on social policy.[87] While cognizant of this, the CCC accords great normative weight to Article 12 of the 1966 International Covenant on Economic Social and Cultural Rights (ICESCR). Ratifying states to the ICESCR undertake to protect, respect and fulfil

international duties to realise the right to the 'highest attainable standard of physical and mental health', through health care and socio-economic measures that target the determinants of health and by seeking international aid and cooperation. Health services, goods and facilities should be available, accessible, acceptable and of good quality,[88] within the limit of the maximum available resources.[89]

While this treaty obligations are generally of progressive nature, the ICESCR also sets out some obligations endowed with immediate normative force. Article 2 urges states to taking immediate steps to move towards the full realisation of socio-economic rights and shaping existing laws and policies regarding socio-economic rights in a non-discriminatory way. To prevent indefinite delay in the realisation of progressive state duties, several scholars and domestic courts have, since the 1980s, elaborated a 'minimum core approach', which was eventually embraced by the Committee on Economic, Social and Cultural Rights (CESCR) – the monitoring body of the ICESCR – in the 1990s.[90] The CESCR indicated that among their core obligations specified in the ICESCR, states, under the compelling guidance of the Declaration of Alma Ata, must ensure essential primary health care, along with essential drugs, food and shelter, for everyone in their jurisdiction.[91] This authoritative public health declaration, embraced by the World Health Organization and recently recast with the Declaration of Astana, defines primary health care as a *strategy* for eliminating health inequity and realising the right to health by prioritising primary and preventive care as well as other *social* determinants of health.[92] In terms of the *level* of health care, *primary* and *preventive care* – which should be prioritised in the realisation of the right to health – includes addressing, at the local level, the main health problems in the community, including the treatment of common diseases, the provision of essential drugs and vaccinations against major infectious diseases.[93] In line with the vulnerability-oriented approach of human rights law, the CESCR specified that 'access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups', and the provision of essential drugs are core obligations regarding the right to health under the Covenant[94] and that irregular migrants are a particularly vulnerable group.[95]

The Convention on Migrant Workers (CMW), which is widely ratified in South America unlike other regions of the world, is also an applicable standard of reference in Colombia.[96] This treaty stipulates that irregular migrants 'have the right to receive any

medical care that is *urgently* required for the preservation of their life or the avoidance of irreparable harm to their health'.[97] This approach is also embraced by the Human Rights Committee (HRCtee), which is the quasi-judicial monitoring body of the International Covenant on Civil and Political Rights (ICCPR).[98] The HRCtee's *Toussaint* case, adjudicating on the right to life (in dignity) as per Article 6 ICCPR, established that states have a positive obligation to provide irregular migrants with health services that avoid serious threats to life and health and that limiting these services to emergency life-saving treatment is a disproportionate limitation of the right to life in dignity.[99] These legal standards supplement broader obligations under the ICESCR. Indeed, the 'urgent treatment approach' adopted by HRCtee is based on the interpretation of the right to life in dignity and not technically on the right to health. Furthermore, it is worth noting that the Committee of Migrant Workers has attempted to bridge the distance between the CMW and other human rights treaties by establishing that the CMW's provisions must be read in the light of those of the ICESCR which encompasses 'primary health care'.[100] Unfortunately, this *contextual* interpretation, which should be particularly persuasive whereas, like in Colombia, general comments are granted normative value, is 'hidden' behind an unequivocal treaty *text*. Equalised health and social care with country nationals are reserved for regular migrant workers, as per Article 43 CMW.

4.1.1. The scope of the international corpus juris v. the constitutional jurisprudence

As far as immediate obligations are concerned, Colombian constitutional case law is generally aligned with Article 28 CMW and the position of the HRCtee, according to which urgent care should be provided to everyone, regardless of their migration status. However, compliance with the obligations under the ICESCR – as interpreted by the CESCR – is only partially endorsed. The CCC correctly identified that the right to the highest attainable standard of health is to be realised progressively and that states are not asked to immediately provide an equalised level of health and social care to nationals and regular and irregular migrant adults under IHRL.[101] However, the application of the principle of non-discrimination in relation to elements of the right to health that are available and accessible for the entire registered population (Article 2.2 ICESCR), the rule of rights limitation (Article 4 ICESCR) and the core obligations established by the CESCR would require broader effective access to primary care and preventive treatment

for (Venezuelan) irregular migrants who are explicitly qualified as especially vulnerable people by both national and international institutions.[102]

Most cases before the CCC demonstrate that the main obstacles to accessing necessary care generally emerge after a referral to a specialist by a general practitioner at the health unit level. Therefore, it seems that irregular migrants *de facto* and in principle enjoy essential primary care check-ups but that access to essential drugs and necessary treatment is restricted, unless prescribed for a life-threatening degenerative disease such as cancer or HIV/AIDS. It is worth noting that the CCC employs the wording 'primary' and 'basic' medical care to refer to something different from primary care as an element of the right to health in IHRL: basic or primary needs, for the CCC, are often synonymous with urgent care, and primary care means free check-ups to spot cases requiring urgent care.[103] The constitutional case law refers to the fact that some regional health units, supported by development organisations, are reported to have taken certain primary care measures,[104] although it does not clarify whether these actions correspond to any legal obligation or are simply regarded by the Court as good practice.

The core obligations of the CESCR establish that guaranteeing access to essential drugs and essential primary health care on a non-discriminatory basis − which is not limitable for vulnerable people in IHRL − requires a different course of action.[105] Even by seeking international aid and cooperation, states still have the duty to realise core obligations, particularly to benefit vulnerable people.[106] Migrants' access to check-ups and treatment for common diseases (which do not require specialised care) at the local level should not be subject to the rule of 'progressive realisation' as these services are – albeit imperfectly – operationalised and universally accessible in the health system for the mainstream insured population in Colombia.

Regarding preventive care, in line with a 2017 Circular of the Minister of Health, the CCC (and the government) held that the right to urgent health care for irregular migrants includes access to *collective public health measures* with preventive focus (e.g. vaccinations against major infectious diseases).[107] Colombia and other Latin American countries have been excessively responsive in this regard, to the extent that some migrants moving across countries have received the same vaccine several times.[108] As recalled by NGOs and several human rights bodies,[109] the provision of primary and preventive care is beneficial both financially and from a public health perspective as it prevents many

health conditions from deteriorating and jeopardising the life and health of others and, thus, reduces urgent health care costs.[110] Restricting the right to health to life-saving or urgent treatment in the case of irregular migrants is not enough for the implementation of international law, as the CCC is starting to recognise.[111] It would not be justifiable under Article 4 ICESCR – according to which rights limitations should be, *inter alia*, 'compatible with the *nature* of these rights and solely for the purpose of *promoting the general welfare* in a democratic society', which includes public health considerations – or under the normative frameworks developed by the CESCR.[112] Public health arguments were key to the outcome of T-246/20, one of the CCC's most recent cases. Granting universal access to antiretroviral drugs that reduce transmission of HIV was not only required for individual urgent health needs but was, for the Court, a necessary measure to comply with the collective right to health of migrant and national communities.[113] Considering that the decision was taken during the first wave of the Covid-19 pandemic in Colombia, this preventive approach appeared particularly promising in terms of access to Covid-19 vaccines for irregular migrants. However, to date, the government has indicated that migrants should pursue status regularisation to be included in the country's vaccination plan against Covid-19.

As far as the non-discrimination test is concerned, the CCC does acknowledge that, in line with IHRL, limitations or differentiation on the grounds of nationality or legal status are permissible only when they pursue a legitimate aim and have a proportionate impact on the rights of targeted people or groups. Other factors to be considered in this 'permissible limitation test' are the type of right at stake (i.e., whether it is fundamental or not) and – significantly for this analysis – the potential violation of international human rights norms.[114] In accordance with a non-selective appreciation of the right to health priorities, not only emergency and urgent care but also essential primary and preventive care should be made accessible to all vulnerable people, while progressively targeting and realising a fully equitable health system with universal coverage in line with the Agenda for Sustainable Development.[115]

4.2. The InterAmerican human rights system and its potential to enhance health standards for irregular migrants

The CCC has not extensively resorted to AHRL as a primary source of law in the case law at hand. The Court preferred to employ IHRL (again, with this I mean UN human rights standards) to depict the normative contours of fundamental rights and referenced AHRL in only three cases concerning maternal and child health.[116] Three other mentions were made to Article 1 American Convention on Human Rights (ACHR) to restate that (irregular) migrants are human rights holders.[117] Nonetheless, regional standards and case law are worthy of analysis because they reinforce IHRL-based arguments and contribute to the development of a consistent human rights law composed of 'living instruments, the interpretation of which must evolve with the times and current living conditions'.[118]

Until recently, the jurisdictional bodies of this regional system only indirectly adjudicated on socio-economic interests via the fully justiciable civil rights in the ACHR. Article 10 of the Protocol of San Salvador to the ACHR establishes that States Parties agree to ensure the realisation of the right to health in primary health care-, poverty- and vulnerability-oriented ways, which is not directly justiciable.[119] Against this framework, recent jurisprudence has begun to declare socio-economic rights directly justiciable via Article 26 ACHR,[120] which led to a technical and detailed assessment of potential violations of socio-economic treaty rights.[121] *Poblete Vilches* was the first judgment of the InterAmerican Court to extend this new approach specifically to the right to health. In this case, which concerned an elderly person who had received negligent medical care in Chile and eventually died, the IACtHR stated that the ACHR (particularly, Article 29 which embodies the pro persona approach) could not be interpreted in any way that limits the right to health set out in the Organization of American States Charter, the American Declaration, IHRL and national constitutions.[122] The international *corpus juris* on the right to health, including the jurisprudence of the CESCR, was extensively referenced as a normative standard to establish state obligations of social nature under Article 26 ACHR.[123] The Court also held that states have an obligation, which is reinforced towards people who are particularly vulnerable, including the elderly, to take positive measures to guarantee 'access to medical health services on an equal footing' with others.[124] In subsequent cases, the IACtHR confirmed that 'when complying with the obligation to respect and ensure the right to health, [states] must pay special attention to vulnerable and

marginalized groups', including people living with tuberculosis[125] or HIV,[126] those in poverty,[127] as well as children and pregnant and post-partum women.[128] The Court – referring to the AAAQ framework of the CESCR – clarified the 'general obligation to protect health results in the duty of the State to ensure that everyone has access to essential health services, guaranteeing the quality and efficiency of medical services, and to facilitate the improvement of the health of the *whole population'*, [129] with a wording that echoed the primary health care approach to public health and human rights.

Within this InterAmerican framework, the area of migrant rights has been developed significantly over the last 20 years and has greatly benefitted from the pro persona approach of the IACtHR.[130] For instance, the Court's Advisory Opinion (AO) on the rights of undocumented migrant workers acknowledged their 'individual situation of absence or difference of power with regard to non-migrants' and their particular vulnerability to various forms of discrimination and right violations in receiving states.[131] Non-discrimination in the enjoyment of human rights was considered a *jus cogens* norm and its scope extended to differentiations on the grounds of migratory legal status.[132] Passages of this AO relating to combined vulnerabilities based on irregular status, poverty, gender and age have been reproduced in binding judgments of the Court (e.g. *Velez Loor, Pacheco Tineo, Expelled Dominicans and Haitians*) to reassert negative and positive state duties in rights implementation.[133] In line with the evolutive and pro persona principles of the ACHR, the IACtHR reinforced the interpretation of the scope of the rights of the Convention via an updated and contextual interpretation of IHRL.[134] If these remarks are considered alongside the fact that the conventionality control doctrine prohibits domestic courts from contradicting the findings of the IACtHR, the InterAmerican corpus juris has huge potential in shaping the CCC (and other regional courts) findings in a way would benefit Venezuelan migrants with precarious or irregular status.

In the light of the above cases, for example, some of the outcomes of T-452/2019, such as the denial of the right to medical care to an elderly woman from a disadvantaged background with a series of chronic health conditions, would hardly comply with AHRL or key human rights treaties like CEDAW.[135] In this case, the CCC – without attaching any normative value to the financial, age- and migration-related vulnerabilities of the applicant – supported the health authorities' refusal because the case did not technically

require once-off 'urgent' care.[136] Further findings of the IACtHR may prove particularly useful for Venezuelan irregular migrants with HIV/AIDS, whose numbers have been increasing due to the lack of antiretroviral treatment in Venezuela.[137] Both the IACtHR and CCC consider that access to essential drugs, including antiretroviral drugs, cannot be restricted or suspended as studies show that this might affect life and health irreparably.[138] This good practice is also crystallised in a core obligation under the ICESCR, which is a normative standard that can be considered in the light of the pro persona approach of the IACtHR.[139] Finally, while the InterAmerican Court prescribes that especially vulnerable people should have access to diagnostic tests and treatment for complications and social and psychosocial support,[140] the current CCC approach falls short of including social care and psychological services within the scope of a justiciable right to health of irregular migrants.[141]

4.3. Migrant children and new-borns' special position

The Convention on the Rights of the Child (CRC) is the most ratified UN human rights treaty and was integrated into the child-related InterAmerican jurisprudence via a contextual or systematic interpretation of international law.[142] Article 24 of the 1989 CRC, unlike Article 12 ICESCR, explicitly requires states 'to ensure the provision of *necessary* medical assistance and health care to *all* children with emphasis on the development of primary health care'.[143] The CRC Committee clarified that state core obligations under the treaty include – substantively – 'ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs' and – procedurally – periodic reviewing and monitoring of domestic law and policies regarding the health of children.[144]

The principle of the *best interest of the child* and the physical, mental, moral, spiritual, and social dimensions of their *development* impelled the CRC and CMW Committees to state that 'every migrant child should have access to health care *equal* to that of nationals, regardless of their [or their parents'] migration status'.[145] For IHRL, qualification as a child outweighs migration status and should prevent administrative barriers linked to affiliation with the health system from resulting in a denial of necessary health care. This was precisely the factual and juridical problem of the CCC's cases S.U. 677/17 and T-178/2019. Constitutional, statutory and international rights guided the CCC

to hold that the right to health of new-born children must prevail over other individual and public interests to the extent that temporary affiliation with the health system and full health coverage must be granted.[146] Regarding problems related to the effectiveness of this *ex officio* registration rule, it is worth noting in August 2019, the Congress decided to provisionally grant Colombian nationality to children born in Colombia (between 2015 and 2021) whose parents are Venezuelan migrants, thus reducing the barriers to the effective enjoyment of universal health benefits.[147]

Three other recent CCC judgments concerning children's access to health care restated the *urgent care approach* to migrant health with the same arguments employed for adults.[148] While these cases concerned urgent health needs, it is important to note that, under both UN and Inter-American standards, migrant children – even those older than 1 year – should enjoy the most comprehensive health care available on an equal basis with nationals, which exceeds urgent care, and that their special protection should outweigh migration policy considerations.[149] A partial departure from this approach can be found in T-275/20, which, with reference to several international and InterAmerican standards, relies heavily on the concept of comprehensive care for migrant children as a determinant of their harmonic development.[150]

4.4. Reduced access to reproductive health care as discrimination against women

Human rights law prohibits discrimination among people in comparable situations regarding their enjoyment of human rights on a series of enumerated and unenumerated bases. Non-discrimination on the grounds of sex/gender has occupied a special position in human rights practice for decades: women-specific treaties have established binding rules for state parties,[151] and specific provisions are embedded within general human rights treaties.[152] Among the latter, the ICESCR, in Articles 3 and 2(2), compels states to address inequalities between men and women in the enjoyment of all treaty rights.[153] Regarding reproductive health, the CESCR has built on the targets of the authoritative programme of action of the International Conference on Population and Development and on arguments previously elaborated within the CEDAW system.[154] Accordingly, core obligations under Article 12 ICESCR include 'to *repeal* laws or policies that obstruct access to reproductive health goods and services' and 'to *guarantee universal and equitable access* to affordable, acceptable and quality sexual and reproductive health

services, goods and facilities, in particular for women and *disadvantaged and marginalized groups'*.[155] Prohibition of gender-based discrimination and implementation of measures favouring substantive equality require 'that laws, policies and practices do not maintain, but rather alleviate, the inherent disadvantage that women experience in exercising their right to (sexual and reproductive) health'.[156] The CESCR is explicit in recommending the adoption of 'particular steps to ensure [that irregular migrant women who are particularly vulnerable have] access to sexual and reproductive information, goods and health care'.[157] These steps must consider structural discrimination and stereotypes against women,[158] multidimensional and intersectional discrimination,[159] and the fact that sensitive 'grounds of gender-related discrimination' include 'sex; pregnancy and child bearing; maternity; marital status; family status; … household duties'.[160]

Most of the CCC's judgments concerning maternal health contain arguments based on the compounded vulnerability of irregular status, gender and poverty to extend free prenatal check-ups and urgent care to all (pregnant) migrant women to avoid irreparable harm to their life and health.[161] What is missing from this picture is a more explicit gender-based approach to comprehensive reproductive health care outside the case of pregnancy and gender-stereotyping roles.[162] A health care system that lacks services to prevent, detect and treat health-related conditions specific to women or unduly restrict their access because of their irregular migration status fails to take discrimination against women seriously.[163] Such structural discriminatory practices against women's bodily autonomy – including restricted access to sexual and reproductive health services – may constitute obstetrical violence (a form of gender-based violence).[164]

While, the CCC has declared that intersections of certain personal or social factors (poverty, pregnancy and migration status) with gender/sex give rise to phenomena of multidimensional discrimination, this argument has not been developed further to establish protective arguments and enhanced health care standards for cases such as those of older women or women/mothers with mental health issues outside of urgent care.[165] State parties to the CEDAW, in particular, 'must legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them', including where such women are irregular migrants.[166]

4.5. Barriers to the effective exercise of rights

It is a well-established maxim of international (and domestic) law that states have broad sovereign powers to regulate the entry and stay of non-nationals and that migrants have a duty to comply with domestic immigration law.[167] However, this does not mean that the rights of migrants and the social policies concerning them can be unlimitedly and unreasonably restricted. International human rights law, as interpreted by judicial and quasi-judicial treaty bodies, have progressively established greater constraints on this sovereign power, at least in theory.[168] In practice, irregular migrants do not enjoy social rights on an equal or comparable basis with nationals or regular migrants.[169] Colombia is no exception, even though the humanitarian management of migration has led the government to engage with hundreds of international and independent actors to provide essential goods and services.[170]

In the constitutional judgments under assessment, I counted 146 references to the obligations of state, private and public health regulators and providers to respect everyone's human rights regardless of migration status and 91 statements on the abstract and concrete duties of migrants to regularise their position in order to gain affiliation with the health system. The balance between the two arguments varies from judgment to judgment, but the latter is particularly prevalent in the most restrictive decisions. The CCC's jurisprudence has fluctuated between victim-blaming statements on the duty of migrants to regularise their migratory position – which is de facto impossible for many of those who had already fallen into irregularity – in order to access state-funded necessary health care benefits, including essential medicines,[171] and dicta regarding the several administrative obstacles to accessing urgent care and excessively burdensome conditions for status regularisation as a prerequisite for accessing comprehensive health care.[172]

While international law does not establish any obligation to regularise the status of people on the move who do not meet the criteria for international protection, IHRL has recommended such regularisation schemes as they would lift the main source of migrant vulnerability to rights violation.[173] Prior to 2021, Colombia had introduced visas and Venezuelan-targeted temporary residence schemes that entitled their holders to social and health services. However, the apparently neutral eligibility criteria for registering with the subsidised health system and accessing comprehensive care left room for indirect

discriminatory phenomena. The condition of having identification documents, a passport, a visa or a residence permit are disproportionally difficult for irregular migrants arriving from Venezuela vis-à-vis other non-affiliated people. Indeed, regularisation criteria remained narrow for poor or unskilled migrants, and calls for transitioning from irregular to regular status did not normally apply to people who had *entered* the territory irregularly.[174] One of the most recent judgments of the CCC explicitly pointed to insurmountable barriers to inclusion by ordering the government's migratory agency to find a feasible regularisation solution for a woman and her family members who had sufficiently demonstrated their inability to have or obtain the necessary identification documents to regularise their migrant status and thus to gain access to social services and the labour market.[175] This decision is an example of a case-based solution to an as yet unresolved systemic problem. Indeed, the InterAmerican Commission on Human Rights had already acknowledged in 2018 that Venezuelan migrants were in a situation of extreme social vulnerability and that a lack of documentation, which was not unusual, prevented regularisation and access to services in destination countries.[176]

The CCC has noted that on the ground, the precarious situation of irregular migrants vis-à-vis health authorities is made worse by a certain disregard for constitutional judgments, a lack of coordination between competent agencies and a failure to provide adequate information to vulnerable migrant populations.[177] The analysis of the complaints and the nature of the defendants in these cases sheds light on the complexity of the highly privatised Colombian health system and the difficulty experienced by migrants in navigating it and accessing care without resorting to tutela actions. Issues regarding access to health care can easily become rights accountability challenges in a mixed health system.[178] In the case at hand, whereas regional health departments and the state are financially responsible for the provision of urgent care to non-affiliated migrant populations, the services must be concretely offered and provided by private and public health insurers and centres with different levels of specialisation[179] to avoid interfering with the right to health.[180]

A lack of awareness of health rights, procedures and obligations among both service users and providers is another significant barrier to rights enjoyment in general and migrants' enjoyment of the right to health in particular. The analysed case law demonstrates that the scope of the right to urgent care is not always made clear to health

operators and that migrant populations are not often aware of the procedures required to regularise their status and gain affiliation with the health system.[181] Such awareness and information failings are confirmed by the fact that, according to government sources, only 40% of *regular* migrants are affiliated with the social security system.[182]

Because of the barriers to accessing health care highlighted in this article, the majority of people on the move have resorted to support offered by the many national and international organisations in the field, either affiliated with the Interagency Group for Mixed Migration Flows (GIFMM) or independent.[183] While the duties of protection and fulfilment of human rights ultimately rest with the state, seeking international aid and cooperation and liaising with charitable initiatives to realise the core social rights of people of the move – via the provision of essential drugs, primary care, psychosocial support, food and water – is a strategy that complies with IHRL.[184] However, as the case law of the CCC appears to confirm, actions that realise the right to health of irregular migrants beyond urgent care remain beyond the justiciable realm.[185]

Within this challenging context, the year 2021 began with the adoption of an internationally praised general regularisation scheme, which was considered necessary to grapple with the multidimensional vulnerabilities of irregular migrants to human rights violations in a non-stop immigration scenario.[186] However, only those irregular migrants who were in Colombia at the end of January 2021 are eligible for this process, which cast doubts about grey areas, like new 'clandestine' entries during extended times of border closure (as a pandemic containment measure). While the general approach to irregular migrants' health continues to be restricted to urgent care, if the almost 1 million eligible undocumented people manage to regularise their status, they will be able to work regularly, register with the social security system and have access to the same comprehensive health and social care available to Colombian nationals, including Covid-19 vaccines.

5. Conclusions

At a crucial time, when the number of irregular migrants in Colombia is set to reduce considerably as a result of a massive status regularisation, this examination of the Colombian constitutional jurisprudence demonstrates instances of both compliance and non-compliance with IHRL and AHRL, which all states should attentively consider when shaping their health responses to irregular migration. This paper goes beyond an analysis

of domestic jurisprudence and practice to clarify the current and prospective contours of international human rights instruments on the right to health care of irregular migrants. It is notable that the CCC has generally been keener to develop protective equity-oriented arguments in judgments where human rights law (including soft law material) and the meta-legal concept of vulnerability have been salient. This trend is particularly visible in early judgments, while recent decisions have generally reflected this consolidated constitutional trend based on international human rights frameworks.

Table 2. Vulnerability and human rights law in the CCC judgments on Venezuelan migrant right to health

Case No.	Number of references to the vulnerability of the applicant(s)	Number of references to HRL
T-239/17	0 - on the merits 2 - to meet admissibility criteria	6 (1 to the CESCR's GC14 in a dissenting opinion)
SU677/17	29 - on the compounded vulnerability based on age, gender, pregnancy, migration status and poverty (including concurring/dissenting opinions)	25 - Including to CEDAW, CRC, ICESCR, ACHR, ACRC, CBdP
T-705/17	3 - on the grounds of age and severe health condition	1
T-210/18	15 - compounded forms of vulnerability based on age, sex, motherhood, irregular migration status and poverty	40 - including extensive quotations of soft law material of the UN human rights system
T-348/18	1 – migrant vulnerability	0
T-025/19	5 – on the grounds of irregular migration status, health condition and poverty	3
T-074/19	4 – on the grounds of age, migrant status and poor financial conditions	14
T-178/19	7 – on the grounds of young age and migrant status	7
T-197/19	9 – on the grounds of the severity of the disease and migrant status	8
T-403/19	3 – on the grounds of the severity of the disease and migrant status	2
T-452/19	10 – on the grounds of migration status	13
T-246/20	1 – in consideration of the administrative barriers	4
T-275/20	2 – on the grounds of young age and migrant status	9
T-436/20	5 – socioeconomic and legal vulnerability of irregular migrants	10

The only exception to the above is the judgment in T-452/19, which is also one of the only two judgments which refers to the principle of 'state sovereignty' as a justification

to limit migrant rights. While it refers to many international frameworks, it eventually reached a particularly constrained outcome in terms of migrant rights. It is hoped it does not represent the beginning of a rhetorical but in practice restrictive approach now that migrant vulnerability is heightened by exposure and response measures to Covid-19 which exacerbate pre-existing inequalities. As a rule, IHRL and AHRL are deemed to support the interpretation of the constitutional right to health (and other rights such as social security, vital minimum, life, integrity, and equality) to include access to urgent care for poor, irregular migrants to prevent irreparable harm to life and health, as supplemented with preventive actions of a collective nature, full health treatment for HIV/AIDS and cancer, free check-ups for pregnant women and primary care for children under the age of 1.

The CCC has correctly interpreted international obligations as including the duty to *progressively* move towards the *equalisation* of health care for all migrants and nationals, as well as resorting to international cooperation.[187] What is missing here, regarding international and regional standards implementation, is a reference to *primary care* (including the treatment of common diseases at the local level and provision/prescription of essential drugs) − as an essential component of the primary health care approach to public health and a core obligation regarding the non-discriminatory implementation of the right to health care[188] which, according to statistics, is what Venezuelan migrants appear to need most.[189] As a procedural remark, refusals of primary care and cure of common diseases (in primary care settings) would likely not meet the admissibility criteria of the CCC's tutela proceedings, which are designed for 'irreparable' violation of human rights.

On the one hand, this paper demonstrates that combining considerations of the key role played by preventive measures and primary health care within public health and human rights with a recognition of the situational vulnerability of irregular migrants should carry significant weight in domestic and international discrimination tests regarding the enjoyment of essential services by irregular migrants. On the other hand, the inherent vulnerability and development needs of children and the adoption of measures that target gender-based discrimination are stronger human rights-based argument than migrant vulnerability to extend the coverage of health care benefits for irregular migrant children and women, respectively. These are areas where human rights

law would require a different course of action: Indeed, while IHRL (most notably, the CRC) requires states to provide all necessary health care to all children, the CCC has continued, except in one case, to rely on the concept of urgency of treatment to order public authorities to grant health services to children, unless they are under 1 year of age. Regarding migrant women, the CCC has extended health care protection to essential maternal care (including prenatal check-ups and delivery assistance), while gender equality in the field of health – as developed by IHRL – would require access to comprehensive women's health care on an equal basis with nationals.

On a structural and methodological level, the CCC, while widely referring to international human rights standards and jurisprudence, has sometimes made use of their provisions in a selective way, striving to reach a balance between openness to universal values and conservative sovereignty-oriented decisions. By contrast, this article underlines an important level of consistency between international and InterAmerican instruments on the need to address essential health needs or capabilities of vulnerable people such as irregular migrants. A pro-persona, evolutive, and contextual treaty interpretation, combined with the doctrine of InterAmerican conventionality control and the constitutional consideration of UN human rights standards as a source of law, may guide the exportation of a legal model capable of improve health equity and address structural discrimination against irregular migrants.

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[26] Ibid., 15–17. A new PEP scheme was launched on 9 October 2020, https://www.migracioncolombia.gov.co/noticias/migracion-colombia-lanza-nuevo-permiso-especial-de-permanencia-para-venezolanos. The Minister of Interior Affairs' Decree no. 402, 13 March 2020, dictated that the border between Colombia and Venezuela be closed as a containment measure to reduce the spread of Covid-19. To date (13 October 2020). To date (June 2021), this measure has been periodically renewed.
[27] DeJusticia, 'Intervención ciudadana en el proceso T-7.210.348 AC', 16 August 2019, p.17. This was a third-party submission before the CCC in the case was resolved with judgment T-452/2019 (infra note 70).
[28] R4V/GIFMM, 'Country Situation: Colombia', https://r4v.info/es/situations/platform/location/7511.
[29] Political Constitution of Colombia [Const.] (1991), Articles 1, 114, 150, 298, 300.
[30] Ibid., Article 132, 135, 287.
[31] Ibid., Article 93; CCC, Judgment C-750 of 24 July 2008.
[32] CCC, Judgments C-067 of 4 February 2003.
[33] InterAmerican Court of Human Rights (IACtHR), *Almonacid Arellano et al. v Chile*, 26 September 2006, Series C No. 154, § 123–124; Auto Arcenio Velandia Sánchez, *Bloque de Constitucionalidad y Control de Convencionalidad en Colombia* (independently published, 2019).
[34] Juan Sebastián Villamil Rodriguez, 'The Internationalization of Judicial Review in the Colombian High Courts', *Constitutional Review* 5, no. 1 (2009).
[35] Const. (note 29), Articles 86, 241(9); Liliana Carrera Silva, 'La acción de tutela en Colombia', *JUS – Revista del Institutio de Ciencias Juridicas de Puebla* 27 (2011) 72–94.
[36] Roberto Gargarella, *Latin American Constitutionalism: 1810-2010* (Oxford: OUP, 2013); Helena Alviar García, 'Distribution of Resources led by Courts' in *Social and Economic Rights in Theory and Practice. Critical Inquiries*, eds Helena Alviar García, Karl Klare, Lucy A. Williams (Abingdon: Routledge 2015) 67.
[37] Const. (note 29), Article 13.
[38] CCC Judgments T-458 of 24 September 1997.
[39] Const. (note 29), Articles 48 and 49. The original regulation is contained in Act no. 100 of 1993 ('Diario Oficial' no 41148, 23 December 1993).
[40] Health Act (Ley Estatutaria en Salud) no. 1751, 16 February 2015.
[41] Aquiles Arrieta-Gómez, 'Realizing the Fundamental Right to Health through Litigation: The Colombian Case', *Health and Human Rights Journal* 20 (2018) 133; Everaldo Lamprea and Johnattan García, 'Closing the Gap Between Formal and Material Health Care Coverage in Colombia' *Health and Human Rights Journal* 18 (2016) 45.
[42] David Landau, 'The Promise of a Minimum Core Approach: The Colombian Model for Judicial Review of Austerity Measures' in *Economic and Social Rights after the Global Financial Crisis,* ed Aoife Nolan (Cambridge: CUP, 2014) 270, 277, 288.
[43] Alicia Ely Yamin and Oscar Parra-Vera, 'Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates' (2010) 33 *Hastings International and Comparative Law Review* 432. Emphasis added.
[44] Arrieta-Gómez (note 41) 139.
[45] Regulatory Commission on Health, Agreement no. 32/ 2012, 17 May 2012.
[46] Health Act (note 40), Articles 1 and 6.
[47] Lamprea and García (note 41), 49.
[48] Alviar García (note 36) 67, 87–94.
[49] Health Act (note 40), Articles 2 and 9. Emphasis added.
[50] Ibid., Article 6; CESCR (note 12) par. 12.
[51] CCC, Judgment T-025 of 29 January 2019, par. v.
[52] e.g., Health Act (note 40), Articles 10 and 14.
[53] CCC, Judgment T-239 of 24 April 2017, par. 54, 55, referring to article 13 and 100 Constitution.
[54] Ibid., par. 70.
[55] Ibid., par. 100.
[56] CCC, Judgment SU 677 of 15 November 2017, par. 56, 57. The concept of 'basic' care, which was not developed by the CCC on this occasion, can be reconstructed via reference to Article 165 of Act 100 de 1993 'atencion basica en salud' and includes the provision of health-related information, with an emphasis on campaigns of health promotion and preventive care against transmissible diseases.
[57] CCC Judgment T-705 of 30 November 2017, par. 3.2, 3.5.
[58] Ibid., par. 5.10–11.

[59] Ibid., par. 6.
[60] Act no. 100/1993 (note 39), Article 168, Act 715 of 2001, (*Diario Oficial* no 44654, 21 December 2001), Article 67 and CCC, T-239/2017 (note 53) speak of *atención inicial de urgencia* (Spanish for initial urgent care).
[61] CCC Judgment T-210 of 1 June 2018, par. 34 elaborates on *atención de urgencia* (Spanish for urgent care).
[62] Ibid., paras 36 and 54.
[63] Ibid., Section III, par. 17, 18, 21, 40, 43, 47.
[64] Ibid., par. 45.
[65] Administrative Decree of the Presidency of the Republic no. 1288 of 25 July 2018.
[66] CCC, Judgment T-348 of 28 August 2018, par. 4.5.3, 4.5.4, 4.6.
[67] CCC (note 51), par. iii) and v). Emphasis added.
[68] Ibid., par. iii).
[69] CCC, Judgment T-074 of 25 February 2019, par. 8.
[70] Ibid., par. 5, 6.
[71] CCC, Judgment T-178 of 6 May 2019, par. 34, 35
[72] Ibid., par. 24, 28, 41.
[73] CCC, Judgment T-197 of 14 May 2019.
[74] Ibid., par. 2.2, 3.1, 3.2.
[75] CCC, Judgment T-403 of 30 August 2019, par. 7.
[76] CCC, Judgment T-452 of 3 October 2019, par. 65.
[77] Ibid., par. 51.
[78] CCC, Judgment T-246 of 15 June 2020, par. 21, 27, 28, 35.
[79] CCC, Judgment T-275 of 31 July 2020, par. 21-34. E.g., IACmHR, 'Forced Migration of Venezuelans', Res no. 2/2018.
[80] Ibid. (CCC), par. 34, 51-54, 57, 58.
[81] CCC, Judgment T-436 of 2 October 2020.
[82] Committee on Migrant Workers (CMW Committee), Concluding Observations (Colombia), 27 January 2020, par. 7 and 38.
[83] Ibid., par. 25; Committee on the Elimination of Racial Discrimination (CERD Committee), Concluding Observations (Colombia), 22 January 2020, par. 10.
[84] Ibid. (CERD Committee) par. 26-27; Ibid (CMW Committee) par. 31.c; Committee on the Elimination of Discrimination against Women (CEDAW Committee), Concluding Observations (Colombia), 8 March 2019, par. 45.
[85] Judgment T-025 of 2004, par. 8, 9.
[86] This section is partly based on Stefano Angeleri, *Irregular Migrants and the Right to Health* (Cambridge: CUP, 2022 forthcoming) Chapter 3.
[87] Daniel Whelan and Jack Donnelly, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight' *Human Rights Quarterly* 29 (2007) 908.
[88] CESCR (note 12) par. 12.
[89] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) (ICESCR), UNGA Res 2200A (XXI), Article 2.
[90] Audrey Chapman and Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Antwerp: Intersentia, 2002).
[91] CESCR, 'General Comment No. 3: The nature of states parties' obligations (Art. 2§1, of the Covenant), 14 December 1990, par. 10; CESCR (note 12) par. 43; Declaration of Alma-Ata - Health for All, International Conference on Primary Health Care (6–12 September 1978).
[92] Global Conference on Primary Health Care, Declaration of Astana, 25–26 October 2018; WHO, *Primary Health Care towards Universal Health Coverage – Report by the Director-General*, A72/12, 1 April 2019; WHA, *Primary Health Care*, Res 72.2, 24 May 2019.
[93] Brigit Toebes, *The Right to Health as a Human Right in International Law* (Oxford: Hart Publishing, 1999) 348; WHO and UNICEF, *A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals* (UN publishing, 2018) 2.
[94] CESCR, (note 12) par. 43.
[95] CESCR, Statement on the duties of states towards refugees and migrants under the International Covenant on Economic, Social and Cultural Rights, 13 March 2017.
[96] International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted 18 December 1990, entered into force 1 July 2003), UNGA Res 45/158.

[97] Ibid., Article 28.
[98] International Covenant on Civil and Political Rights (adopted 16 December 1966 entered into force 23 March 1976) UNGA Res 2200A (XXI).
[99] HRCtee, *Toussaint v Canada,* Com. No. 2348/2014, Views of 24 July 2018, par. 11.
[100] CMW Committee, 'General Comment No 2: The rights of migrant workers in an irregular situation', 23 August 2013, par. 72.
[101] CCC (note 61).
[102] The special vulnerability is acknowledged by both the CCC (notes 59, 49, 69) and the Colombian Government (Department of Health and Social Protection, 'Lineamientos para la prevención, detección y manejo de casos de covid-19 para población migrante en Colombia, March 2020, https://www.minsalud.gov.co/salud/publica/PET/Documents/TEDS05%20Poblacio%CC%81n%20Migrante.pdf.
[103] CCC (note 73) par. 2; (note 69) par. 4.
[104] CCC (note 61) par. 42.
[105] Stefano Angeleri, 'The Impact of the Economic Crisis on the Right to Health of Irregular Migrants, as Reflected in the Jurisprudence of the UN Committee on Economic, Social and Cultural Rights', *European Journal of Migration and Law* 19, no. 2 (2017): 165.
[106] Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* (Oxford: Hart Publishing, 2016) 124–125.
[107] Circular of the Minister of Health of 31 July 2017, as recalled in, e.g., CCC (note 61) par. 35, 40(c) and CCC (note 51) par. 5.
[108] Colombian Ministry of Health and Social Protection, 'Las Américas ya cuentan con Tarjeta Unificada de Vacunación', press release, 15 October 2019, available at: https://www.minsalud.gov.co/Paginas/Las-Americas-ya-cuentan-con-Tarjeta-Unificada-de-Vacunacion.aspx (accessed 25 March 2020).
[109] DeJusticia (note 27); CESCR, 'General Comment No 19: The right to social security, 4 February 2008, par. 37; Anand Grover, 'migrant worker's right to health', Report of the Special Rapporteur on the right to […] health, 15 May 2013, par. 40.
[110] European Union Agency for Fundamental Rights, *Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation* (Vienna: FRA Publishing 2015); WHO, *Building the Economic Case for Primary Health Care: A Scoping Review*, Geneva: WHO, 2018) 2.
[111] CCC, Judgment T-565 of 26 November 2019, par. 23-35, 43-49.
[112] ICESCR (note 89) Article 4; CESCR (note 12).
[113] CCC (note 78) par 20, 27, 28.
[114] For example, CCC, Judgments C-768/1998, C-913/2003, C-070/2004 and C-834/2007.
[115] UN General Assembly Resolution No. 70/1 'Transforming our world: the 2030 Agenda for Sustainable Development, 25 September 2015.
[116] CCC (notes 56, 71). Further details in section 4.3.
[117] CCC (notes 51, 69 and 76).
[118] IACtHR, *Artavia Murillo et al. ("In vitro fertilization") v. Costa Rica*, Judgment of 28 November 2012, Series C No. 257, par. 245.
[119] Additional Protocol to the American Convention on Human Rights in the area of Economic Social and Cultural Rights 'Protocol of San Salvador' (adopted 17 November 1988, entered into force 16 November 1999) OAS Treaty Series No. 69. The Protocol of San Salvador is monitored via a state reporting mechanism to the Working Group of the Protocol, http://www.oas.org/en/sare/social-inclusion/protocol-ssv/.
[120] IACtHR, *Lagos del Campo v Peru,* Judgment of 31 August 2017, Series C No. 340.
[121] Pedro Villareal, 'The Direct Justiciability of the Right to Health at the IACtHR', *Völkerrechtsblog,* 22 October 2018, https://voelkerrechtsblog.org/the-direct-justiciability-of-the-right-to-health-at-the-iacthr/ (accessed 20 May 2020).
[122] IACtHR, *Poblete Vilches et al. v Chile*, Judgment of 8 March 2018, Series C No. 349, par. 108. Emphasis added.
[123] Ibid., par. 111–117.
[124] Ibid., par. 121–124, 127.
[125] IACtHR, *Case of Hernández v. Argentina,* Judgment of 22 November 2019, Series C No. 395, par. 78
[126] IACtHR, *Case of Cuscul Pivaral et al. v. Guatemala*, Judgment of 23 August 2018, Series C No. 359, par. 72, 109.
[127] Ibid., par. 131
[128] Ibid., par. 132.

[129] Ibid., par. 105; IACtHR (note 125) par. 76–77. Emphasis added.
[130] Dembour (note 5) 7; Belen Olmos Giupponi, 'Assessing the Evolution of the Inter-American Court of Human Rights in the Protection of Migrants' Rights: Past, Present and Future', *The International Journal of Human Right*s, 21, no. 9 (2017) 1477–1503.
[131] IACtHR, *Juridical Condition and Rights of the Undocumented Migrants*, Advisory Opinion OC-18 of 17 September 2003, Series A no 18, par. 112–114.
[132] Ibid., par. 158, 169, 170.
[133] IACtHR, *Case of Vélez Loor v Panama*, Judgment of 23 November 2010, Series C No. 218, par. 98–100; IACtHR, *Case of Pacheco Tineo Family v. Bolivia*, Judgment of 25 November 2013 Series C No. 272 par. 128; IACtHR, *Case of Expelled Dominicans and Haitians v. Dominican Republic*, Judgment of 28 August 2014, Series C No. 282, par. 197.
[134] Ibid. (*Pacheco Tineo*) par. 129; (*Expelled Dominicans and Haitians*) par. 263.
[135] CEDAW Committee, 'General Recommendation No. 27 on older women and protection of their human rights, 16 December 2010, par. 13.
[136] CCC (note 76) par. 73–77.
[137] Patrick Ammerman, 'Venezuela's HIV Crisis Crosses the Border', *Foreign Policy*, August 28, 2019; Gabriela Mesones Rojo, 'Leave or die. The choice confronting HIV-positive Venezuelans', *The Humanitarian*, 5 November 2019.
[138] IACtHR (note 126) par. 110; CCC (note 71) par. v.
[139] CESCR (note 12) par. 43.
[140] IACtHR (note 126) par. 114, 116, 123.
[141] CCC (note 57) par. 6 and (note 76) par. 84.
[142] e.g., IACtHR*, "Street Children" (Villagran Morales et al) v. Guatemala,* Judgment of 19 November 1999, Series C No. 32, par. 194; *Juridical Condition and Human Rights of the Child*, Advisory Opinion OC-17/02, 28 August 2002, Series A No. 17, par. 24; *Pacheco Tineo* (note 133) par. 219, 224, 229. For further details, see Alejandro Fuentes and Marina Vannelli, 'Human Rights of Children in the Context of Migration Processes. Innovative Efforts for Integrating Regional Human Rights Standards in the Americas' *Laws* 31 no 8 (2019) 7.
[143] Convention on the Rights of the Child 1989 (CRC) 1577 UNTS 3, Article 24.2(b). Emphasis added.
[144] CRC Committee, 'General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health, 17 April 2013, par. 73.
[145] CMW and CRC Committees, Joint General Comment No. 4/23 on state obligations regarding […] children in the context of international migration […]', 16 November 2017, par. 55 and 56. Emphasis added.
[146] CCC (note 56) par. 50, 65 and (note 71) par. 13, 31, 35.
[147] Colombian Congress Act no. 1997 of 16 September 2019.
[148] CCC (note 57), par. 3, 5.11, 6; CCC (note 61) par. 58, 64; CCC (note 76) par. 96.
[149] CMW and CRC Committees (see note 131); IACtHR, *Rights and guarantees of children in the context of migration and/or in need of international protection*, Advisory Opinion OC-21/14 of 19 August 2014, Series A No. 21, par. 104 and 164.
[150] CCC (note 79) par 24 and 34.
[151] e.g., Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) (CEDAW) UNGA Res 34/180; Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (or Convention of Belém do Pará) (adopted 9 June 1994, entered into force 3 February 1995).
[152] e.g., ICCPR (note 98), Article 3; ICESCR (note 89), Article 3.
[153] CESCR, 'General Comment No. 16, the equal right of men and women to the enjoyment of all economic, social and cultural rights'), 11 August 2005.
[154] International Conference on Population and Development, Programme of Action, Cairo, 5–13 September 1994, par. 7.6, 7.30, 8.6. CEDAW Committee, 'General Recommendation No. 24: […] women and health', 1999, par. 6; CEDAW Committee, 'General Recommendation No. 26 on women migrant workers', 5 December 2008, par. 17, 18.; CEDAW Committee, 'General Recommendation No. 28 on the Core Obligations of States Parties', 16 December 2010, par. 5.
[155] CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health, 2 May 2016, par. 49.
[156] CESCR, *S.C. and G.P. v Italy* Complaint no 22/2017, Views of 28 March 2019, par. 8.2.
[157] CESCR (see note 155) par. 31.
[158] IACmHR, 'Access for Justice for Women Victims of sexual Violence in Mesoamerica', Report, 9 December 2011, par. 56.

[159] IACmHR, 'Human Rights of Migrants and Other Persons in the Context of Human Mobility in Mexico, Thematic Report, 30 December 2013, par. 83, 352; CEDAW Committee (note 135) par. 13.
[160] Ssenyonjo (note 106) 138.
[161] CCC (note 56) par. 61 and (note 61) par. 53.
[162] IACmHR, *I.V. v Bolivia (Case 12.655)*, Final Report No. 72 of 15 August 2015, par. 100, 131, 162.
[163] CEDAW Committee, *Alyne da Silva Pimentel Teixeira v Brazil*, complaint no. 17/2008, Views, 2011, par. 7.4. Emphasis added.
[164] Convention of Belém do Pará (note 151), Article 9 as referred in CCC (note 56) Dissenting opinion, § 26–27.
[165] CCC (note 76) par. 79-84.
[166] CEDAW Committee, GR 28 (note 154) par. 18.
[167] Catherine Dauvergne, 'Sovereignty, Migration and the Rule of Law in Global Times' *The Modern Law Review* 67, no 4 (2004) 588, 590; Global Compact for Safe, Orderly and Regular Migration, 19 December 2018, UNGA Res 73/195, par. 15.c.
[168] E.g., IACtHR (note 131); CESCR (note 95), CMW (note 96).
[169] Ryszard Cholewisnky, *Study on Obstacles to Effective Access of Irregular Migrants to Minimum Social Rights* (Strasbourg: Council of Europe Publishing, 2005).
[170] R4V/GIFMM (note 28).
[171] E.g., CCC (note 53) par. 79, 100, 112; (note 66) par. 4.5.1; (note 76) par. 58-60.
[172] E.g., CCC (note 61) par. 31, (note 71) par. 24.
[173] Global Compact (note 167) par. 23.h; CESCR, Concluding observations (Argentina), 12 October 2018, par. 39.
[174] DeJusticia (note 27).
[175] CCC (note 81) par 56.
[176] IACmHR, Resolution 2/2018 'Forced Migration of Venezuelans' (2018).
[177] CERD Committee (note 75) par. 26-27; CCC (note 69) par. 5 and (note 71) par. 24. Emphasis added.
[178] Audrey Chapman, 'The Impact of Reliance on Private Sector Health Services on the Right to Health' *Health and Human Rights* 16, no 1 (2014).
[179] CCC (note 57) par. 6 and CCC (note 61) par. 54.
[180] CCC (note 79) par. 12.
[181] Profamilia and USAID, *Desigualdades en salud de la población migrante y refugiada venezolana en Colombia*, 2020, 34.
[182] Webinar Presentation of Mr Espinosa, director of Migración Colombia, at the Irish Centre for Human Rights /Embassy of Colombia to Dublin webinar 'Colombia's Approach to the Venezuelan Migrant Crisis', 26 May 2021.
[183] R4V/GIFMM (note 28).
[184] ICESCR (n. 89) Article 2.
[185] CCC (note 61).
[186] The long preamble of the TPSV (note 4) makes many references to international and domestic instruments for the preservation and implementation of human rights.
[187] PAHO / OPS, *Documento de Orientación sobre Migración y Salud*, April 2019, https://www.paho.org/hq/index.php?option=com_content&view=article&id=15106:paho-provides-guidance-on-improving-the-health-of-migrants-in-countries-of-the-americas&Itemid=1926&lang=es.
[188] CCC (note 61) par. 17–21.
[189] GIFMM/R4V, 'Colombia: FactSheet - Evaluación rápida de necesidades de personas en tránsito – REACH, August 2020, 4.