MIGRATION AND HEALTH IN THE AMERICAS:

Needs and Services Assessment 2021-2023

IFRC

In collaboration with:

Norwegian **Red Cross**

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Address
Ricardo Murgas Street, building 220, Ciudad del Saber, Clayton, Ancon, Panama City, Panama.
+507 317 3050 | health.americas@ifrc.org | www.ifrc.org

Author: Leila Coppens
Designer: Diana De León

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"I still have a feeling,
it is a feeling of uprootedness,
a feeling that I express many times through tears".

Elder person on the move, 66, El Salvador (HelpAge, 2021)

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Foreword

Migration in the Americas is not new, but the growing intensity of this phenomenon presents us with a challenge that requires urgent collective action to save lives and share the burden.

The record number of migrants in transit and returned to our region shows that despite the search for solutions to promote orderly and safe migration, in line with the principles of the Global Compact on Migration, restrictive policies have not reduced migratory flows, or the risks faced by migrants, most of whom are seeking family reunification or fleeing climate change, poverty, violence, political instability and armed conflict.

While this scenario prevails, migration is not expected to stop, humanitarian assistance and protection will continue to be urgent, and improving conditions in countries of origin is indispensable but not sufficient. Hence, solutions to respond to migration should be multidimensional and interconnected, just as the causes and impacts of migration are.

To address a humanitarian challenge of this scale, we must act from a place of ethics, guided by the humanitarian imperative and strategic collaboration, but also from evidence-based decision-making. This study provides exactly that: data on the health needs of migrant populations, as identified by governments, humanitarian agencies, and civil society organizations, as well as those expressed by migrants themselves. This evidence is critical for designing informed, effective, and dignified solutions that truly meet the needs of people on the move.

Access to healthcare is a basic human right and a cornerstone of human dignity. Yet, for many migrants, this and other rights remain elusive. Along the often perilous migratory routes, access to essential health services is severely restricted, compounded by legal, cultural, and logistical barriers that deepen inequalities and exacerbate present and future vulnerabilities.

Migrants, regardless of their status, frequently face unmet health needs, from basic medical care to more complex issues such as chronic illnesses, mental health, and disability services. The IFRC's approach recognizes this complexity and calls for health care and humanitarian assistance that are inclusive, equitable, and responsive to the diverse and evolving needs of people on the move.

The findings presented in this study ratify the pertinence of our vision and highlight the urgent need to scale up comprehensive healthcare services for migrants in the Americas. It also reveals that despite ongoing efforts, significant gaps remain in ensuring that healthcare solutions in destination countries and along migratory routes meet the needs of this vulnerable population, who often fear deportation and face discrimination, exclusion, and administrative and cultural obstacles.

Our response to these challenges must be multidimensional, coordinated and adequately funded. It should also go beyond medical expertise and promote a deep understanding of the unique social, cultural, and political contexts in which migration occurs.

This is where the IFRC network, with its unparalleled reach and trusted presence in origin, transit and destination countries, plays a critical role. Through our Global Route-Based Migration Program, we provide safety, dignity, and well-being of migrants in 22 countries in the Americas, where we deliver life-saving services, provide protection, and advocate for migrant's rights.

At the core of these efforts is our commitment to protection, gender and inclusion, ensuring that services are accessible, responsive to gender-based discrimination and violence, and tailored to the specific needs of children, women, older adults, LGBTIQ+ people and individuals with disabilities.

Working together to guarantee predictable, flexible, and sustained investment in healthcare for migrants it is not only a moral imperative but also a pragmatic one: by ensuring access to healthcare, we can share the burden, reduce the risk of communicable diseases, and foster more resilient, inclusive communities. Hundreds of thousands of lives depend on it.

Addressing the health data gaps identified in this report is another concrete and powerful action we can take collectively to increase the impact of our current and future interventions. But above all, governments, donors, and humanitarian stakeholders must step up to dismantle all the barriers that prevent migrants from accessing healthcare.

We hope that this report will help your organisations and teams to strengthen the provision of comprehensive health care for migrants, and we encourage you to join the IFRC's efforts in this area. Our work is based on the belief that people's rights must be upheld in all circumstances and that everyone, regardless of gender, age or background, deserves to be treated with dignity, to have access to services, to participate meaningfully in decisions that affect them, and to be safe from harm.

> *"You see on the news what the people who pass through the Darien go through, they come with their complications, there are people who have even died on the way....*
>
> *And to see the joy of the adults, when we take care of their children, when they have their medicines and the possibility of healing their wounds, is the most valuable thing. People always leave grateful, giving you blessings".*
>
> Dr. Leonardo Baca, Medical Doctor, Honduran Red Cross (Danlí, Honduras, 2023)

> *"No matter where they come from, most are fleeing a difficult life and face an uncertain, dangerous path with no access to essential services. That's why, even if it seems little, we go out in the racer to look for them. That's why, even if it seems little, we leave water for them at the altars they build in the desert".*
>
> Lupita González, Emergency Medical Technician, Mexican Red Cross. (Nogales, Mexico, 2023)

Acknowledgements

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The report was written by Leila Coppens and designed by Diana De León.

This research and subsequent report would not have been possible without the financial support of the Norwegian Red Cross.

A special thanks to the technical teams from across the IFRC network that contributed with their inputs to this research.

Acronyms and definitions

Acronyms

GBV	Gender-based Violence
MMR	Maternal Mortality Rate
r4v	Regional Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela
RCRC	Red Cross and Red Crescent Movement
SIS	Seguro Integral de Salud (Peru)
STI	Sexually Transmitted Infections
USA	United States of America

Definitions

Host Community	Local population affected by the arrival and presence of refugees and migrants (R4V, 2023c)
In-Destination	Individuals who have left their usual place of residence with the intention to remain in a host country (R4V, 2023c)
In-Transit	Individuals who are transiting through a country prior to entering their intended country of destination (R4V, 2023c)
Pendular	Temporary and usually repeated population movements, which may represent a movement pattern between Venezuela and a neighboring country (R4V, 2023c)

Introduction

Background

Migration flows in the Americas are intensifying and the variety of migrants´ origins expanding. Historically, there has been a massive displacement of populations from Central America and Mexico towards the United States of America (USA) and Canada. Citizens from South American nations and from the Caribbean have also migrated toward the north or neighboring countries in search of better opportunities. In the past years, the crisis in Venezuela has generated the second-largest displacement of people after the one in Syria. Furthermore, South America and Central America are transit grounds for remote citizens of the world coming from Africa, Asia, East Europe aiming for North America.

Migrants, regardless of their legal status, are entitled to the right to health. However, healthcare for migrants along migration routes and upon arrival in receiving countries is often limited.

Providing medical services to migrants presents a unique set of challenges that the healthcare systems and organizations must address, among others:

- Language and Cultural Barriers: Migrants often come from diverse linguistic and cultural backgrounds. Communicating effectively with patients who may not speak the local language can hinder the delivery of quality healthcare. Language barriers can result in misunderstandings, misdiagnoses, and inadequate treatment. Additionally, cultural differences may affect healthcare-seeking behaviors and the patients' understanding of medical practices, leading to challenges in providing appropriate care.
- Limited Access to Healthcare: Migrants, particularly undocumented or irregular migrants, may face barriers to accessing healthcare services. They may lack health insurance or legal status, making it difficult for them to seek medical attention. This limited access can result in delayed or insufficient treatment, worsening health conditions, and potential public health risks.
- Legal and Policy Issues: Migrants' eligibility for healthcare services often depends on local laws and policies. In some cases, migrants may not have access to the same level of healthcare as citizens or legal residents. Even when eligible, the legal restrictions and uncertainty about entitlements can create confusion and deter migrants from seeking medical care.
- Continuity of Care: Migrants often move across regions or countries, disrupting the continuity of their medical care. Lack of medical records, difficulty transferring information between healthcare providers, and different healthcare systems can hinder the provision of continuous and coordinated care for migrant patients.
- Stigmatization and Discrimination: Migrants may face social stigma, discrimination, and xenophobia, including within healthcare settings. This can create

barriers to seeking care, resulting in substandard treatment when they access healthcare services. Overcoming these biases and promoting a culturally sensitive and inclusive healthcare environment is crucial to ensuring equitable care for migrants.

This study is a need and service assessment. It aims to identify migrants´ health needs and establish whether these are covered by the offer by governments, civil society and international cooperation, complying with quality standards.

Objectives

The main objective of the study consists of a need and service assessment for migrants and refugees in the Americas and the Caribbean January 2021 to December 2023.

As secondary objectives, the study seeks to identify facilitating and hindering factors to health care for migrant population.

Health services under consideration for the report are:

- Emergency care (including prehospital care and response to general and sexual violence).
- Primary health care (including nutrition, infectious and chronic diseases, mental health).
- Sexual and reproductive health care.
- Maternal care.
- Childcare (including nutrition and vaccination services).

Conceptual framework

A conceptual framework was used to produce a rigorous and focused study. A key determinant analysis paradigm was adopted (UNICEF, 2012). These key determinants are classified into four main groups: enabling environment, supply, demand and quality (Table 1).

Table 1. Determinants for assessing bottlenecks and barriers to equitable outcomes (UNICEF, 2012)

	Determinants of bottlenecks and barriers	Description
Enabling environment	Social norms	Widely followed social rules of behavior
	Legislation/policy	Adequacy of laws and policies
	Budget/expenditure	Allocation & disbursement of required resources
	Management/coordination	Roles and Accountability/Coordination/ Partnership
Supply	Availability of essential commodities/inputs	Essential commodities/ inputs required to deliver a service or adopt a practice
	Access to adequately staffed services, facilities and information	Physical access (services, facilities/information)
Demand	Financial access	Direct and indirect costs for services/practices
	Social and cultural practices and beliefs	Individual/ community beliefs, awareness, behaviors, practices, attitudes
	Continuity of use	Completion/continuity in service, practice
Quality	Quality	Adherence to quality standards (national or international norms)

Methodology

The study is based on a documentary review (regulatory frameworks, recently published and unpublished reports, scientific literature) available online. It includes a revision of PAHO database on frameworks and scientific literature as of Octobre 2023 (OPS, no date). As much as possible, original sources were reviewed. This practice turned out to be very relevant since several information transcription and interpretation errors were observed.

Geographically the study covers the entire American continent including the Caribbean. In Canada and the USA, the search was focused on migrants of American/ Caribbean origin.

The time frame is 2021 to 2023, to avoid reflecting the acute disruption of health needs and services during the pandemic. However, the impact on the provision of health services continues long after the acute phase of the COVID-19 pandemic.

The study presents several limitations. First, it relies on many surveys. Surveys are often based on convenience sampling using humanitarian organizations ´databases. It means respondents are often beneficiaries of services offered by these organizations. Hence little is known about in-destination and in-transit migrants who do not access these services. Second, samples are often limited in size, especially in migration flow monitoring exercises. To counteract this limitation, as much as possible, geographical scope and sample sizes are indicated along sources in this study. Third, women are keener to respond health surveys than men. Fourth, eligibility criteria for participation in surveys usually include legal age. Hence the voices of minors, including adolescent mothers, are not well reflected. Fifth, interviews conducted over the phone exclude migrants with no phone and are not conducive to data collection on sensitive topics such as violence, mental health, and others. All these limitations entail that data presented is indicative and not representative of the migrant population in its full diversity.

CHAPTER 1:
Overview of migration in the Americas

1.1 Migration stocks

Overall, since 2010, the number of international migrants in the Americas has steadily increased, as illustrated by the two charts below (figures 1 and 2):

Figure 1. Evolution of the number of international migrants in Northern and South Americas from 2010 to 2020 (Our World in data, 2020)

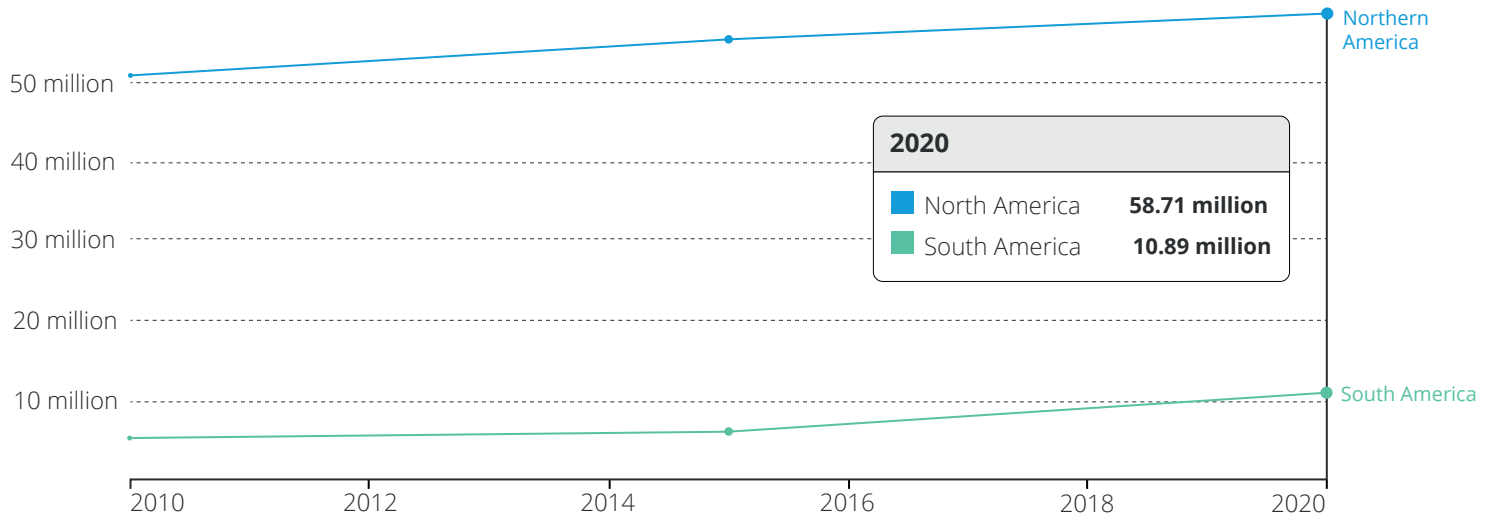
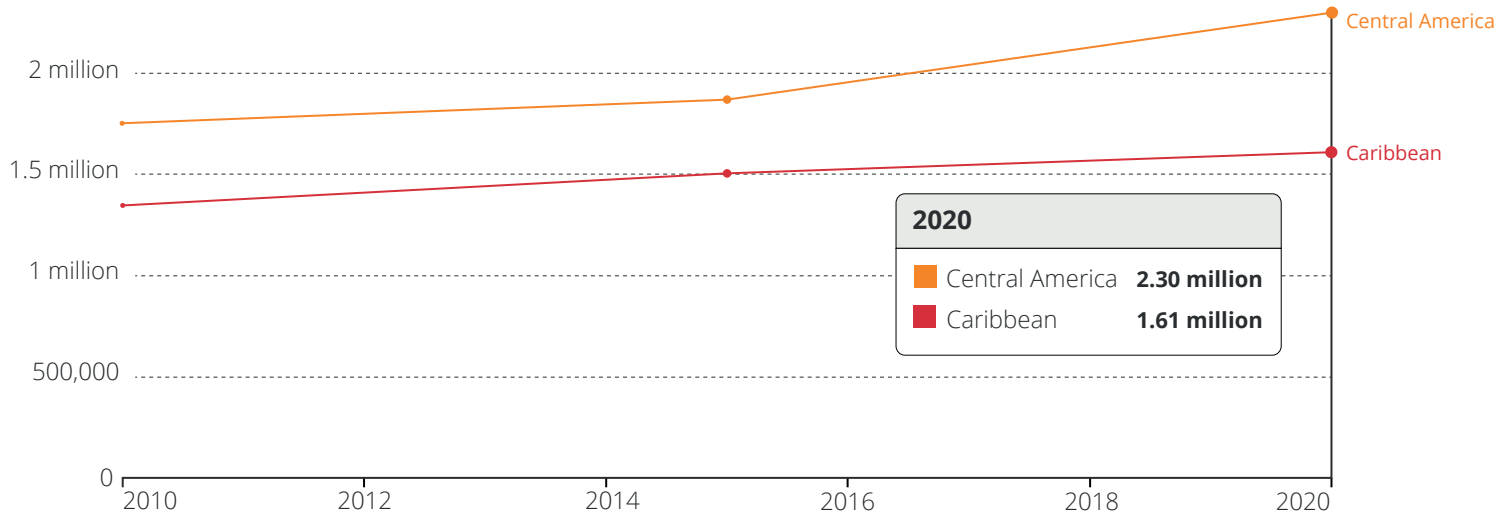


Figure 2. Evolution of the number of international migrants in Central America and the Caribbean from 2010 to 2020 (Our World in data, 2020)



Zooming in at country level, there is a broad diversity in terms of the absolute number of international migrants and the proportion of migrants out of the total population of the country. The five countries with more international migrants are the USA, Canada, Argentina, Colombia and Chile. The five countries with a higher proportion of international migrants are Antigua and Barbuda, Canada, the Bahamas, Belize and in fifth position both Saint Kitts and Nevis and the USA (table 2).

Table 2. Number of international migrants and international migrant stock as a percentage of the total population (Migration Data Portal, 2020)

	Countries	Number of international migrants	International migrant stock as a porcentage of the total population
South America	Argentina	2,300,000	5%
	Bolivia	164,100	1%
	Brazil	1,100,000	1%
	Chile	1,600,000	9%
	Colombia	1,900,000	4%
	Ecuador	784,800	4%
	Guyana	31,200	4%
	Paraguay	196,600	2%
	Peru	1,200,000	4%
	Surinam	47,800	8%
	Uruguay	108,300	3%
	Venezuela	1,300,000	5%
Central America	Belize	62,000	16%
	Costa Rica	520,700	10%
	El Salvador	42,800	1%
	Guatemala	84,300	1%
	Honduras	39,200	0%
	Nicaragua	42,200	1%
	Panama	313,200	7%
Caribbean	Antigua and Barbuda	29,400	30%
	Barbados	34,900	12%
	Cuba	3,000	0%
	Dominica	8,300	12%
	Dominican Republic	603,800	6%
	Granada	7,200	6%
	Haiti	18,900	0%
	Jamaica	23,600	1%
	Saint Kitts and Nevis	7,700	15%
	Saint Lucia	8,300	5%
	Saint Vincent and the Grenadines	4,700	4%
	Bahamas	63,600	16%
	Trinidad and Tobago	78,800	6%
North America	Canada	8,000,000	21%
	Mexico	1,200,000	1%
	United States	50,600,000	15%

Less than 100,000 or 1%.

100,000 - 999,999 or 1%-9.99%.

Over 1,000,000 or 10%.

International migrants in the table above are understood broadly as persons living outside their country of birth (UN, no date). It includes but does not equate with refugees and migrants who flee death, violence, natural and man-made disasters and poverty. These situations affect the Americas frequently, producing internal and external migrations flows. In 2020, 4.5 million people were displaced (IFRC, 2022b).

1.2 Migration flows

The map below summarizes main migration routes through the continent.

Figure 3. Migrations flows in the Americas (IOM, 2023a)

Few countries in the region fuel migration flows in the continent.

For decades, inhabitants of Central America have fled poverty, violence and natural disasters. Approximately 10% of the population of El Salvador, Guatemala and Honduras live abroad (Gobierno de la República de Honduras, 2020). Ninety per cent of those who have left from these countries and Mexico live in North America (SE-COMISCA y SICA, 2023). Many citizens from Nicaragua and Panama have moved to Costa Rica. People from Honduras, Guatemala y El Salvador have gone to Belize. Despite representing less than 3% of the world population, Central America and Mexico contribute 7% of migrants in the world (SE-COMISCA y SICA, 2023).

Recently, not shown on the map above, citizens from El Salvador, Honduras and Guatemala have been returned to their home countries. From January to November 2021 to 2022, the returning flow increased by 93%, 51% and 75% respectively (IOM, 2023a). These returnees are irregular migrants who have been detained in North America. A proportion of them cannot return to their origin communities as they fled violence and threats.

Similar to Central America, **Haitians, Cubans and Colombians have also a history of fleeing their country because of the politico-socio-economic situation.**

The major displacement of people in the continent is currently caused by the Venezuelan crisis. An estimated 7.7 million people have left Venezuela. Eighty-four percent of them – about 6.5 million – live in Latin America and the Caribbean (R4V, 2023b). The principal host countries are Colombia, Peru, Brazil, Ecuador and Chile (table 3). The USA is also a major destination with 545,200 Venezuelans as of 2021 (R4V, 2023b).

> *"I had to leave my home, where I lived for more than ten years with my two little ones. My husband was killed by gangs for refusing to continue paying extortion. I followed the migratory route and they returned me from Mexico: first I was displaced and then a migrant, and now I am back in Honduras without being able to return to my community of origin."*
>
> Honduran, displaced and migrant woman, Honduras (ICRC, 2020)

In terms of trends, **from 2021 to 2023, the number of Venezuelan migrants and refugees is on the rise in all countries but Panama**. Migrants who had been living in Panama have left the country in 2023 (R4V, 2023a). In 2023, there seems to be a sharp increase of migrants in Mexico, Argentina, Uruguay, Colombia, Brazil and Bolivia. Among the Caribbean islands, Dominican Republic hosts close to 200,000 Venezuelan migrants and refugees (table 3). In 2020, the estimated numbers of Venezuelans in Guatemala, El Salvador, Nicaragua and Honduras were very low: 303, 245, 165, 103 respectively (R4V, 2023b).

Table 3. Venezuelan population in American and Caribbean countries (R4V, 2023b)

		2021	2022	2023 Projection*	Trend 2021-2023
South America	Argentina	173,248	171,050	330,893	
	Bolivia	12,123	13,776	23,781	
	Brazil	261,441	412,902	716,240	
	Chile	448,138	444,423	666,635	
	Colombia	1,842,390	2,477,588	4,341,890	
	Ecuador	508,935	502,214	712,418	
	Guyana	24,540	19,643	32,514	
	Paraguay	5,645	5,769	8,012	
	Peru	1,286,464	1,505,416	2,313,006	
	Uruguay	16,622	26,306	49,409	
Central America	Costa Rica	29,906	30,107	44,108	
	Panama	121,598	147,550	87,237	
Caribbean	Aruba	17,000	17,000	25,628	
	Curacao	14,159	14,000	21,000	
	Dominican Republic	115,283	115,283	186,212	
	Trinidad and Tobago	28,478	35,314	54,327	
North America	Mexico	82,976	87,152	169,662	

Less than 100,000

100,000 - 999,999

Over than 1,000,000

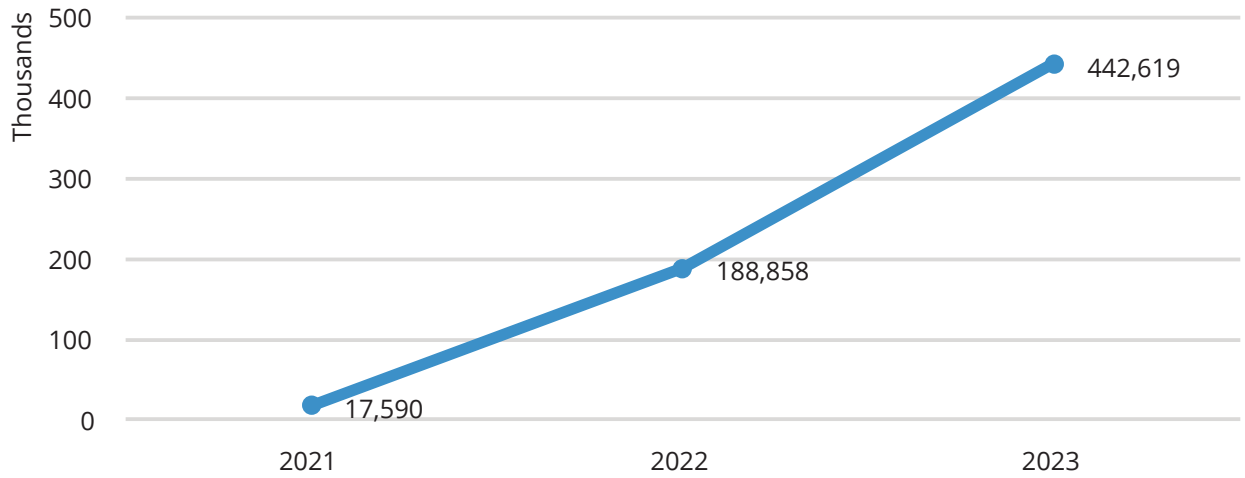
* 2023 projection based on data from January to August 2023.

The flow of irregular migrants along the northern route follows an increasing trend from 2021 to 2023, as can be seen with data from the Colombia-Panama border, Honduras and the Mexico-USA border.

The number of migrants crossing irregularly the border from Colombia to Panama increased by 86% from 2021 to 2022, reaching a total of 248,284 (IOM, 2023a). The same trend is intensified the following year. A three-fold increase (total 333,700 migrants in 2023) (UNHCR, 2023b) is observed between January-August 2023 and the same period in 2022 (R4V, 2023a).

Likewise, in Honduras, the number of migrants registered by the migration authorities has undergone dramatic increases over the past couple of years (figure 4).

Figure 4. Number of irregular migrants registered by authorities from 2021 to 2023 in Honduras (Instituto Nacional de Migración, 2023)



Note: Data for 2023 is up to 31/10/2023

The same increasing trend is observed at the southwest border of the USA. Compared to 2021, in 2022, the USA reported a 27% increase in the number of encounters (total 2,577,669) (IOM, 2023a). For the first time, South Americans top the list of immigration nationalities in the USA (IOM, 2023a).

These trends can also be confirmed by looking at the IFRC migration dashboard monitoring population movement in Central America (figures 5, 6 and 7) :

Figure 5. Migration flows and numbers in Central America (IFRC, 2024)

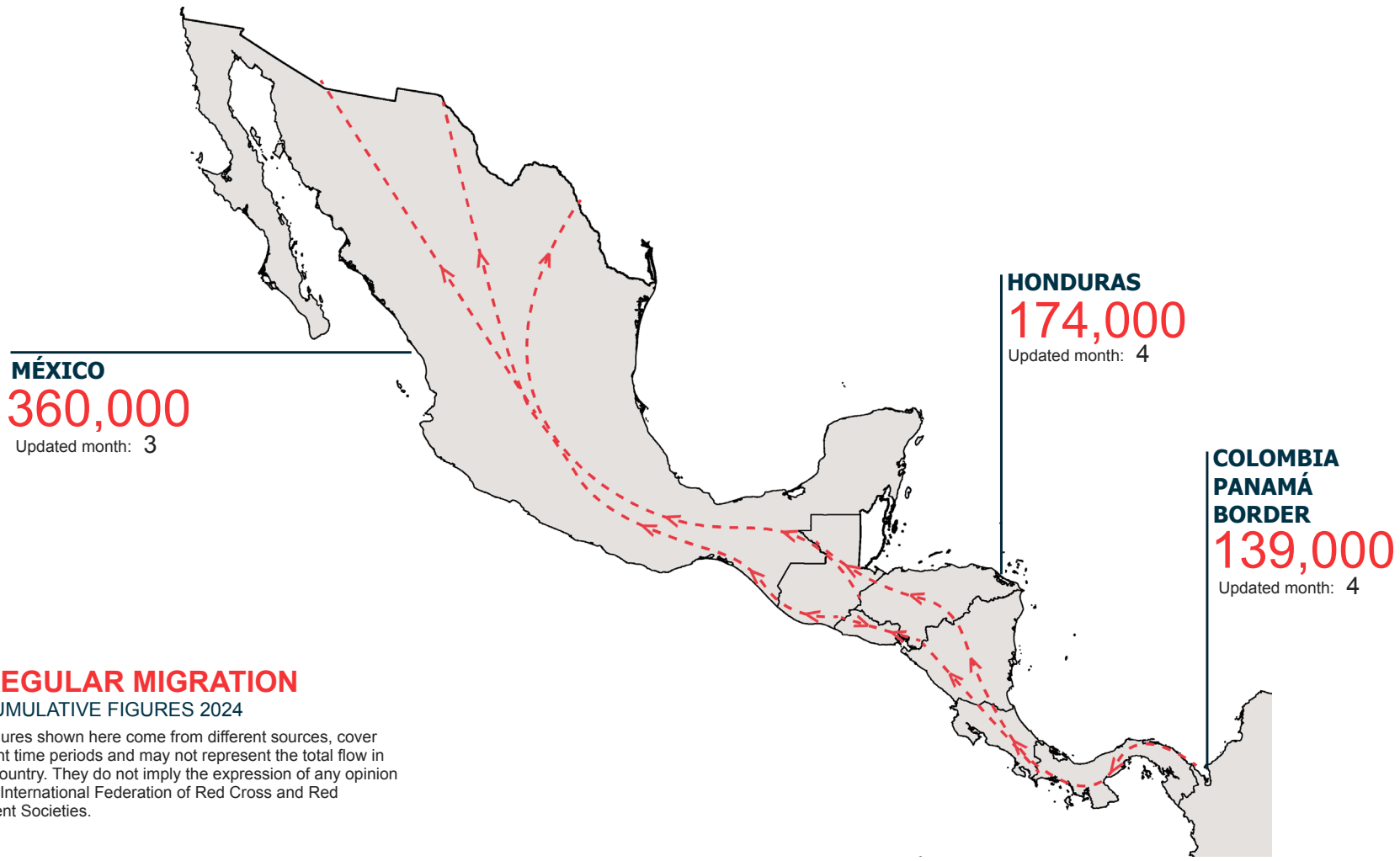
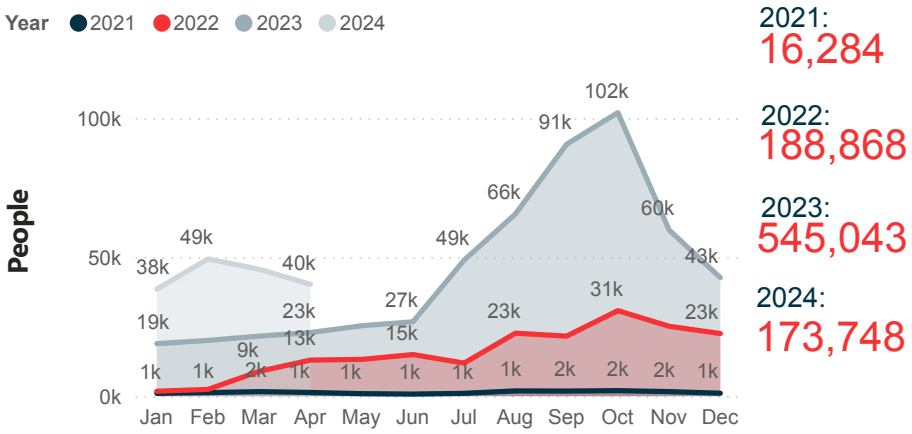


Figure 6. Numbers and trends of irregular migrants in Central America (IFRC, 2024)

HONDURAS

Irregular Migration



2021: 16,284

2022: 188,868

2023: 545,043

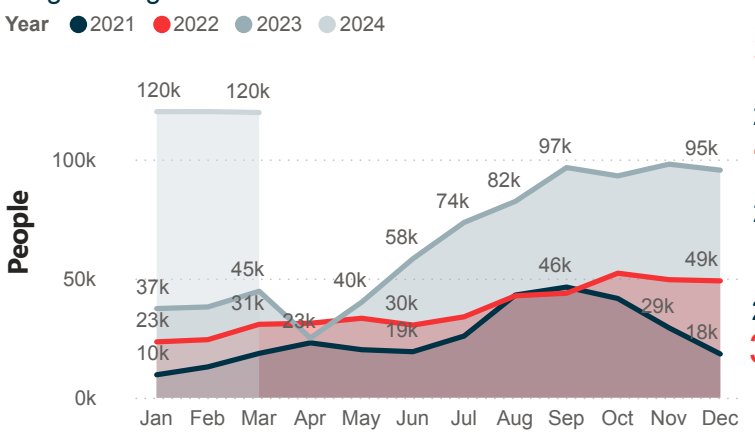
2024: 173,748

Country	2021	2022	2023	2024	Total
Honduras	16,284	188,868	545,043	173,748	**923,943**
Mexico	307,679	444,439	782,185	359,697	**1,894,000**
Panama	133,726	248,284	520,085	139,267	**1,041,362**
Total	**457,689**	**881,591**	**1,847,313**	**672,712**	**3,859,305**

The figures shown here come from different sources, cover different time periods and may not represent the total flow in each country. They do not imply the expression of any opinion by the International Federation of Red Cross and Red Crescent Societies.

MÉXICO

Irregular Migration



2021: 307,679

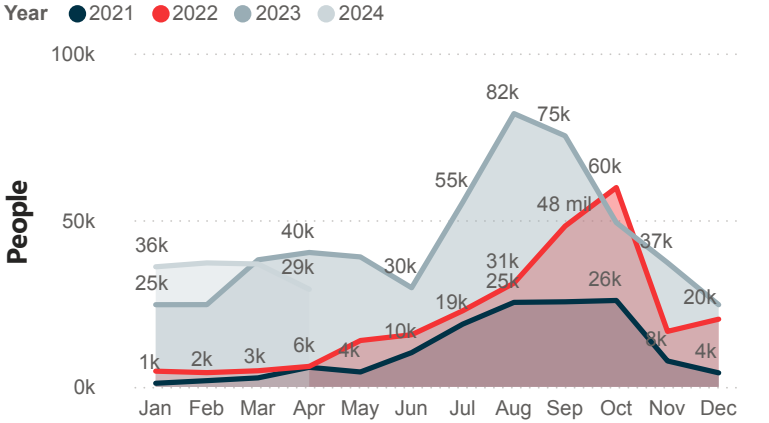
2022: 444,439

2023: 782,185

2024: 359,697

COLOMBIA/PANAMÁ

Irregular Migration



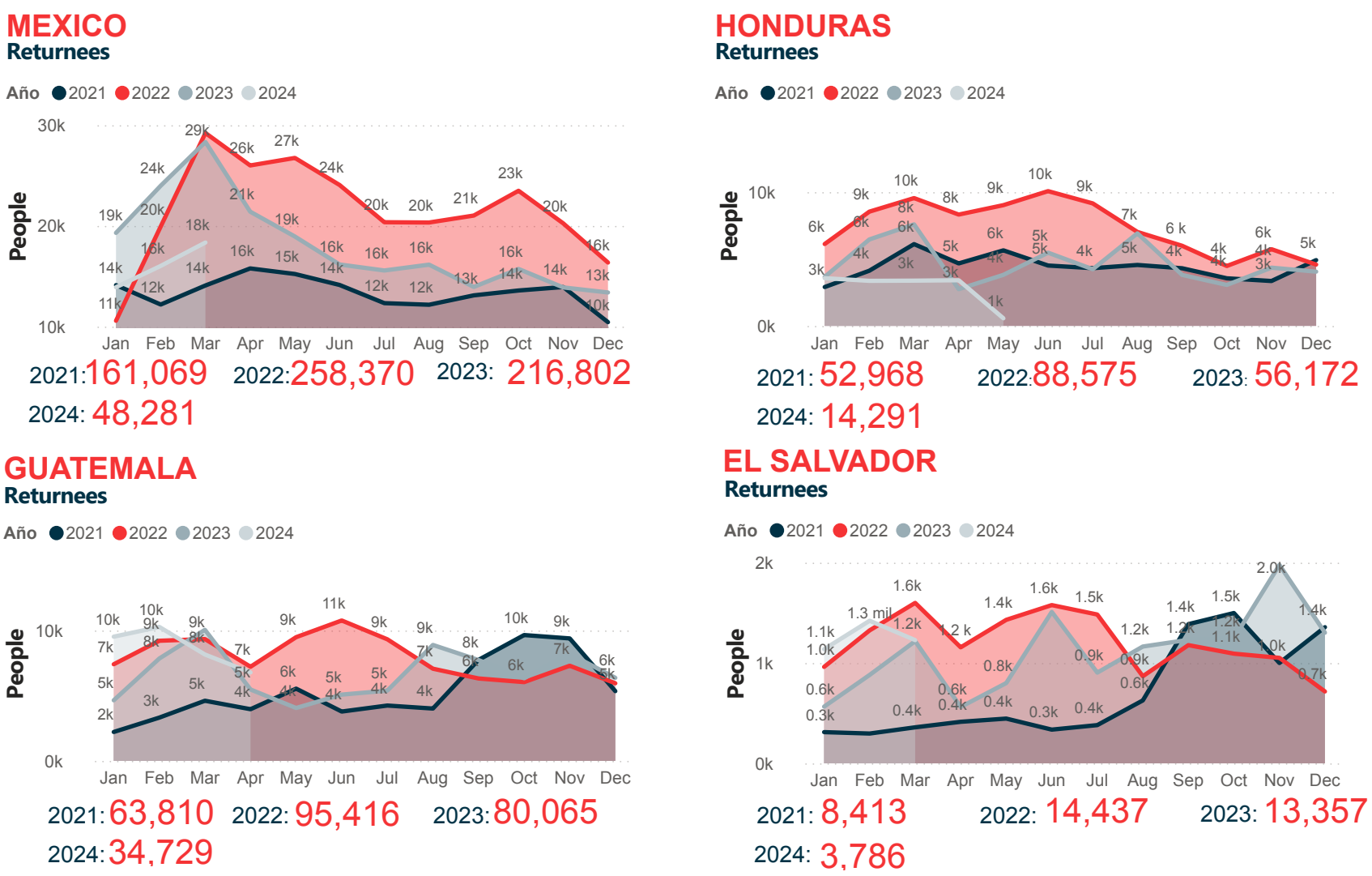
2021: 133,726

2022: 248,284

2023: 520,085

2024: 139,267

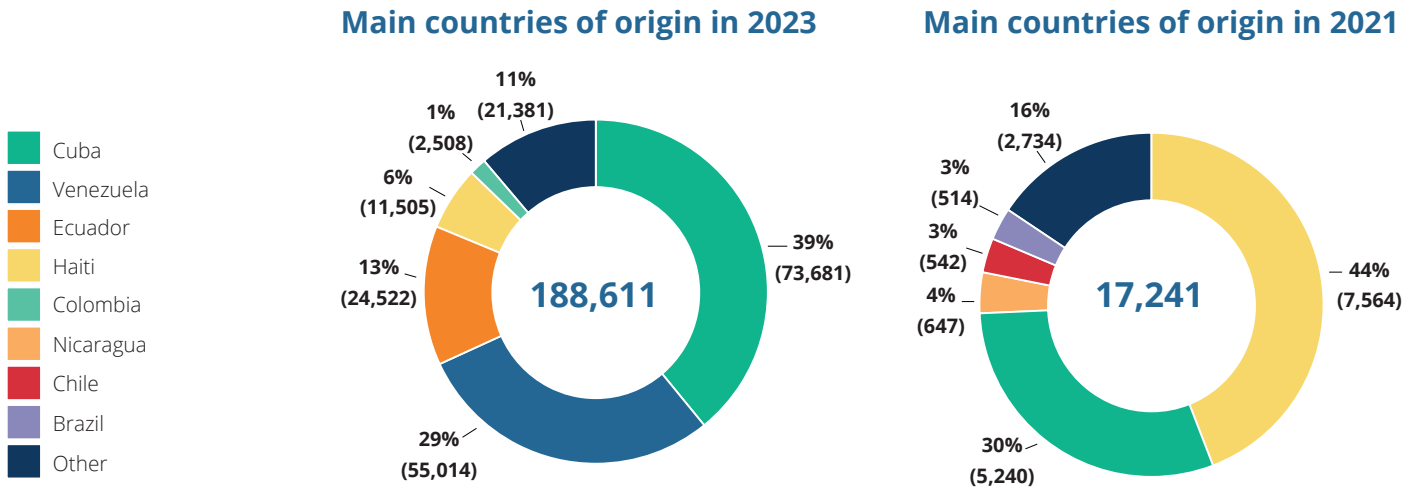
Figure 7. Numbers and trends of returnees in Central America (IFRC, 2024)



Along the migration route towards the North, the distribution of irregular migrants from diverse origins varies, as illustrated in the following charts.

At the Colombia-Panama border, most migrants are from Venezuela, Ecuador and Haiti (Figure 8).

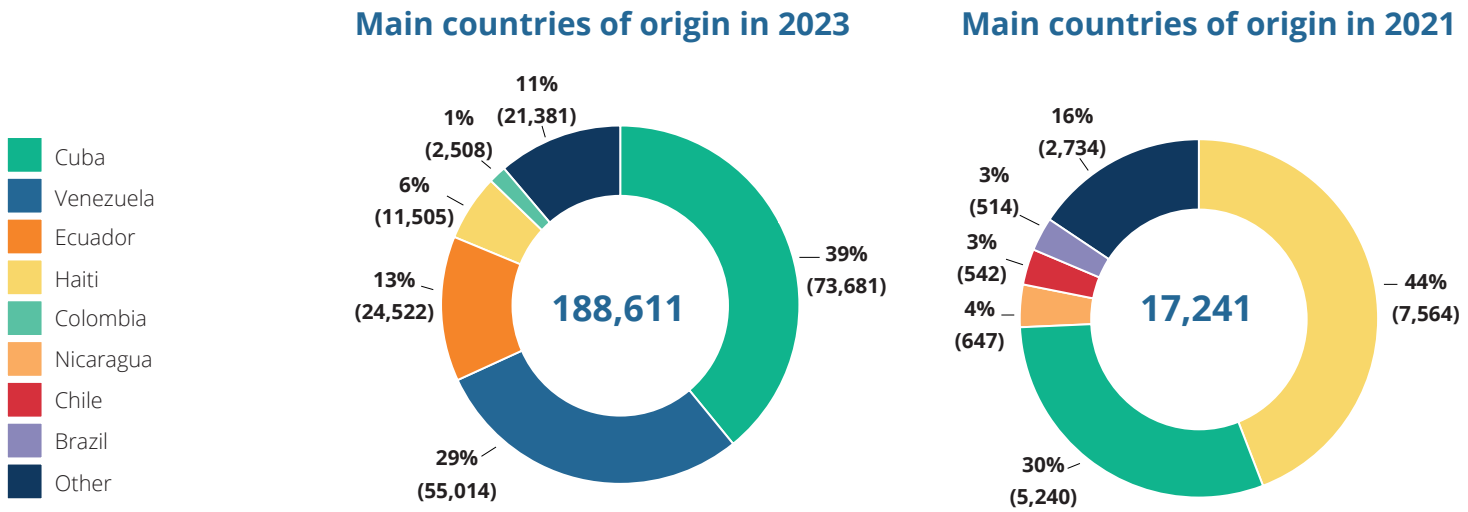
Figure 8. Countries of origin of irregular migrants moving from Colombia to Panama in 2022 (Jan-Dec) and 2023 (Jan-Feb) (IOM, 2023a)



At the Colombia-Panama border, 76% of irregular migrants were heading to the USA while 9% and 7% aimed to reach Mexico and Panama respectively (GIFMM, 2023b; Darien; 6,391 participants,). Another survey showed that 95% wanted to reach the USA, 2% Canada and 1% Mexico and Panama. In case they would not be able to reach their preferred destination, 8 out of 10 planned to wait in another country until allowed to proceed (UNHCR, 2023a; Darien and Chiriqui; 107 participants).

At the Nicaragua/Honduras border, the same origins prevail, accompanied by Cubans (figure 9).

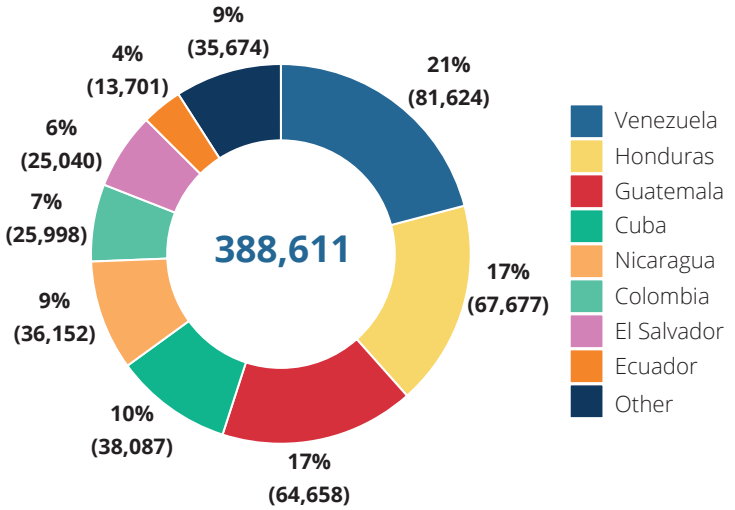
Figure 9. Countries of origin of irregular migrants moving from Nicaragua to Honduras in 2021 and 2022 (IOM, 2023a)



In Guatemala, Mexico, Costa Rica and Panama, 82% of migrants intended to reach the USA and 9% Mexico (UNHCR and WFP, 2023; 3,456 participants). In Mexico, a survey to 251 migrants indicated that 71% aimed to USA and 39% to Mexico (OIM, 2023c; Tapachula and Tenosique; 251 participants in shelters and public spaces).

At the Southern Mexican border, there is still a high proportion of Venezuelan and Cubans. Migrants from Central America (Honduras, Guatemala and Nicaragua) are well represented (Figure 10).

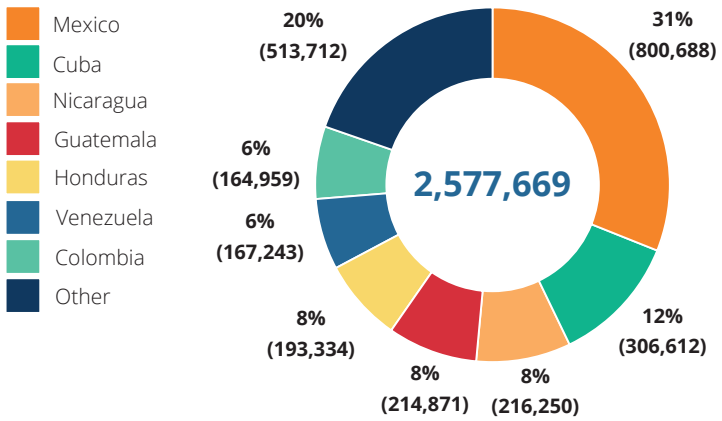
Figure 10. Countries of origin of irregular migrants arriving to Mexico in 2022 (Jan-Nov) (IOM, 2023a)



At the USA border, almost 1 in 3 irregular migrants is from Mexico. Most common origins are Cuba and countries from Central America (Nicaragua, Guatemala, Honduras) (Figure 11)**.**

American and Caribbean citizens are not the only ones transiting through the continent. In 2022, more than 5,000 migrants were coming from countries beyond the Americas, mainly India, Afghanistan and Angola. **In 2023 (up to 31/10/2023), over 32,000 migrants had made their way to Honduras from China, Senegal, Guinea, Mauritania and Uzbekistan (Instituto Nacional de Migración, 2023).**

Figure 11. Countries of origin of irregular migrants identified at the southwest border of the USA in 2022 (IOM, 2023a)



1.3 Demographic profile

In the adult population in transit, surveys show a higher proportion of men than women. The ratio is roughly 60% men–40% women (table 4).

Table 4. Proportion of men and women in migrant adult population

Countries	In-transit migrants
Costa Rica	43% women 57% men R4V, 2022c; 268 participants
Panama	35% women 65% men UNHCR, 2023a; Darien and Chiriqui; 107 participants.
Guatemala Mexico Costa Rica Panama	35% women 65% men UNHCR and WFP, 2023; 3.456 participants

Countries	In-transit migrants
Panama Honduras Costa Rica Mexico Dominican Republic	40% women 60% men OIM, 2023a; 26,800 surveys in adult population from 1/1/2022-31/10/2023

Taking into account minors, the distribution is approximately 16-33% of minors, 24-29% of women, 41-55% of men. There are two exceptions. A much higher proportion of men is returned to Central America. Among Venezuelan migrants in pendular movements between Venezuela and Colombia and Venezuelans settled in Colombia, women (31-46%) and minors (39-45%) are more represented than men (14-26%) (Table 5).

Table 5. Proportion of minors, women and men in migrant population

Countries	In-destination migrants	In-transit migrants
Chile		29% minors 29% women 41% men OIM, 2023d; Colchane; 520 participants
Colombia	Venezuelan migrants in destination: 43% minors 31% women 26% men GIFMM, 2022; 13 regions; 3,295 households Venezuelan migrants in destination 45% minors 31% women 24% men GIFMM, 2023a; 14 regions; 2,387 households	Venezuelan migrants in transit: 33% minors 24% women 42% men Venezuelan migrants in pendular movements: 39% minors 46% women 14% men GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements
		16% minors 29% women 55% men Colombian migration, 2023; 446,805 migrants
Costa Rica		16% minors in the South 14% minors in the North OIM, 2022; Southern and Northern borders; 5,727 and 19,425 migrants respectively

Countries	In-destination migrants	In-transit migrants
Honduras		21% minors 24% women 55% men Consorcio | Life Honduras, 2023; 20,552 migrants
		20% minors 26% women 54% men Instituto Nacional de Migración, 2023; from 01/01/2023 to 10/31/2023
El Salvador, Honduras, Guatemala		2021 Returnees: 20% minors 16% women 64% men 2022 Returnees (up to 11/2022): 19% minors 21% women 61% men OIM, 2023a
Mexico		26% minors 27% women 46% men OIM, 2023c; Tapachula and Tenosique; 251 participants in shelters and public spaces.

According to UNICEF (2023), **migrant groups include a growing proportion of children**. This is observed in the Darien jungle and less clearly at the USA border (table 6). More than half of minors who crossed Darien in 2023 were under 5 (UNICEF, 2023).

As is, the Americas has a higher proportion of minors among migrants and refugees compared to the world average (25% vs 13%). Back in 2019, the proportion of migrant children in the Americas was 19% (UNICEF, 2023).

Table 6. Number of migrant minors crossing through Darien and the USA border (UNICEF 2023)

	2021	2022	2023 Projection*	Trend 2021-2023
Darien Jungle	29,000	40,000	90,000	
USA Border	149,000	155,000	142,286	

*based on 8 first months data for Darien and 7 months data for USA

1.4 Migrant mortality during transit

In 2023, at least 1,148 migrants lost their lives on migration routes in the Americas and the Caribbean. The main causes of deaths were drowning (398); vehicle accidents (290); hostile environment combined with lack of adequate shelter, food, water (150); acts of violence (81); accidental deaths (76); illnesses combined with lack of access to healthcare (36); and mixed or unknown (117).

Most deaths occurred at the border between Mexico and the USA (533), from the Caribbean to the USA (75), El Darien (42) and from Dominican Republic to Puerto Rico (41).

The previous year, in 2022, at least 1,462 migrants were missing (Missing migrants project, 2023).

CHAPTER 2:
Demand for heath services

2.1 Epidemiological profile of migrants

This section provides a description of the burden of disease for in-destination and in-transit migrants by age group: children under five years, children aged 5-17, adults aged 18-59, elder people aged 60+. Whenever the age group was unspecified, the information was included in the adult group.

2.1.1 Children under five years

Low birth weight

In Brazil, during health activities conducted in shelters and spontaneous settlements in Boa Vista and Pacaraima, 24% of births to Venezuelan migrants were classified as low weight birth (UNICEF, 2022; 145 births in total). In Colombia 11% births to Venezuelan migrants were low weight (MinSalud, 2023). In 2020, the national prevalence of low birthweight stands at 5-10% in Brazil and 10-15% in Colombia (WHO, 2023b). **Thus, the proportion of low birthweight to Venezuelan migrants in Colombia is within the national range whereas in Brazil, it is more than double the national average.**

Exclusive breastfeeding

Exclusive breastfeeding prevalence among infants aged 0-5 months ranged as low as 18% in Brazil to as high as 74% in Brazil too (table 7). The world target for exclusive breastfeeding is a rate of 50% by 2025 and 70% by 2030.

Table 7. Exclusive breastfeeding among Venezuelan migrant infants aged 0 to 5 months

	In-destination Venezuelan migrants	In-transit Venezuelan migrants	Host communities
Bolivia	**25%** of 0-5 months exclusively breastfed R4V, 2023a		
Brazil	**18%** of 0-5 months of age exclusively breastfed **35%** of 0-5 months not breastfed at all. UNICEF, 2022; 812 under 5 in shelters and spontaneous settlements of Boa Vista and Paracaima.		**57%** of 0-5 months exclusively breastfed in Northern region of Brazil. **53%** of 0-5 months exclusively breastfed in Brazil. UNICEF, 2022
	74% of 0-5 months of age exclusively breastfed. R4V, 2023d; 11 states; 800 households		
Colombia	**57%** of 0-5 months exclusively breastfed. GIFMM, 2023a; 14 regions; 2,387 households; 84 0-5 months assessed	**El 38%** of 0-5 months in-transit exclusively breastfed. **67%** of 0-5 months in pendular movement exclusively breastfed GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements	
	43% of 0-5 months exclusively breastfed. WFP, 2023; 7,097 participants		
Ecuador	**59%** of 0-5 months exclusively breastfed. **9%** of 0-5 infants not breastfed at all. GTRM, 2023; 23 provinces; 2,541 households		

Nutritional status

According to the international classification of acute malnutrition levels in humanitarian settings (UNHCR, 2019), acute malnutrition prevalence among migrant children under 5 is low in Colombia (2.5-5%), moderate in Bolivia and Honduras (5-10%) and very high in Brazil (over 15%) (Table 8)**.**

According to a classification of chronic malnutrition levels (de Onis *et al.*, 2019), chronic malnutrition prevalence among migrant children under 5 is

moderate in Bolivia (10-20%), between moderate and high in Brazil (20-36%). Depending on the type of migrant, it is moderate or high in Colombia (Table 8)**.**

On the **body mass index** scale, while 17% of under five children were found to be underweight or severely underweight in Brazil, in Colombia overweight and obesity affected between 6-12% and 4-7% of Venezuelan children aged 0-23 months and 24-59 months respectively. There is a double burden of malnutrition (Table 8).

The comparison of nutritional status between migrant and host community children shows sizeable disparities in Brazil but no disparity in Colombia (Table 8).

Table 8. Nutritional status among migrant children under five years

Countries	In-destination Venezuelan migrants	In-transit Venezuelan migrants	Host communities
Bolivia	**2%** of under 5 with severe acute malnutrition **5%** of under 5 with moderate acute malnutrition **31%** of children aged 2 to 23 months with chronic malnutrition **12%** of children aged 2 to 59 months with chronic malnutrition R4V, 2023a; Desaguadero, El Alto y La Paz		
Brazil	**17%** of under 5 with acute malnutrition, of which **4%** with severe acute malnutrition **11%** of under 5 with acute malnutrition in Boa Vista, Roraima **20%** of under 5 with acute malnutrition in Pacaraima, Roraima **4%** with very low height/age (chronic malnutrition) **16%** with low height/age (chronic malnutrition) **4%** of under 5 severely underweight **13%** of under 5 underweight **0%** of under 5 obese UNICEF, 2022; 812 under 5 in shelters and spontaneous settlements of Boa Vista and Paracaima		**4%** of under 5 with acute malnutrition in Roraima state, Brazil **6%** of under 5 with acute malnutrition in Brazil R4V, 2022a

Countries	In-destination Venezuelan migrants	In-transit Venezuelan migrants	Host communities
Colombia	**Acute malnutrition** **0%** of under 5 with severe acute malnutrition **2%** of under 5 with moderate acute malnutrition **Chronic malnutrition** **18%** of under 5 with chronic malnutrition **Overweight/obesity** **8%** of 0-23 months overweight **2%** of 0-23 months obese **3%** of 24-59 months overweight **1%** of 24-59 months obese WFP, 2023; 13 regions; 831 under 5 in destination assessed	**Acute malnutrition** **3%** of under 5 in-transit with severe acute malnutrition **2%** of under 5 in-transit with moderate acute malnutrition **2%** of under 5 in pendular movements with severe acute malnutrition **2%** of under 5 in pendular movements with moderate acute malnutrition **Chronic malnutrition** **16%** of under 5 in transit with chronic malnutrition **26%** of under 5 in pendular movements with chronic malnutrition **Overweight/obesity** **3%** of 0-23 months in-transit overweight **3%** of 0-23 months in-transit obese **6%** of 0-23 months in pendular movements overweight **6%** of 0-23 months in pendular movements obese **6%** of 24-59 months in-transit overweight **1%** of 24-59 months in-transit obese **3%** of 24-59 months in pendular movements overweight **2%** of 24-59 months in pendular movements obese WFP, 2023; 135 under 5 in-transit assessed and 216 under 5 in pendular movements assessed	**Acute malnutrition** **1%** of under 5 with severe acute malnutrition **2%** of under 5 with moderate acute malnutrition **Chronic malnutrition** **16%** of under 5 with chronic malnutrition **Overweight/obesity** **10%** of 0-23 months overweight **3%** of 24-59 months overweight **1%** of 24-59 months obese WFP, 2023, 395 under 5 assessed

Countries	In-destination Venezuelan migrants	In-transit Venezuelan migrants	Host communities
		3% of under 5 in pendular movements with severe acute malnutrition **20%** of under 5 in-transit with low height/age (chronic malnutrition) **23%** of under 5 in pendular movements with low height/age (chronic malnutrition) GIFMM, 2022; 13 regions; 717 participants in-transit and 648 participants in pendular movements; 58 under 5 in-transit assessed and 217 under 5 in pendular movements assessed	
Honduras*		**5%** of under 5 with moderate acute malnutrition **2%** of under 5 with severe acute malnutrition Consorcio | Life Honduras, 2023; 445 migrants under 5 years assessed in January 2023.	

*Data for Honduras is for migrants from mixed origins.

With regards to anemia, in Bolivia and Colombia, 31 to 65 % of migrant children under five presented some degree of anemia. The prevalence of anemia among Colombian children was included within this range (49%) (table 9).

Leaving aside mild anemia, the lowest prevalence of moderate or severe anemia prevalence was found among migrant children under 5 settled in Colombia and Colombian children under 5 (18%). The highest prevalences affected Venezuelan children under 5 in pendular movements (36%) and in Bolivia (over 30%). **In other words, moderate or severe anemia affects as many as one in three or one in five children** (table 9).

Table 9. Anemia among Venezuelan migrant children under five years

Countries	In-destination Venezuelan migrants	In-transit Venezuelan migrants	Host communities
Bolivia	**65%** of under 5 with some degree of anemia **More than 30%** of under 5 with moderate or severe anemia R4V, 2023a; Desaguadero, El Alto and La Paz		
Colombia	**26%** of under 5 with mild anemia **17%** of under 5 with moderate anemia **1%** of under 5 with severe anemia WFP, 2023; 13 regions; 831 under 5 in destination assessed	**13%** of under 5 in-transit with mild anemia **30%** of under 5 in-transit with moderate anemia **1%** of under 5 in-transit with severe anemia **19%** of under 5 in pendular movements with mild anemia **34%** of under 5 in pendular movements with moderate anemia **2%** of under 5 in pendular movements with severe anemia WFP, 2023; 135 under 5 in-transit assessed and 216 under 5 in pendular movement assessed	**31%** of under 5 with mild anemia **16%** of under 5 with moderate anemia **2%** of under 5 with severe anemia WFP, 2023; 13 regions; 395 under 5 assessed
		31% of under 5 in-transit with anemia **37%** of under 5 in pendular movements with anemia GIFMM, 2022; 13 regions; 717 participants in-transit and 648 participants in pendular movements; 58 under 5 in-transit assessed and 217 under 5 in pendular movements assessed	

To assess infant and young child feeding practices, the WHO and UNICEF recommend an indicator called Minimum Acceptable Diet which consists of the proportion of children between 6 and 23 months who receive a minimum frequency and variety of foods. **In Colombia, 24% of Venezuelan children in-destination (GIFMM, 2023a; 14 regions; 2387 households; 337 children under 2), 18% of those in pendular movements and 3% of those in transit had a Minimum Acceptable Diet (R4V, 2023a).** Compared to the previous year, the value of the indicator has deteriorated for children in destination and in transit. In 2022, the proportions for the three groups were estimated as follows: 35%, 14% and 11% (R4V, 2023a).

Acute conditions

Information on acute conditions among children under 5 is limited to one study among Venezuelan migrants settled in Lima, Peru. **In the previous month to the survey, 35% of under 5 years had a medical condition:** respiratory condition/allergy (84%); diarrhea (12%); malnutrition (3%); musculoskeletal problems (2%); parasitosis (2%); mental health problem (2%); relapse of chronic disease (2%); other (6%) (OPS, 2022; Lima; 426 households).

In the focus group discussions, which were part of the same study, participants pointed to diarrhea and anemia/malnutrition as the main issues in this age category. Diarrhea affected all age groups but particularly infants, children and adolescents. Participants identified lack of access to drinkable water as the main reason for diarrhea (OPS, 2022).

Vaccines

Vaccine coverage among in-destination Venezuelan under five years migrants seems quite consistent in Brazil, Ecuador and Peru. **About 70% of children were fully vaccinated** (table 10). The recommended vaccination coverage for diphtheria, pertussis, tetanus, Neisseria meningitidis, Streptococcus pneumoniae is 90% (Immunization Agenda 2030, 2021).

Table 10. Vaccine coverage among Venezuelan migrants under five years

	Migrantes venezolanos en destino
Brazil*	**69%** of under 5 received the number of vaccines recommended by Brazilian authorities. UNICEF, 2022; 812 under 5 in shelters and spontaneous settlements of Boa Vista and Paracaima
Ecuador	**75%** of under 5 completed the regular vaccination schedule. **15%** of under 5 had not received any vaccine included in the regular vaccination schedule. **8%** received some vaccinations. GTRM, 2023; 23 provinces; 2,541 households
Peru	**73%** of 0-3 years completed the regular vaccination schedule. OPS, 2022; Lima; 426 households; 121 children 0-3 years

*Data for Brazil is a combination of Venezuelan in-destination and in-transit migrants.

Chronic diseases

Two studies provided information on chronic diseases estimates among Venezuelan migrants aged 0-5 years settled in Peru. **One study at the national level yielded a proportion of 4%** (INEI, 2022; 8 cities; 3,680 households). **Another study in Lima with a broad definition of chronic diseases estimated a proportion of 10%** with the following distribution of conditions: 15% anemia; 15% neurological problems; 10% asthma; 10% heart problems; 10% lactose intolerance; 5% allergies; 5% pulmonary disease; 5% mental health problem; 5% developmental problem; 5% musculoskeletal problem; 10% other diseases; 10% do not remember (OPS, 2022; Lima; 426 households).

Disability

A study among migrants settled in Lima provides insights on the disability level in the 0- 5 years age group: 2% had a speech disability; 2% a cognitive disability; 2% motor disabilities; 2% disability for social relations (OPS, 2022; Lima; 426 households).

2.1.2 Children and adolescents (6-17 years)

Nutritional status

15%-45% of school aged children and adolescents (6-17 years) were suffering from anemia (table 11).

The double burden of malnutrition is observed in this age category too. While 13% of children in transit aged 5 to 9 were overweight in Colombia, **10-24% were found underweight in Brazil and Bolivia and 20% of children aged 5 to 9 in pendular movements in Colombia had a low height for her/his age (chronic malnutrition)** (table 11).

Table 11. Nutritional status of Venezuelan migrants aged 5-17 years

	In-destination Venezuelan migrants	In-transit Venezuelan migrants
Bolivia	**6% o**f children aged 5-17 severely underweight **18%** of children aged 5-17 underweight **45%** of children aged 5-17 with anemia R4V, 2023a; Desaguadero, El Alto and La Paz	
Brazil	**0%** of children aged 5-17 severely underweight **10%** of children aged 5-17 underweight UNICEF, 2022; shelters and spontaneous settlements of Boa Vista and Paracaima	
Colombia		**13%** of children aged 5 to 9 in transit overweight **15%** of children aged 5 to 9 in transit with anemia **3%** of children aged 5 to 9 in pendular movements underweight **20%** of children aged 5 to 9 in pendular movements with low height/age (chronic malnutrition) **37%** of children aged 5 to 9 in pendular movements with anemia GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements; 41 children in transit aged 5-9 assessed and 119 children in pendular movements aged 5-9 assessed

Acute conditions

In Lima, Peru, in the previous month, 34% of Venezuelan migrants aged 6-17 had a medical condition. Of these, 77% had a respiratory condition/ allergy; 6% skin problems; 6% neurological problems; 5% diarrheal disease; 3% anemia or malnutrition; 3% musculoskeletal problems; 2% parasitosis, 2% relapse of chronic disease; 6% other (OPS, 2022; Lima; 426 households).

In the focus group, **participants from Lima, Peru mentioned that children and adolescents suffered mostly from numerous accidents due to physical activity, respiratory diseases, diarrhea, mental health issues and menstrual abnormalities (OPS, 2022).**

Child and adolescent pregnancy

One out of 10 pregnancies in the Venezuelan migrant population was from a girl. Between 2021 and 2022 there has been a surge of 68% pregnancies among Venezuelan girls below 12 in Colombia (from 37 to 58) (MinSalud, 2023). The minimum age for sexual consent in Colombia being 14 years, it entails that in 2021 and 2022 there were 619 and 754 rapes among Venezuelan girls respectively (table 12).

Table 12. Child and adolescent pregnancy among Venezuelan migrants

	In-destination Venezuelan migrants	In-transit Venezuelan migrants
Brazil	**11%** of Venezuelan pregnant girls/women were under 18 UNICEF, 2022; shelters and spontaneous settlements of Boa Vista and Paracaima	
Colombia	**11%** of Venezuelan girls/women who gave birth were under 18 in 2022 R4V, 2023a **2021** **9%** of Venezuelan pregnant girls/women were under 18 **37** pregnancies in girls under 12 **717** pregnancies in girls aged 12-14 **9009** pregnancies in girls aged 15-17 **2022** **10%** of Venezuelan pregnant girls/women were under 18 **58** pregnancies in girls under 12 **561** pregnancies in girls aged 12-14 **5837** pregnancies in girls aged 15-17 MinSalud (2023)	
	11% of Venezuelan pregnant women were under 18 GIFMM, 2023a; 14 regions; 2,387 households	
Ecuador	**1%** of household with a pregnant child/adolescent **1%** of household with a lactating child/adolescent GTRM, 2023; 23 provinces; 2,541 households	

Vaccines

A study in Brazil revealed that 70% of migrants aged 5-17 years had completed the regular vaccine calendar (UNICEF, 2022). This is approximately the same coverage as for children under 5 years.

Chronic diseases

Two studies among Venezuelan migrants aged 6-17 years settled in Peru provide chronic diseases estimates. One study at the national level yielded a proportion of 8% living with chronic diseases (ENPOVE, 2022; 8 cities; 3680 households). **Another study in Lima with a broad definition of chronic diseases estimates a proportion of 20%** with the following distribution of conditions: 54% asthma; 13% allergies; 13% neurological problems; 5% diabetes; 3% thyroid disease; 3% mental health problems; 3% musculoskeletal problems; 3% other diseases (OPS, 2022; Lima; 426 households).

These are the same sources used for children under the age of 5. For both groups, one of the sources provided double the estimate of the other source.

Disability

According to a study among migrants in transit in Colchane, Chile, **9% of children and adolescents (aged 0 to 17) had difficulties to perform some daily tasks:** 4% did not communicate easily; 3% had issues seeing (OIM, 2023; Colchane; 420 surveys).

2.1.3 Adults aged 18-59 years/general population

Under this section the information refers to adults aged 18-59 years and general population. When age range is known, it is specified.

Nutritional status

Only one source of information was found on migrant adults´ nutrition status. Among Venezuelan adults settled in Colombia, **approximately half were overweight or obese, less than 10% were underweight** (Red Somos, 2023; Bogota, Soacha, Barranquilla, Soledad; 6221 participants).

Acute conditions

For both migrants settled and in transit, the most common acute conditions reported were respiratory infections, gastrointestinal conditions, diarrhea, skin problems, mental health and conditions related to maternal health (table 13).

Migrants in displacement had conditions specific to their displacement such as wounds, dehydration, joint injuries, insolation.

Among migrant adult men, data in Colombia show frequent head, wrist and hand trauma (MinSalud 2023). This may due to work accidents. Irregular migrant men often have to work in precarious and physical occupations (OPS, 2022; Lima). Men may also be victims of violence especially when they are

involved in illegal activities such as organized crime and drug trafficking in border areas (GIFMM, 2022; R4V, 2023a).

Between 2021 and 2022, a rise in infectious diseases has been documented in Colombia: over 100 additional notifiable cases have been reported for each of the following diseases: dengue, HIV/AIDS, malaria, varicella, tuberculosis.

A sharp increase in suicidal attempts, gender-based violence (GBV) and domestic violence has been registered. Almost 3,000 cases of GBV and domestic violence were reported in the first 24 weeks of 2022. Of note, these cases may relate to migrants who have settled, in displacement or those who come and go between Venezuela and Colombia (table 13).

Table 13. Acute conditions among migrant adults

	In-destination migrants	In-transit migrants
South America		
Brazil	Main conditions of Venezuelan migrants were respiratory and gastrointestinal symptoms. R4V, 2022a	
Chile	In the past six months, **51%** of Haitians had acute illnesses: 46% had common cold, 2% gastritis and 2% influenza. Luengo Martinez *et al.*, 2021; Chillan; 41 haitianos	
Colombia	**Main diagnosis among Venezuelan migrants** (irregular migrants can only access emergency): **Ambulatory care** Women: 3% hypertension; 3% care related to fetus, amniotic cavity and possible delivery issues; 2% non-inflammatory disorders of the female genital organs. Men: 5% HIV AIDS; 5% hypertension; 3% acute respiratory infection. **Emergency consultation** Women: 18% diagnosis related to pregnancy and delivery. Men: 7% head trauma; 6% wrist and hand trauma; 6% acute respiratory infection **Emergency** Women: 15% diagnosis related to pregnancy and delivery; 4% urinary tract conditions. Men: 7% head trauma; 5% wrist and hand trauma; 4% urinary lithiasis.	

	In-destination migrants	In-transit migrants
	Hospital admissions Women: 38% diagnosis related to pregnancy and delivery. Men: 5% infections of the skin and subcutaneous tissue; 5% wrist and hand trauma; 5% head trauma. MinSalud, 2022	
	Most common notifiable conditions in the first 24 weeks of 2022 among Venezuelan population: GBV and domestic violence (2,907); extreme maternal morbidity (1,740); aggressions by animals potentially transmitting rabies (1,595); malaria (1,569); gestational syphilis (1,485); HIV/AIDS (1,345); low birth weight (1013); dengue fever (682); tuberculosis (519); late perinatal and neonatal mortality (502); poisoning (458); suicide attempts (404); acute malnutrition in children under 5 years of age (387); varicella (264); congenital syphilis (158); unusual severe acute respiratory infection (130); ophidic accident (116); surgical site infections due to surgical procedure (108). INS, 2022	
	The comparison between the first 24 weeks of 2021 and 2022 showed 2944 more occurrences of notifiable conditions among Venezuelan. Over 100 additional cases were registered for each of the following notifiable conditions: GBV and domestic violence (+557); attacks by animals potentially transmitting rabies (+542); dengue (+396); HIV/AIDS (+308); malaria (+307); varicella (+155); tuberculosis (+154); suicide attempt (+129). INS, 2022	
		35% of travel groups reported that they suffered from illnesses during their transit. R4V, 2023a
Peru	In the past month, **52%** of Venezuelan households faced a health issue: 25% had respiratory condition/allergy; 18% mental health problem; 12% diarrhea; 10% gastrointestinal illness; 4% skin condition; 3% malnutrition; 2% chronic disease relapse; 2% parasitosis. ACH, 2022a; Lima; 374 participants	
	In the past month, **42%** of Venezuelan migrants aged 18-59 faced a health issue. Of these, 67% had respiratory condition/allergy; 7% chronic disease relapse; 6% had gynecologic problems and 6% had gastrointestinal illness. OPS, 2022; Lima; 426 households	

	In-destination migrants	In-transit migrants
Central America		
Border points in Panama, Costa Rica, El Salvador, Honduras, Guatemala, Mexico		Most common health conditions of migrants were: wounds (25%); other (16%); insect bite (16%); dehydration (14%); allergy (12%); joint injury (9%); sun burn/ insolation (8%). Other conditions include diarrhea, vomiting, headaches, fluid retention, preeclampsia in pregnant women, vaginal infections, colds common, respiratory problems, fevers, abscesses, malnutrition. IFRC, 2022a; Panamá, Costa Rica, El Salvador, Honduras, Guatemala, México; 586 participants
Honduras		Increase in infectious, gastrointestinal and dermatological diseases. Increased demand for pregnancy tests Post-traumatic disorders ACH, 2022b
North America		
Canada	Infectious diseases, mental health conditions, anemia, diabetes, dental caries, poor nutritional status Salami *et al.*, 2022	

> *"I have severe pain in my hip, in my legs and I can't walk well. I found out that my brother had an accident in Nicaragua and I haven't heard from him for two days. I really don't know what to do and this makes me feel very helpless, very stressed because I can't do anything for him."*
>
> Pakistani migrant man, Honduras (MSF, 2023b)

> *"She got sick in the jungle [his one-year-old daughter has been suffering for more than five days with acute diarrhea and a high fever], and we ran out of money because they took everything from us in other countries. We've been in Honduras for more than three days. My wife suffers from severe headaches, and at night she wakes up because she dreams that she's still in the jungle—still in the river."*
>
> Venezuelan migrant man, Honduras (MSF, 2023a)

> *"In the office we treat digestive diseases, fevers, skin disorders. We have had to refer dozens of cases to hospitals. We have also seen minors with dehydration and bloody diarrhea. Sometimes we have had to stabilize them on the spot. Respiratory illnesses are also common, due to the sudden changes in the environment to which these people are exposed."*
>
> Nurse, Honduras (MSF, 2023b)

Sexual and reproductive health

A survey in Brazil unveils that about 2 in 3 pregnant migrant women did not want to be pregnant. The exact percentage is 71% for Venezuelan pregnant women in destination (Moverse, 2022; all regions but Roraima; 2,000 participants) and 64% for Venezuelan pregnant women in transit (Moverse, 2022; Roraima; 682 participants from shelters).

Multiple constraints affect sexual and reproductive health of migrant women during transit: sexual violence; transactional sex; limited access to preventive and post-exposure healthcare and legal services; limited access to water, sanitation and menstrual pads for menstrual hygiene (Letona *et al.*, 2023).

> *"To be honest, I lived it [trading sex for transport and food]. At that moment when my sister got seriously ill, I experienced it with the man who took us from Lima to Tacna. He never stopped taking care of my sister, he always gave us food... Necessity obliges..."*
>
> Venezuelan migrant woman, 19, Chile
>
> *"I have heard that too often, sexual abuse. For example, truckers are predators ... "I'll take you, as long as...". That, of course, for both men and women. Or, for example, it happened to my wife too, she used to ride up in the front and fall asleep, tired from the road, and they would touch her breasts, her private parts. Things like that. That's where it starts. And in men too, they offer money, things like that."*
>
> Venezuelan migrant man, 24, Chile
>
> *(Obach, et al., 2022)*

Infectious diseases

Four data analyses or studies related to sexually transmitted infections (STI) in four countries were identified (HIV/AIDS, syphilis, herpes (VHS-2)). In all of them, **the prevalence among migrants was about twice as much as the national prevalence, which points towards a higher vulnerability to STI** (table 14).

The reported values for syphilis prevalence in Colombia and the Americas date from 2016 and 2019. Since then, syphilis prevalence has increased in the country and the continent. High syphilis prevalence among migrants is in line with the findings under the section on acute conditions. In the first 24 weeks of 2022, 1,485 cases of gestational syphilis and 158 cases of congenital syphilis among Venezuelan migrants were reported to the national surveillance system in Colombia (INS, 2022).

Aside from STI, data reported under the section on acute conditions suggested **ongoing transmission of other infectious diseases among Venezuelan migrants in Colombia.** The comparison between the first 24 weeks of 2021 and 2022 revealed additional cases of dengue (+396); malaria (+307); varicella (+155) and tuberculosis (+154) (INS, 2022).

Table 14. Infectious diseases among migrant adults

	In-destination migrants	In-transit migrants	Host communities
Brazil	**Comparison of detection rate of HIV/AIDS in Roraima (bordering region near Venezuela) vs national in 2022** HIV/AIDS detection rate in Roraima: **29.3 per 100,000** HIV/AIDS detection rate among pregnant women in Roraima: **5.6 cases/1,000 live births** **28%** of new HIV/AIDS cases were from Venezuelans, an increase of 32% compared to 2021. R4V, 2023a		National HIV/AIDS detection rate: **16.5 per 100,000** National HIV/AIDS detection rate among pregnant women: **3 cases/1,000 live births**
Colombia	**HIV/AIDS** **1%** of Venezuelan migrant adults had laboratory-confirmed HIV. Estimated prevalence in Venezuelan migrant population: **1%.** Estimated prevalence in Venezuelan key populations: **6%.** Estimated number of Venezuelan living with HIV/AIDS: **22,300.** **Syphilis** **5%** of Venezuelan migrants had laboratory-confirmed syphilis infection. Estimated prevalence in Venezuelan migrant population: **5%** Estimated prevalence in Venezuelan key populations: **13%** **Syphilis and HIV** **24%** of Venezuelan migrants living with HIV had a syphilis co-infection. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants		**0.5%** estimated national HIV prevalence in Colombia and Venezuela. **1%** estimated syphilis prevalence among Colombian adults in 2016 Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants
Peru	Estimated number of Venezuelan living with HIV/AIDS: **8,000**. Estimated HIV rate: 1% R4V, 2023a		**0.3-0.4%** is the estimated HIV rate. R4V, 2023a
Mexico		**5%** of migrants have syphilis **30%** of migrants have herpes (VHS-2) Sánchez-Alemán *et al.*.2023; Chiapas; 462 migrants in shelters	Estimated syphilis prevalence in the Americas in 2016: **0.9%** **13%** estimated global VHS-2 prevalence in 2016 Sánchez-Alemán *et al.,* 2023

Chronic diseases

The proportion of migrants with chronic diseases was 13-15% among migrants in transit and 7-29% among migrants in destination. Among migrants in destination, the most common chronic diseases are hypertension, diabetes, asthma, cardiovascular diseases. Other less prevalent conditions include arthritis, mental health and cancer (table 15).

Earlier, the only one source on adult migrants' nutritional status indicated that over half of them were overweight/obese (refer to section 2.1.3/nutritional status), which may explain hypertension, diabetes and cardiovascular diseases prevalence.

Table 15. Chronic diseases among migrant adults

	In-destination migrants	In-transit migrants
Chile	**15%** of Venezuelans entering Chile suffered a chronic medical condition that required treatment. OIM, 2021; 8 regions; 300 participants	**15%** of migrants had a chronic disease OIM, 2023d; Colchane; 520 participants
	20% of Haitians had a chronic disease: 10% hypertension, 8% diabetes; 2% dyslipidemia. Luengo Martinez *et al.,* 2021; Chillan; 41 Haitians	
Colombia	**20%** of Venezuelan migrants had one or more chronic pathologies. GIFMM, 2023a; 14 regions; 2,387 households	
	19% of Venezuelan migrants had a diagnosis of a chronic disease: 6% hypertension; 2% diabetes; 1% chronic kidney disease. GIFMM, 2023a; 14 regions; 2,387 households	
	9% of households had a member with a chronic disease. Of these, 63% had hypertension, 23% diabetes; 16% heart problems; 16% respiratory problems. GIFMM, 2022; 13 regions; 3,295 households	
Ecuador	**30%** of surveyed Venezuelan households had a member with a chronic disease. Most common conditions were hypertension (32%); asthma (20%); cardiovascular diseases (9%); diabetes (8%); osteoarthritis (8%); cancer (4%); anemia (3%); epilepsy (3%); thyroid (2%); HIV (2%). GTRM, 2023; 23 provinces; 2,541 households	
Guyana	**7%** of Venezuelan migrants had a chronic medical condition. Of these, 21% had diabetes; 21% asthma; 18% hypertension; 8% heart disease. IOM, 2021; 6 regions; 1,363 participants	

	In-destination migrants	In-transit migrants
Peru	**29%** of Venezuelan migrants aged 18-59 suffered from some chronic disease or illness: hypertension (15%); diabetes (4%). OPS, 2022; Lima; 426 households	
	11% of Venezuelan migrants aged 18-29 had chronic diseases; 13% of those aged 30-44; 31% among those aged 45-59. **14%** of Venezuelan migrants suffered from some chronic disease or illness. Of these 32% have asthma; 26% hypertension, 10% diabetes; 5% arthritis; 5% heart problems; 2% cancer; 2% cholesterol; 1% mental health disorders; 1% rheumatism. INEI, 2022; 8 cities; 3,680 households	
	28% of Venezuelan migrants suffered from some chronic disease or illness. Of these 32% had hypertension; 22% asthma, 10% diabetes; 4% cancer; 4% arthritis; 3% heart problems; 3% HIV/AIDS; 2% cholesterol; 2% mental health disorders; 1% obesity; 1% rheumatism; 33% others. ACH, 2022a; Lima; 374 participants	
	29% of Venezuelan migrants aged 18-59 lived with a chronic disease including 15% with hypertension; 4% with diabetes. OPS, 2022; Lima; 426 households	
	26% de los migrantes venezolanos padecía una enfermedad crónica. DRC and SJM, 2021; Lima; 996 participants	
Panama		**5%** of those having transited the Darien reported having travelled with someone with a chronic or critical medical condition UNHCR, 2023a; Darien and Chiriqui; 107 participants
Border points in Panama, Costa Rica, El Salvador, Honduras, Guatemala, Mexico		**13%** of migrants had hypertension or/ and diabetes. **84%** did not know whether they had a chronic disease. **3%** had no chronic disease. IFRC, 2022a; Panamá, Costa Rica, El Salvador, Honduras, Guatemala, México; 586 participants

Mental health

Migrants face mental health issues. It is, however, difficult to grasp the scope of the issue as most surveys are small studies and do not use standard instruments. Some questionnaires rely on mental health self-perception, others on the existence of mental health symptoms, others on a combination of mental health symptoms and frequency, others on a diagnostic (anxiety or depression), others on diverse standardized instruments.

A shortlist of studies using standardized tools shows that **21-90% of migrants had moderate or high anxiety and/or depression** (90% comes from a small-scale study and is an outlier compared to studies that use standardized tools). About 15% of Venezuelan migrants in Peru had suicidal thoughts. 21% of Venezuelan migrant population in Colombia had hazardous or active alcohol use disorders (table 17). Under the section on acute conditions, it was observed that suicide attempts among Venezuelan migrants in Colombia, were common and on the rise. It cannot be excluded that the high prevalence of gender-based and domestic violence observed among migrants in Colombia is related to mental health issues.

Of note, 30% of mental healthcare provided to migrants in the Colombian public system concerned children (R4V, 2023a). A study by IFRC underlines the **need for psychosocial support for migrant children** in Central America as they look sad, lack appetite, feel fear and report suicidal thoughts (IFRCa, 2022)

Table 16. Mental health among migrant adults

	In-destination migrants	In-transit migrants
Chile	**10%** of Venezuelan migrants considered their mental health as bad. R4V, 2023[a]	**67%** of migrants rated their mental health as good or very good.. OIM, 2023d; Colchane; 520 participants
Colombia	**82%** of Venezuelan households reported mental health symptoms: 63% fear; 50% anxiety; 43% depression. GIFMM, 2023a; 14 regions; 2,387 households	**81%** of Venezuelan migrants in transit and **59%** of Venezuelan migrants in pendular movements had a mental health symptom such as fear, anxiety, uncertainty, sleep disorders, anger.GIFMM, 2022; 13 regiones; GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements
	An estimated **21%** of Venezuelan migrant population had moderate to severe anxiety or depression according to the Patient Health Questionnaire for Depression and Anxiety (PHQ-4). An estimated **21%** of Venezuelan migrant population had hazardous or active alcohol use disorders according to AUDIT-C. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants	

	In-destination migrants	In-transit migrants
	Between March 2017 and May 2023, 32,747 migrants received mental healthcare through the public system (30% were children). Most frequent diagnoses were psychoactive substance abuse and schizophrenia. R4V, 2023[a]	
Ecuador	**62%** of migrants from Venezuela, Colombia, Bolivia in one middle-size city had low self-esteem and 26% middle level self-esteem as per Rosenberg self-esteem scale. **71%** and **19% (90%)** had high and medium levels of anxiety respectively as per State-Trait Anxiety Inventory tool. Medina García and Gavilanes Gómez, 2022; Ambato; 100 participants	
Peru	**47%** of Venezuelan migrants had anxiety and/or depression according to the WHO self-reporting questionnaire. **33%** of Venezuelan migrants classified as low in the WHO-5 Well-being index. **15%** of Venezuelan migrants reported suicidal thoughts. CAPS, 2022; Lima and Tumbes; 300 participants	
	About half of Venezuelan migrants felt worried or sad all the time or most of the time. Consejo Danés para Refugiados and SJM, 2023	

> *"We want a space in hospitals for mental health because we have many Venezuelan people who have been raped, have psychiatric problems and practice prostitution."*
>
> *"Loneliness has been the hardest thing I have ever experienced."*
>
> *"My biggest fear is dying here, because I'm alone, I don't have anyone, I don't have a family, if I die, I die alone"*
>
> *"The street is hard, with the street comes the cold, then comes hunger, then comes despair and then depression, and finally vices, and we do not have the tools to get out of that situation".*
>
> Migrants, Peru (IRC, 2021)

A survey among Venezuelan migrants in Colombia illustrates the relationship between mental health problems and livelihood difficulties. Among households reporting at least one mental health symptom, 81% lacked resources to buy food, 14% had health needs and 9% had education needs (GIFMM, 2023a; 14 regions; 2,387 households). Likewise, a study on anxiety among Central American Migrants in Mexico put forward that for most migrants, their anxiety symptoms can be resolved through humanitarian aid that would take care of their everyday needs while another significant proportion of migrants require psychosocial support (Berenzon Gorn *et al.*, 2023).

It is worth noting some of the possible traumatic events along the journey in the Darien jungle. 1 in 3 experienced mistreatment or abuse; 15% were victims of threats, intimidation and attacks; 67% were affected by physical security (attacks, drownings, falls); 50% saw between 1 and 15 cadavers during the 7 days prior to data collection (UNHCR, 2023a; Darien and Chiriqui; 107 participants).

Disability

There were a few sources of information on disabilities. 10-23% of migrants in displacement and 2-26% of settled migrants had a disability (table 16). In the latter group, the most common disabilities were physical/motor and sensory. Usually, studies refer to the Washington Group scale, a standard classification of disability, which enables comparison between countries (table 16).

Some of the proportions are much lower, others much higher than the global proportion of 15% (Consejo Danés para Refugiados, 2022a).

Table 17. Disability among migrant adults

	In-destination migrants	In-transit migrants
South America		
Argentina	**17%** of migrants had some disability. Most frequent disabilities were physical (64%) and sensory (23%). Consejo Danés para Refugiados, 2022a	
Brazil	**14%** of Venezuelan households reported that at least one member had a disability. Of these, 54% indicated physical disability, 32% intellectual disability and 26% sensory disability. R4V, 2023d; 11 states; 800 households	
Chile		**10%** of migrants had a disability. OIM, 2023d; Colchane; 520 participants
Colombia	**11%** of Venezuelan migrants had a disability. Consejo Danés para Refugiados, 2022a	
Ecuador	**8%** of migrants had a disability. Consejo Danés para Refugiados, 2022a	
	20% of surveyed Venezuelan households had a member with disability. GTRM, 2023; 23 provinces; 2,541 households	
Guyana	**3%** of Venezuelan migrants lived with a disability. Of these, 46% have a motor disability; 22% have sensorial disabilities; 20% have multiple disabilities. IOM, 2021; 6 regions; 1,363 participants	
	Indigenous Venezuelan migrants had the following disabilities: 8% seeing; 5% communication; 4% hearing; 4% walking; 4% cognitive; 3% self-sufficiency. IOM, 2023b; 4 regions; 162 participants	

	In-destination migrants	In-transit migrants
Peru	**2%** of Venezuelan migrants lived with a permanent disability. INEI, 2022; 8 cities; 3,680 households	
	26% of Venezuelan migrants had a disability. DRC and SJM, 2021; Lima; 996 participants	
Central America		
Border points in Panama, Costa Rica, El Salvador, Honduras, Guatemala, Mexico		**23%** of migrants had disabilities: 10% seeing; 7% walking and climbing stairs; 5% cognitive; 3% hearing; 3% communication; 2% self-sufficiency. IFRC, 2022a; Panamá, Costa Rica, El Salvador, Honduras, Guatemala, México; 586 participants
Honduras		**7%** of groups included a member with disability. Consorcio | Life Honduras, 2023; 20,552 migrants
Caribbean		
Trinidad and Tobago	**10%** of migrants reported having a lot or complete difficulty to see, even if wearing glasses. **10%** had complete difficulty to walk or climb step. UNHCR, 2023c; 12 regions; 1,286 households.	
North America		
Mexico	Among migrants with disability, most frequent type of disability were visual (33%) and sensory (43%). Consejo Danés para Refugiados, 2022a	**11%** of migrants had difficulty seeing; hearing (1%); speaking (2%); walking or climbing stairs (2%); remembering or concentrating (1%) OIM, 2023c; Tapachula and Tenosique; 251 participants in shelters and public spaces

Violence

Migration has become a source of income for criminal groups all throughout the continent. **Migrants are often victims of all types of violence: physical, psychological, sexual.** A study in Colombia shows than in 60% of cases the perpetrator was a stranger (Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants). In 2022, out of the 47 femicides of Venezuelan migrant women in Colombia, 12 were perpetrated by criminal bands and 11 by the women´s life partners (*Red feminista antimilitarista*, 2023).

Among migrant men and women in transit, about 13-18% had experienced violence. 5-33% of traveling groups knew a victim of GBV (table 18).

Among settled migrants, 5-13% of men and women had experienced some form of violence. The range is higher for women only: 10-31% (table 18).

Table 18. Violence among migrant adults

	In-destination migrants	In-transit migrants	Host communities
South America			
Argentina	**31%** of women experienced some form of GBV. **3%** of men experienced some form of GBV. R4V, 2022b		
Bolivia	**More than 20%** per cent of Venezuelan refugee and migrant women survived a GBV incident in either La Paz or Santa Cruz de la Sierra. R4V, 2023a		
Brazil	**5%** of Venezuelan women and men suffered violence. Of these, 54% experienced physical violence, 44% psychological violence, 12% sexual violence. Moverse, 2022; all regions but Roraima; 2,000 participants	**13%** of Venezuelan women and men suffered violence. Of these, 43% experienced physical violence, 44% psychological violencel. Moverse, 2022; Roraima; 682 participants from shelters	

	In-destination migrants	In-transit migrants	Host communities
Colombia	**15%** of Venezuelan households have one or more members who reported having suffered psychological or physical violence. 68% of victims are women, 30% are children. R4V, 2023a	**16% o**f travel groups in transit and **5%** of the pendular population reported knowing a survivor of GBV. Between 2021 and 2022, the number of cases reported to authorities by Venezuelan women increased by 11% in sexual assaults and 32% in intimate partner. R4V, 2023a	
	3% of Venezuelan knew a GBV victim. GIFMM, 2022; 13 regions; 3,295 households	**33%** of Venezuelan in transit knew a GBV victim. **7%** of Venezuelan in pendular movements knew a GBV victim. GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements	
	6% of Venezuelan migrants experienced psychological, physical, and/or sexual violence in the past 12 months. **12%** experienced violence while living in Colombia. Most common types of violence are psychological abuse (8%); physical violence (7%); sexual exploitation (2%); sexual violence (1%). In all types of violence, the perpetrator was a stranger in most cases (60%). **10%** of Venezuelan migrant women reported experiences of violence while living in Colombia. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants		In 2018, in Colombia **20%** and **12%** of ever-partnered women reported lifetime or past 12 months intimate partner violence. In Venezuela, for the same year, the estimates were 19 and 8% respectively. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants

	In-destination migrants	In-transit migrants	Host communities
Peru	**1%** of Venezuelan migrants experienced GBV CAPS, 2022; Lima and Tumbes; 300 participants		
	27% of Venezuelan migrant women endured violence from her partner. ACH, 2022a; Lima; 374 participants		
	18% of Venezuelan women suffered some kind of violence. OPS, 2022; Lima; 426 households		
Central America			
Panama		**10%** of interviewed individuals reported traveling with a survivor of violence in their group (sexual, physical or psychological). UNHCR, 2023a; Darien and Chiriqui; 107 participants.	
Guatemala Mexico Costa Rica Panama		**18%** of migrants reported physical, psychological, or sexual violence and/or abuse. UNHCR and WFP, 2023; Guatemala, Mexico, Costa Rica, Panama; 3,456 participants	

The testimonies below show how sexual violence is part of the migration process.

> *"When we passed by, the coyote picked us up, a man forced one of the girls to do oral things (oral sex), otherwise he was going to kill her and a girl (unaccompanied), she had to do it, it was her life, that of the girl and ours. She left with her self-esteem on the floor, her dignity... if it wasn't for her I wouldn't be here".*
>
> Migrant, Colombia

> *"Any trail is a point where, especially sexual violence, is systematic. Many women report that their bodies were used as part of payment to cross the trails (...) the border is very large, there are drug trafficking routes, both men and women are forcibly recruited, trafficking networks operate associated with armed actors who may be dissidents. or paramilitary groups, but not necessarily, there are also civilians involved".*
>
> EIC, national campaign for legal abortion, Colombia

> *When I came from Maracaibo to Maicao (Colombia), I arrived and I didn't know anyone, I slept in the square. During the day I sold anything and at night I slept on a cardboard. You know what? They abused me! It is something I still haven't been able to get over, three men abused me in a park (...)".*
>
> Venezuelan migrant woman, Colombia

> *"On the way to Costa Rica, while still in Nicaragua, they raped me, I don't even know how many men there were, I counted seven and then I stopped counting. To this day I feel dirty, I can't get over it, I feel guilty".*
>
> Nicaraguan refugee woman, Costa Rica
>
> (ACNUR and HIAS, 2022)

2.1.4 Elder people (60+ years)

In Ecuador, 4% of Venezuelan groups who have settled included a person aged 60+ (GTRM, 2023; 23 provinces; 2,541 households). For 76% of elder persons established in Ecuador, access to health services was one of the main motivations for migration (HelpAge 2021; main cities and towns; 187 participants).

Nutritional status

One source indicates that the body mass index of elder migrants residing in Colombia or in transit through Colombia was distributed as follows: **3% low weight; 13% normal; 11% overweight; 73% obesity** (WFP, 2023). This information is in line with the fact that approximately half of migrant adults were overweight in Colombia (Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants).

Acute conditions

In the previous month, 56% of Venezuelan migrants aged 60+ settled in Lima, Peru had an illness or discomfort. Of these, 57% had a respiratory illness or allergy; 11% had relapses of chronic illnesses; 7% had mental health problems (such as depression, insomnia, etc.). In focus group discussions, the most common complaints in this age group were rheumatologic diseases and disabilities. Joint and bones pains were made worse by the imperative of daily income-generating activities (OPS, 2022; Lima; 426 households).

Chronic diseases/mental health

The prevalence of chronic diseases increases with age. **Between 62 and 78% of Venezuelan migrants aged 60+ had a chronic disease**. The most common conditions were: hypertension (39-53%); mental health (18-56%); gastro intestinal conditions (11-36%); diabetes (12-23%); respiratory conditions (9-25%) and heart problems (9-20%) (table 19).

Table 19. Chronic diseases among elder migrants

	In-destination migrants
Colombia	**42%** of internally displaced, migrants, returnees, refugees had hypertension; 19% heart problems; 18% gastrointestinal problems; 18% diabetes; 18% mental health problems; 16% respiratory problems; 3% cancer; 45% other . HelpAge, 2021; main cities and towns; 170 participants
Ecuador	**53%** of migrants and refugees had hypertension; 39% mental health problems; 23% gastrointestinal problems; 19% heart problems; 17% respiratory problems; 15% diabetes; 4% cancer; 50% other . HelpAge, 2021; main cities and towns; 187 participants
Peru	**41%** of migrants and refugees had hypertension; 28% mental health problems; 13% heart problems; 13% gastrointestinal problems; 12% diabetes; 10% respiratory problems; 5% cancer; 50% other . HelpAge, 2021; main cities and towns; 150 participants
	62% of Venezuelan migrants had a chronic disease. INEI, 2022; 8 cities; 3,680 households
	78% of Venezuelan migrant lived with a chronic disease including 50% with hypertension; 16% with diabetes. OPS, 2022; Lima; 426 households
El Salvador	**56%** of internally displaced, deportees and migrants had mental health problems; 48% hypertension; 36% gastrointestinal problems; 25% respiratory problems; 23% diabetes; 20% heart problems; 3% cancer; 20% others. HelpAge, 2021; main cities and towns; 82 participants
Honduras	**39%** of internally displaced, deportees, refugees and migrants had hypertension; 22% mental health problems; 12% diabetes; 11% gastrointestinal problems; 9% respiratory problems; 9% heart problems; 1% cancer; 40% others HelpAge, 2021; main cities and towns; 82 participants

"We have seen more of the sadness issue with them [elder people]. When we carry out the assessment many are sad, there is anxiety about the uncertainty of what is going to happen tomorrow because they are living only in the now and have nothing certain for tomorrow. That is what we have identified. Many times we try to intervene so that these feelings do not lead to depression".

Man, religious organization, Honduras (HelpAge, 2021)

Disability

One study focused on elder migrants, internally displaced and deportees. **Disability affected between 16% and 66% of them depending on the country**. The most common types of disability were physical (6-47%) and visual (4-41%). Hearing, cognitive, and communicative impairments were more unusual: 4-15%; 2-12%; 1-5% respectively (table 20).

Table 20. Disability among elder migrants

	In-destination migrants
Colombia	**45%** of internally displaced, migrants, returnees, refugees had some type of disability: visual disability (24%); physical disability which makes it difficult for them to walk or climb stairs (21%); difficulty remembering or concentrating (12%); hearing disability (8%); communicative disability (2%). HelpAge, 2021; main cities and towns; 170 participants
Ecuador	**41%** of migrants and refugees had some type of disability: visual disability (24%); physical disability which makes it difficult for them to walk or climb stairs (6%); difficulty remembering or concentrating (6%); hearing disability (4%); communicative disability (2%). HelpAge, 2021; main cities and towns; 187 participants
Peru	**38%** of migrants and refugees had some type of disability: physical disability which makes it difficult for them to walk or climb stairs (21%); visual disability (19%); difficulty remembering or concentrating (5%); hearing disability (5%); communicative disability (1%). HelpAge, 2021; main cities and towns; 150 participants
	56% of elder Venezuelan migrants lived with a disability including physical disability (34%) and visual disability (34%). OPS, 2022; Lima; 426 hogares
El Salvador	**66%** of internally displaced, deportees and migrants had some type of disability: physical disability which makes it difficult for them to walk or climb stairs (47%); visual disability (41%); hearing disability (15%); difficulty remembering or concentrating (10%); communicative disability (5%). HelpAge, 2021; main cities and towns; 146 participants
Honduras	**16%** of internally displaced, deportees, refugees and migrants had some type of disability: physical disability which makes it difficult for them to walk or climb stairs (11%); hearing disability (5%); visual disability (4%); communicative disability (4%); difficulty remembering or concentrating (2%).). HelpAge, 2021; main cities and towns; 82 participants

2.1.5 Pregnant and breastfeeding girls/ adolescents/women

Pregnant and breastfeeding girls/adolescents/ women have specific needs in terms of healthcare and nutrition. On these grounds, some countries in the continent grant them and children under five access to healthcare regardless of their migration status (refer to section 5.1 on legislation/policy).

Qualitative research in Brazil (Moverse, 2022) and Chile (Obach *et al.*, 2022) indicates that **pregnancy is a motivation for migration**. Women look for better pregnancy and childbirth services than in their home countries.

The experience of childbirth far from home and one's network and culture can be tough. A qualitative study among Haitian women in Chile puts forward the difficulty to manage a non-wanted pregnancy and to navigate the healthcare system; the contradictions between own conceptions of maternity and child-raising and those of the host country; the loneliness due to the absence of support or partner/family members who have no choice than carrying out long daily working shifts. Postpartum depression is prevalent. (Carreño *et al.*, 2022)

Proportion of pregnant and breastfeeding migrants

About 10-14% of women in transit were pregnant and 10-17% were breastfeeding (table 21)**. For migrants in destination, 2-10% were pregnant; 11-19% were breastfeeding** (table 21).

> *"In Haiti when a person is pregnant you have the whole family at your service (...). The woman can spend 3 months without doing anything, washing, ironing, nothing, lying with her son, nothing more (...). Here a person has her child and has a normal life, they don't have that help".*
>
> Haitian migrant woman, Chile

> *"In my country my mom gave me flour that is prepared with plantain and cassava, a kind of food prepared for the baby, it is not found here".*
>
> Haitian migrant woman, Chile haitiana, Chile

> *"She even had to send me to the psychologist because I left [the consultation room] very badly, I was very sad because my son had problems with his passport".*
>
> Haitian migrant woman, Chile
>
> (Carreño *et al.*, 2022)

Table 21. Proportion of pregnant and breastfeeding girls/adolescents/women among migrants

	In-destination migrants	In-transit migrants
South America		
Brazil	**14%** of Venezuelan migrants were pregnant or lactating women. R4V, 2023a	
	21% of Venezuelan households had at least one woman pregnant or breastfeeding. R4V, 2023d, 11 states, 800 households	
Chile	**13%** of Venezuelan households had a pregnant or lactating women. R4V, 2023a	**10%** of migrant women were breastfeeding. OIM, 2023d; Colchane; 520 participants
Colombia	**2%** of Venezuelan women and girls above 12 were pregnant; **11%** were breastfeeding . GIFMM, 2023a; 14 regions; 2,387 households	
Ecuador	**22%** of Venezuelan households included lactating women; 5%, pregnant women. GTRM, 2023; 23 provincias; 2.541 hogares	
Guyana	**10%** of Venezuelan indigenous women were pregnant; **19%** breastfeeding. IOM, 2023b; 4 regions; 162 participants	
Peru	**2%** of women were pregnant. OPS, 2022; Lima; 426 households; 299 women aged 15 to 49.	
Central America		
Guatemala Mexico Costa Rica Panama		**14%** of migrant women were pregnant; **17%** were breastfeeding. UNHCR and WFP, 2023; Guatemala, Mexico, Costa Rica, Panama; 3,456 participants
Costa Rica		**12%** of migrant women were pregnant. OIM, 2022; 4,737 participants in shelters and along the route from 15/12/2022-05/10/2023
		10% of migrant women were pregnant. OIM, 2022; Northern border; 19,425 participants

	In-destination migrants	In-transit migrants
North America		
Mexico		**8%** of migrant women were pregnant or breastfeeding. OIM, 2023c; Tapachula and Tenosique; 251 participants in shelters and public spaces.
		10% of migrant women were pregnant. OIM, 2023b; Tenosique; 165 participants

Nutritional status

As many as 60% of migrant pregnant women suffered from anemia in Bolivia. In Colombia severe anemia affected 14-19% of Venezuelan pregnant women (table 22).

Table 22. Nutritional status of pregnant migrant girls/adolescents/women

	In-destination migrants	In-transit migrants
Bolivia	**60%** with anemia R4V, 2023a	
Colombia		Of Venezuelan pregnant women in pendular movements: 24% were underweight 29% had overweight 24% had anemia GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements; 87 pregnant women.
	14% of Venezuelan pregnant women with severe anemia; 18% with mild anemia. WFP, 2023, 7097 participants, 78 pregnant women	**19%** of in pendular movements Venezuelan pregnant women with severe anemia; 18% with mild anemia. WFP, 2023, 1399 in pendular movements participants, 62 pregnant women

Maternal mortality

In Colombia, the maternal mortality rate (MMR) among Venezuelan mothers is twice the national MMR. In addition, in the first 24 weeks of 2022, with 1740 occurrences, extreme maternal morbidity was the second type of notifiable conditions after gender-based and domestic violence (refer to section 2.1.3/ acute conditions).

In Brazil, Venezuelan mothers make up a significant proportion of mothers in the bordering state of Roraima. The state MMR is about twice the national MMR (table 23).

Table 23. Comparison of national and migrant Maternal Mortality Rates (MMR)

	In-destination migrants	Host communities
Brazil	2021 Roraima MMR: 309/100,000 live births. Roraima is a border state to Venezuela. A significant proportion of births were to Venezuelan mothers. R4V, 2023a	National MMR: 117/100,000 live births R4V, 2023a
Colombia	2021 MMR for Venezuelan mothers: 91.77/100,000 live births 2022 MMR for Venezuelan mothers: 125.3/100,000 live births R4V, 2023a	National MMR: 43.8/100,000 live births R4V, 2023a

Infectious diseases

A couple of reports provide information on syphilis among Venezuelan pregnant women in Colombia. A recent study showed that 9% of pregnant participants in the study had syphilis. Nonetheless, in the same study the prevalence of syphilis among women who had ever been pregnant during their stay in Colombia was similar to the general syphilis prevalence among women found in the study (4%) (Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants; 1,156 women ever pregnant in Colombia; 150 pregnant women at the time of study). In addition, in the first 24 weeks of 2022, 1,485 cases of gestational syphilis and 158 cases of congenital syphilis among Venezuelan migrants were reported to the national surveillance system in Colombia (refer to section 2.1.3 on acute conditions).

2.2 Expressed Need

2.2.1 Expressed need by type of care

Ranking need for different types of healthcare is complex. Studies are not systematic in the classification of types of care. Some lump up, other dissociate types of healthcare. Timeframes of indicators vary. Denominators are often unclear. It would be desirable to use standardized packages of care such as emergency healthcare, primary healthcare, specialized healthcare, minimum initial service package for sexual and reproductive health in emergencies, among others.

Among in-transit migrants, the need for healthcare was high (59-69%). Most required a general practitioner. With regards to general sexual and reproductive health 6-41% were in need. Main needs were contraception, STI prevention and management and maternal care. **Twelve per cent of migrants in transit required emergency care upon their arrival to Chile. Psychological first aid was also identified as necessary** (table 34).

Among in-destination migrants, healthcare needs were substantial (23-74%) (table 34). **The percentage varies depending on the country and the timeframe under consideration. The most needed type of care was a general practitioner. Other types of care required were maternal and pediatric care, exams and tests, medicines, chronic diseases management and specialized care. One survey included mental health services as a need**, and it was formulated by about 6% of respondents. Another study mentioned that mental health surfaced in focus group discussions despite not being a topic (IRC, 2021; Lima and North Peru). **With regards to sexual and reproductive health, 22-36% of migrants in destination required these services (table 34). One study in Peru states that 30% of migrants required emergency care** (DRC, 2023).

Table 24. Expressed need by type of healthcare

	In-destination migrants	In-transit migrants
Brazil	Types of health care services required by households: 53% general practitioner; 25% pediatrician; 15% gynecologist; 8% cardiologist; 5% neurologist; 5% orthopedist; 4% dentist. R4V, 2023d, 11 states, 800 households	
	25% of Venezuelan migrants needed contraceptive methods. **16%** required assistance for STI and AIDS services Moverse, 2022; all regions but Roraima; 2,000 participants	**34%** of Venezuelan migrants needed of contraceptive methods. **25%** required assistance for STI and AIDS services. Moverse, 2022; Roraima; 682 participants from shelters
Colombia	**52%** of Venezuelan households required a health service in the past 3 months. Of these, 62% required medical control; 32% consultation for an acute condition; 13% consultation for a chronic disease; 6% medicines for a chronic disease. **22%** of Venezuelan households required sexual and reproductive healthcare. Of these: 46% required a gynecologist; 44% contraception; 22% assistance for pregnancy; 17% STI prevention. GIFMM, 2022; 13 regions; 3,295 households	Venezuelan migrants in transit **59%** required health care. Of these, **29%** required a general practitioner. **33%** required sexual and reproductive health. Of these, 37% were interested in contraception, 24% in STI, 18% in gynecology. Venezuelan migrants in pendular movements **62%** required health care. Of these, **25%** required a general practitioner. **41%** required sexual and reproductive health. Of these, 38% were interested in contraception, 20% in care for pregnant women, 10% in gynecology. GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements
	23% of Venezuelan migrants required a health service in the past 3 months (17% for 15-24 years; 23% to 25-54; 41% for 55+). DANE, 2023; 23 cities, 3,605 households of migrants with over 5 years of stay	

	In-destination migrants	In-transit migrants
Chile		**12%** of the refugees and migrants entering the country required immediate medical assistance upon arrival for issues such as dehydration, malnutrition, hypothermia or altitude sickness. R4V, 2023a
		6% of migrants required sexual and reproductive health services. 73% of them are women. OIM, 2023d; Colchane; 520 participants
	Access to mental healthcare services was identified as a gap and an important unmet need. R4V, 2023a	
Ecuador	**81%** of Venezuelan households required medical attention in the past 6 months. Of these, health needs related to general healthcare (86%); specialized healthcare (26%); treatment of chronic diseases (8%); prenatal care (8%), childbirth and postpartum care (7%), mental health services (7%); access to contraception and sexual and reproductive health services (6%); HIV medicines (1%). GTRM, 2023; 23 provinces; 2,541 households	
Guyana	**36%** of Indigenous Venezuelan migrants required reproductive and sexual health services. IOM, 2023b; 4 regions; 162 participants	
Peru	Health requirements for Venezuelan migrants under 5 years: medical care (47%), medical exams or tests (44%); nutritional supplements (42%); needs covered (24%); vaccination (23%); medications (22%); health insurance (19%); health information (9%). Health requirements for Venezuelan migrants aged 18-59: medical exams or tests (67%); medical care (66%); medications (56%); health insurance (54%); health information (7%); needs covered (6%); contraception (4%); dental services (2%); other (1%). Health requirements for Venezuelan migrants aged 60+: medical exams or tests (76%); medical care (74%); medications (48%); health insurance (46%); needs covered (12%); health information (7%). OPS, 2022; Lima; 426 households	

	In-destination migrants	In-transit migrants
	24% of Venezuelan migrants required healthcare in the past 4 weeks. INEI, 2022; 8 cities; 3,680 households; 191 children under 5 in Lima.	
	36% of Venezuelan families reported that a member of their family had tried to access healthcare, despite on average having been in Peru for over 2 years. IRC, 2021; Lima and North Peru; 870 households	
	74% of migrants needed healthcare. Of these, 47% need primary care; 40% emergencies; 11% specialized services. DRC (2023), 1,402 participants	
Panama	64% of migrants required healthcare in the past 3 months. Of these, 49% needed prenatal or pediatric care; 35% treatments for chronic diseases; 33% testing and/or treatment for COVID-19; 25% psychosocial/psychiatric care; 42% other types of medical care. UNHCR, 2022; 400 households	69% required medical attention upon reaching the migrant reception centers in Darien. R4V, 2023a
	35% of refugees and asylum-seekers needed health care. UNHCR, 2022; 400 households	
Border points in Panama, Costa Rica, El Salvador, Honduras, Guatemala, Mexico		Most common health services required: general medicine; first aid; psychological first aid, access to medications and vaccines. IFRC, 2022a; Panamá, Costa Rica, El Salvador, Honduras, Guatemala, México; 586 participants.
Trinidad and Tobago	Venezuelan migrants expressed the following healthcare needs: 54% illness; 30% general checkup; 26% other (mostly dental issues); 13% injury; 11% pre/post-natal care; 3% giving birth. UNHCR, 2023c; 12 regions; 1,286 households.	
Costa Rica		**10%** of migrants expressed need for maternal healthcare. OIM, 2022; Northern border; 19,425 participants
Mexico		**12%** of migrant women required sexual and reproductive healthcare (contraception, STI prevention and diagnosis). OIM, 2023b, Tenosique 165 participants

2.2.2 Self-perception of health status

Two studies in Colombia asked participants about their self-perception of their health status. In the adult population about 3 in 4 rated their health as good or very good.

The proportion decreases as age increases. Among 55+ participants, about half considered themselves in very good or good health (table 25).

Table 25. Self perception of health status among in-destination migrants in Colombia

	In-destination migrants
Colombia	**76%** of Venezuelan migrants described their health overall as good, very good, excellent. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants
	Venezuelan migrants aged 15-24 and 25-54 rated their health as very good (9-13%); good (66-68%); not so good (17-23%); poor (1-2%). Venezuelan migrants aged 55+ rated their health as very good (3%); good (43%); not so good (47%); poor (7%); very poor (2%). DANE, 2023; 23 cities, 3,605 households of migrants with over 5 years of stay

2.3 Needs comparison between migrants and host communities

The R4V, which does not cover all countries in the region, identifies 12 sectors of intervention among which health, nutrition, and GBV. For each of these, it provides a percentage of people in need of these interventions for the following categories: Host communities, Migrants-in destination, Venezuelan migrants in transit, Other migrants in transit.

A lower percentage is expected in host communities, as opposed to migrants, as citizens from the country are supposed to have better access to health and protection systems. Disparities between these communities denote the existence of barriers specific to some groups. The absence of disparities may reveal similar access, absence of interventions, or absence of data disaggregation by type of community. Most likely, the latter explanation applies to Caribbean countries, Brazil and Guyana because figures are exactly the same between host communities and migrants across all three sectors (tables 26, 27,28).

Out of the three sectors under consideration, for the region covered by R4V, most notorious disparities between migrants and host communities relate to GBV while the absence of disparities is evident in nutrition. More than 1 in 3 people in the region require healthcare interventions. (table 26).

Table 26. Percentage of people in need for health, response to gender-based violence, nutrition for different population groups (R4V, 2023a)

	Host communities	Migrants in-destination	Venezuelans in-transit	Others in-transit
Percentage of people in need of interventions in health	36%	54%	42%	47%
Percentage of people in need of interventions against gender-based violence	19%	35%	35%	44%
Percentage of people in need of interventions in nutrition	14%	12%	11%	14%

The country analysis for the health sector suggests that in most countries (Bolivia, Chile, Ecuador, Paraguay, Peru, Uruguay, Costa Rica, Panama), migrants face additional barriers to access healthcare compared to host communities. For Colombia and Mexico, the percentage is similar for host communities and migrants (table 27).

The highest proportion of people in need of health assistance are found in Colombia (around 70% across categories) and Trinidad and Tobago (about 80%). Bolivia, Ecuador, Peru, Costa Rica, Panama, Aruba and Curacao show high levels of health needs for migrants (above 40%) (table 27).

Table 27. Percentage of people in need of health assistance out of total people in need of different types of assistance (R4V, 2023a)

		Porcentage of people in need of health assistance				
		Host communities	Migrants in-destination	Venezuelans in-transit	Others in-transit	Chart
South America	Argentina	36%	12%	N/A	N/A	
	Bolivia	6%	43%	43%	43%	
	Brazil	14%	14%	0%	N/A	
	Chile	10%	22%	N/A	N/A	
	Colombia	69%	74%	77%	74%	
	Ecuador	22%	54%	39%	39%	
	Guyana	33%	33%	N/A	N/A	
	Paraguay	7%	33%	N/A	N/A	
	Peru	27%	51%	N/A	N/A	
	Uruguay	1%	17%	N/A	N/A	
Central America	Costa Rica	8%	72%	45%	45%	
	Panama	19%	19%	48%	23%	
Caribbean	Aruba	42%	42%	N/A	N/A	
	Curacao	42%	42%	N/A	N/A	
	Dominican Republic	36%	36%	N/A	N/A	
	Trinidad and Tobago	79%	79%	N/A	N/A	
North America	Mexico	14%	12%	15%	N/A	

With regards to nutrition, differences in needs between host communities and migrants are not very noticeable except perhaps for Colombia where the percentage of people with nutrition needs in the host community is almost twice that of migrants (33% vs 17%). **Countries with higher nutrition needs are Panama, Colombia, Guyana (above 20%)** (Table 28).

Table 28. Percentage of people in need of nutrition assistance out of total people in need of different types of assistance (R4V, 2023a)

		Porcentage of people in need of nutrition assistance				
		Host communities	Migrants in-destination	Venezuelans in-transit	Others in-transit	Chart
South America	Argentina	N/A	3%	N/A	N/A	
	Bolivia	N/A	5%	5%	5%	
	Brazil	10%	10%	10%	N/A	
	Chile	13%	17%	N/A	N/A	
	Colombia	33%	17%	17%	14%	
	Ecuador	7%	9%	8%	8%	
	Guyana	20%	20%	N/A	N/A	
	Paraguay	N/A	3%	N/A	N/A	
	Peru	5%	5%	5%	5%	
	Uruguay	N/A	9%	N/A	N/A	
Central America	Costa Rica	7%	6%	12%	12%	
	Panama	32%	32%	20%	20%	
Caribbean	Aruba	9%	9%	N/A	N/A	
	Curacao	5%	5%	N/A	N/A	
	Dominican Republic	6%	6%	N/A	N/A	
	Trinidad and Tobago	14%	14%	N/A	N/A	
North America	Mexico	3%	3%	6%	N/A	

Concerning GBV, in Colombia, Guyana, Panama, Aruba Curacao, Trinidad and Tobago, one in three or one in two require assistance. While some countries show enhanced needs for migrants (Peru, Costa Rica, Mexico), other do not (Bolivia, Ecuador) (table 29).

Table 29. Percentage of people in need of assistance to respond to gender-based violence out of total people in need of different types of assistance (R4V, 2023a)

		Porcentage of people in need of assistance for gender-based violence				
		Host communities	Migrants in-destination	Venezuelans in-transit	Others in-transit	Chart
South America	Argentina	5%	5%	N/A	N/A	
	Bolivia	21%	22%	22%	22%	
	Brazil	17%	17%	17%	N/A	
	Chile	10%	11%	N/A	N/A	
	Colombia	42%	49%	54%	47%	
	Ecuador	25%	24%	19%	19%	
	Guyana	40%	40%	N/A	N/A	
	Paraguay	20%	19%	N/A	N/A	
	Peru	8%	31%	29%	29%	
	Uruguay	11%	11%	N/A	N/A	
Central America	Costa Rica	12%	12%	46%	46%	
	Panama	35%	35%	46%	46%	
Caribbean	Aruba	32%	32%	N/A	N/A	
	Curacao	32%	32%	N/A	N/A	
	Dominican Republic	18%	18%	N/A	N/A	
	Trinidad and Tobago	33%	33%	N/A	N/A	
North America	Mexico	7%	15%	13%	N/A	

2.4 Health-seeking behaviors

Information on health-seeking behaviors of migrants in transit was found for Costa Rica and Mexico. In Mexico, when in need of healthcare, 20-32% do not undertake any action. The others **tend to visit public health facilities**, either a public health center (30-41%) or a hospital (11-50%). A few looked for care by NGOs (11-26%). Almost none went to a private facility. In Costa Rica, the pattern is similar. The only notable difference is that 8% resorted to traditional medicine and another 8% to a drugstore (table 30).

There was more information for migrants in destination. Between 5% and 39% of migrants refrained from taking any action despite the need. **Government health facilities emerged as the first option for those who looked for assistance**. 46-93% went to a public health facility. Between 22-36% went to a public health center. Between 24-61% went to a hospital. Resort to private practice or consultation is minor. It oscillated between 6-26%. A similar proportion opted for going directly to a pharmacy (5-23%) or to self-medicate (5-19%). The proportion of migrants who looked for health services from an NGO was low at 2-3%. Of note, there may be some blurred lines between public and private services and NGO as some NGO may provide care through third parties (table 30).

Table 30. Migrants´health-seeking behaviors

	In-destination migrants	In-transit migrants
Brazil	**93%** of Venezuelan migrants went to public health facilities when they had a health problem. UNICEF, 2022; shelters and spontaneous settlements of Boa Vista and Paracaima.	
Chile	In case of healthcare need, most Venezuelan migrants went to a public health facility (43% to a primary health center and 24% to a hospital) followed by private consultation (15%); private clinic (11%); did not look for assistance (7%). OIM, 2021; 8 regions; 300 participants	
Guyana	Among Venezuelan who accessed health care, 46% indicated public healthcare; 32% emergency services (both public and private available); 10% assistance from family\friends; 5% private pharmacy. IOM, 2021; 6 regions; 1,363 participants	
	In case of a health situation, 73% of Indigenous Venezuelan migrants sought assistance at public facilities; 12% used alternative medicine; 6% other; 5% did not seek assistance; 3% went to an NGO; 1% to a private pharmacy; 1% to a community health worker. IOM, 2023b; 4 regions; 162 participants	

	In-destination migrants	In-transit migrants
Peru	Among Venezuelan migrants under 5 years who had a medical condition in the previous month, 21% did not seek attention; 49% were taken to a public health center (MINSA); 8% to private practice; 6% to a social security health center (EsSalud); 3% to a private clinic; 8% were self-medicated; 5% were taken to a pharmacy; 2% other. Among Venezuelan migrants aged 5-17 who had a medical condition in the previous month, 29% did not seek attention; 20% went to a public health center (MINSA); 9% to private practice; 2% to a social security health center (EsSalud); 2% to a private clinic; 19% self-medicated; 17% went to a pharmacy; 3% other. Among Venezuelan migrants aged 18-59 who had a medical condition in the previous month, 23% did not seek attention; 24% went to a public health center (MINSA); 3% to private practice; 3% to a private clinic; 3% to a social security health center (EsSalud); 22% self-medicated; 17% went to a pharmacy. Among Venezuelan migrants aged 60+ who had a medical condition in the previous month, 36% did not seek attention; 36% went to a public health center (MINSA); 7% to private practice; 4% to a private clinic; 11% to a pharmacy; 7% self-medicated. OPS, 2022; Lima; 426 households; 191 under 5 and 191 aged 5-17, 419 aged 18-59 in Lima, 50 aged 60+	
	Among Venezuelan migrants who required care in the past 4 weeks, 73% sought care: 23% went to a pharmacy; 22% to a public health center (MINSA); 16% self-medicated, 9% went to a private consultation; 4% to a private clinic; 2% to social security health center (Essalud). INEI, 2022; 8 cities; 3,680 households	
	Among Venezuelan migrants in need of health care, 39% did not seek care; 24% went to a public health center (MINSA); 12% self-medicated; 7% went to a pharmacy; 6% to private practice; 3% to health care by social security institution (Essalud), 2% to a private clinic; 2% to a NGO.. ACH, 2022a; Lima; 374 participants	

	In-destination migrants	In-transit migrants
Costa Rica		Migrants looked for health care assistance in hospitals (44%); NGO (15%); nearest health center (12%); drugstore (8%); alternative medicine (8%); none (5%); did not know (4%); private health center (1%). OIM, 2022; 4,737 participants in shelters and along the route from 15/12/2022-05/10/2023
Trinidad and Tobago	Venezuelan migrants sought health care from: public hospitals (61%); pharmacy (21%); private clinics (6%); other mostly self-medicated and consulted friends and relatives on medicines to take (5%). UNHCR, 2023c; 12 regions; 1,286 households	
Mexico		When in need of healthcare, 41% of migrants went to a nearby clinic or public health center, 32% reported not going anywhere; 16% went to a NGO that provided basic health services; 11% went to the hospital. OIM, 2023c; Tapachula and Tenosique; 251 participants in shelters and public spaces
		When in need of healthcare, 50% of migrants went to the hospital; 39% did not seek healthcare; 11% went to a NGO. OIM, 2023b; Tenosique; 165 participants
		When in need of healthcare, 30% of migrants went to a nearby clinic or public health center; 26% went to a NGO; 23% to the hospital; 20% did not seek healthcare. R4V, 2023a

2.5 Social and cultural practices and beliefs

According to qualitative data collected in Peru, **there are two critical factors migrants take into account to decide whether to look for healthcare: the severity of symptoms and the age of the person in need**. Adults and elder adults were more inclined to self-medicate while minors are taken for professional assistance (OPS, 2022).

Fear of deportation and mistreatment at the health centers also shapes the use of health services (Chile - Obach *et al.*, 2022; R4V, 2023a).

Likewise, **migrants face many pressing needs**. Healthcare is one of the many needs. Sometimes it is not prioritized, especially when there is no urgency. This may lead to the perception that migrants are somehow careless with their own health (Mexico – Llanez-Diaz *et al.*, 2023). This perception must be contrasted with the multiple uncertainties faced by migrants related to their displacement, to documentation processes and erratic offer of services including health care. The navigation complexities of the health system along with migrants' feelings of being ping-ponged from one service are described further (refer to 4.4.3 on healthcare timeliness and health system navigation) Time spent attempting to access health services represent an opportunity cost for migrants who may opt for not attempting to access services. There is a **trust breach where service providers do not trust migrants as agents of their health status and reversely migrants do not trust they will receive assistance from service providers.**

> *"Going to the hospital makes me insecure, because of everything I've heard ... if I got very ill, and my only solution was to go to the hospital and they denied me care, I could die. I do not trust the health system".*
>
> Colombian migrant woman, 24, Chile (Obach *et al.*, 2022)

> *"Yes (I know my rights), but I prefer to walk alone, I have learned to take care of myself, to defend myself. I know that we have our rights because of our gender status, but the street is very hard."*
>
> Venezuelan trans woman, Colombia" (ACNUR and HIAS, 2022)

Social health is another determinant of use of services (Salami *et al.*, 2022). A study in Peru states that a tighter family network allowed for more solidarity and hence more resources to face health challenges. Most critical patients often lacked family support. Beyond family, virtual and presential migrant and host communities provide economic, emotional support and constitute a valuable source of information on access to and quality of health services. Religious communities were also identified as a facilitator to healthcare. They provide emotional support and information. A few migrants were able to directly connect with health professionals through the church (OPS, 2022).

2.6 Financial Access

Financial access refers to direct and indirect costs patients face to receive care. Direct costs consist of payments or co-payments related to the medical management of the condition (medical services, medicines, etc.). Indirect costs refer to losses incurred as a result of the condition (loss of income, costs related to childcare that would not have been incurred otherwise, food and transportation for caretakers, others).

Financial access is tightly related to health insurance which aims at protecting people from suffering high unexpected costs due to a medical condition. In some countries such as Colombia, Peru, Costa Rica, Panama, people need to be affiliated to a health insurance in order to receive medical care. **Generally, migrants will need a legal status to gain access to the health insurance, which constitutes a major barrier**. Non-affiliated migrants bear the full cost of the services unless there are some provisions for specific populations or for emergency procedures (refer to section 5.1 on legislation/policy). In other countries, for instance Ecuador, access is universal. Anyone who turns up at a health center should be entitled to services for no or little cost. In practice, in both systems, patients including migrants, may incur catastrophic costs due to the unavailability of appointments, lack of staff, out of service equipment, stockout of medicines, etc (refer to sections 3.3 on availability of essential commodities/ inputs and 3.4 on access to adequately staffed services, facilities and information). Purchase of health commodities and services were reported in Peru (OPS, 2022), Ecuador, Honduras (HelpAge, 2021).

2.7 Continuity of use

Continuity of use is critical to certain conditions such as chronic and infectious diseases, maternal care, nutrition treatments among others. The multiple migration routes and the fragmentation of healthcare offer across and within countries makes continuity of care extremely challenging for migrants in transit. One may really question how (un)feasible continuous interventions are for this population. Some reports mention initiation of continuous interventions. For instance, children with acute malnutrition who have received one unit of ready-to-use therapeutic food to on the go or a counselling, supplementation plus medical referral are counted as beneficiaries. Impact as well as harm of the intervention is minimal or nonexistent. Does this intervention make sense and can these children really be considered beneficiaries of a program/project? Perhaps an alternative is to invest more in each beneficiary by trusting them with more supplies – provided these cannot be harmful – and complement the health assistance with other types of assistance such as cash to ensure appropriate use of the health supplies. The analysis of actual cost of average intervention per person (refer to section 5.2.1 on projected and actual costs per person) shows that individual costs can actually reach significant amounts.

CHAPTER 3:
Supply of health services

3.1 Access to the national health system

Access to healthcare depends heavily on the design of the national health system and its provisions with regards to health insurance (refer to section 5.1 on legislation/policy).

Brazil integrates migrants in its health system smoothly with 95% of migrants in possession of a Health Card. Peru has a policy to facilitate enrollment of pregnant women and children under 5 into its national health insurance.

Data below show that these migrant subgroups have improved health insurance coverage – 40-86% and 66-76% respectively – compared to other migrant subgroups (18-34%). Yet, coverage is still below host communities´ (85%). In Colombia and Panama, which do not allow irregular migrants to avail health insurance, the coverage is low: (22-37%) and 10% respectively

.

Table 31. Coverage of health insurance among migrants

	In-destination migrants	In-transit migrants	Host communities
Brazil	**95%** of Venezuelan migrants were in possession of the Unified Health System Card. Moverse, 2022; all regions but Roraima; 2,000 participants	**95%** of Venezuelan migrants were in possession of the Unified Health System Card.Moverse, 2022; Roraima; 682 participants from shelters	
Chile	**89%** of Venezuelan migrants had a health insurance. OPS, 2023b		

	In-destination migrants	In-transit migrants	Host communities
Colombia	**37%** of Venezuelan migrants were affiliated to the national health system. R4V, 2022a		
	64% of Venezuelan migrants were affiliated to the national health system. DANE, 2023; 23 cities, 3,605 households of migrants with over 5 years of stay		
	22% of Venezuelan migrants were affiliated to the national health system. GIFMM, 2022; 13 regions; 3,295 households		
	In 2021 and 2022, of all notifiable events among Venezuelan migrant population, respectively 14% and 24% related to people who were affiliated. MinSalud, 2022		
Peru	**27%** of the Venezuelan refugee and migrant population had some type of health insurance (20% had Seguro Integral de Salud – SIS; 5% social security health insurance (Essalud) and 2% private insurance) INEI, 2022; 8 cities; 3,680 households		**85%** of Peruvians were affiliated to SIS INEI, 2022
	76% of Venezuelan migrant children under 5 years had some type of health insurance. Among them, 95% had the national health insurance (SIS); 3% had the social security health insurance (EsSalud). **86%** of Venezuelan pregnant women had a national health insurance (SIS) **18%** of Venezuelan migrants aged 6-17 had some type of health insurance. Among them, 15% had the national health insurance (SIS); 1% had the social security health insurance (EsSalud). OPS, 2022; Lima; 426 households		

	In-destination migrants	In-transit migrants	Host communities
	34% of Venezuelan migrants had a health insurance. Insurance coverage among special populations: 40% among pregnant women; 20% among breastfeeding women; 66% among children under 5 years of age. Type of insurance for migrants with health insurance: SIS 83%; EsSalud 15%; private insurance 2%. Type of insurance for under 5 migrant children with health insurance: SIS 92%; EsSalud 3%; private insurance 1%; other 3%. Acción contra el hambre (2022), 374 participants in Lima		
	33% of Venezuelan migrants had the national health insurance (SIS) CAPS, 2022; Lima and Tumbes; 300 participants		
Panama	10% of migrants had a health insurance ONU-Habitat, ACNUR and OIM,2021; Ciudad de Panama		

A major barrier to health insurance for migrants is the absence of documentation. This is observed all throughout the region. According to R4V, in the region, more than one in three refugees and migrants is in an irregular situation. A regular status would enable them to access healthcare as well as employment. It would improve their livelihoods and address many of the social determinants of healt (R4V, 2023a).

3.2 Service coverage

3.2.1 Nutrition interventions

The most common nutrition interventions among migrant children under 5 were: nutritional assessment (42 – 57%), deworming (21-36%), micronutrients (12-30%) and management of acute malnutrition (1-4%) (table 27). Colombian children had a similar coverage of these interventions. There seems to be a marked preference for quick, one-touch and inexpensive activities. More complex, longitudinal and costly activities such as management of acute malnutrition had an extremely low coverage.

Among pregnant migrant women, 39-58% received a nutritional assessment, 42-55% received micronutrients and 1-8% received a treatment for deworming. Colombian women benefitted from a better coverage of all interventions (table 32).

Table 32. Coverage of nutrition interventions

	In-destination migrants	In-transit migrants	Host communities
Colombia	**57%** of Venezuelan under 5 received nutritional assessment; 31% deworming; 30% micronutrients; 1% management of acute malnutrition. GIFMM, 2023a; 14 regions; 2,387 households; 1,231 under 5 assessed		
	32% of Venezuelan children aged 5-9 received nutritional assessment; 24% deworming; 17% micronutrients. GIFMM, 2023a; 14 regions; 2,387 households; 1,348 children aged 5-9 years assessed		
	Venezuelan migrants under 5 years received: -nutritional assessment (48%) -deworming (36%) -micronutrients (21%) -acute malnutrition management (4%) WFP, 2023, 13 regions, 831 under 5	Venezuelan migrants under 5 years in transit received: -nutritional assessment (42%) -deworming (26%) -micronutrients (22%) -acute malnutrition management (2%) Venezuelan migrants under 5 years in pendular movements received: -nutritional assessment (30%) -deworming (21%) -micronutrients (12%) -acute malnutrition management (3%) WFP, 2023, 13 regions, 135 under 5 in transit, 216 under 5 in pendular movements	Colombian children under 5 years received: -nutritional assessment (63%) -deworming (39%) -micronutrients (32%) -acute malnutrition management (4%) WFP, 2023, 13 regions, 395 under five
	Venezuelan pregnant migrants received: -nutritional assessment (53%) -deworming (1%) -micronutrients (55%) WFP, 2023, 13 regions, 2130 participants	Venezuelan pregnant migrants in transit received: -nutritional assessment (58%) -deworming (8%) -micronutrients (42%) WFP, 2023, 590 participants Venezuelan pregnant migrants in pendular movements received: -nutritional assessment (39%) -deworming (2%) -micronutrients (48%) WFP, 2023, 1399 participants	Colombian pregnant migrants received: -nutritional assessment (71%) -deworming (19%) -micronutrients (79%) WFP, 2023, 1485 participants
	71% of pregnant women took some supplement; 60% took iron; 60% took calcium. WFP, 2023, 13 regions, 7097 participants in destination and host community; 590 in transit ; 1399 in pendular movements		

3.2.2 Children growth and development

Information on services for children growth and development was only available from Peru. The indicators are different for two sources and are not comparable. According to a report, 58% of Venezuelan migrants aged under 3 years living in Lima had attended growth and development checkups in the past three months (OPS, 2022; Lima; 426 households; 121 children under 3). According to another source, 64% of the Venezuelan refugee and migrant population aged 0 to 5 years accessed growth and development monitoring services: 74% vaccination services, 45% counseling (face-to-face, by telephone or similar) and 58% iron supplements (INEI, 2022; 8 cities; 3,680 households).

3.2.3 Maternal, sexual and reproductive health services

A report in Brazil suggests a breach between coverage of prenatal care among Venezuelan women settled in Brazil (92%) and those in transit (27%). In Peru, 100% of Venezuelan pregnant women had at least one prenatal visit. This is partially due to a policy to facilitate enrollment of pregnant women in the national insurance scheme (refer to sections 3.1 and 5.1 on access to the national health system and legislation/policy) (table 33).

46% of Venezuelan in transit and 42-52% of Venezuelan migrants in destination and their partners used a contraception method. Among contraception users, modern methods (permanent, implant, pills, barrier, Intra Uterine Device IUD) were the most common.

In Peru, services offered by the public health system seem limited. About 1 in 3 of Venezuelan who used contraception accessed their method free of charge from a health center or hospital; 17% accessed sexual and reproductive health counselling. In Colombia, 11% of households were not able to access the sexual and reproductive healthcare they required. In Guyana, 9% of those who required sexual and reproductive services were able to access them (table 33).

Table 33. Service coverage for sexual and reproductive health

	In-destination migrants	In-transit migrants	Host communities
Brazil	**92%** of Venezuelan pregnant women accessed prenatal care **46%** of Venezuelan men and women were using a contraception method including condom. Moverse, 2022; all regions but Roraima; 2,000 participants	**27%** of Venezuelan pregnant women accessed prenatal care **46%** of Venezuelan men and women were using a contraception method including condom. Moverse, 2022; Roraima; 682 participants from shelters	**80%** of Brazilian women reported using some form of contraceptive. R4V, 2023a
Chile	Prompt access to contraceptives and condoms in primary care centers is highly valued by young people aged 18-25 Obach. *et al.*, 2022; Tarapacá		

	In-destination migrants	In-transit migrants	Host communities
Colombia	**52%** of Venezuelan migrants reported contraception use. The most common method was permanent contraception (38%) followed by hormonal methods (implant and pills) Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants		
	11% of Venezuelan households had a non-satisfied need related to sexual and reproductive healthcare. GIFMM, 2023a; 14 regions; 2,387 households		
Guyana	**9%** of the Indigenous Venezuelan migrants who required reproductive and sexual health services (36%) accessed them. IOM, 2023b; 4 regions; 162 participants		
Peru	**42%** of Venezuelan migrants aged 15+ indicated that they or their partner had access to contraceptive methods (condom 27.3%, pill 25.6%, injection 20.8%, implants 17.2%, female sterilization 11.8%). **17%** of the Venezuelan refugee and migrant population accessed sexual and reproductive health education and counseling services. INEI, 2022; 8 cities; 3,680 households		
	50% of Venezuelan migrants aged 18-59 used contraception. Of these 84% used a modern method; 10% condoms; 4% emergency contraception; 3% traditional methods. **100%** of Venezuelan pregnant women had at least one prenatal visit. The average number of prenatal visits was of 3.7. OPS, 2022; Lima; 426 households; 7 pregnant women		
	42% of Venezuelan migrants reported contraception. Of these, 62% used a modern contraceptive method (hormonal, barrier, IUD or permanent); 18% condom; 8% traditional method (rhythm, temp, cervical mucus, exclusive breastfeeding); 2% emergency contraception; 17% another. Among Venezuelan migrants who used contraception, 39% bought it at a pharmacy or other establishment; 35% received it free of charge at the health post or hospital; 11% had it from Venezuela; 7% purchased it at the health post or hospital; 4% other 6% did not know/respond. ACH, 2022a; Lima; 374 participants		

Information on maternal healthcare is limited. The few sources identified tended to explore coverage of prenatal care and overlook coverage of skilled birth attendance and post-natal care. Yet, most maternal deaths occur in the intra and post-partum period.

3.2.4 Prevention and management of chronic diseases

Chronic diseases affect elder people most. A multi country study in Honduras, El Salvador, Colombia, Ecuador and Peru shows that 45-65% of internally displaced, migrants, returnees, refugees aged over 60 were on treatment (table 34). As citizens of their country, internally displaced and returnees had smoother access to their country health system, hence coverage of treatment may be higher for them than for migrants and refugees. For instance, in El Salvador, 92% of deportees, 81% of internally displaced and 50% of migrants had used health care services (HelpAge, 2021; main cities and towns; 146 participants).

A few studies in Peru explore the adequacy of the frequency of the treatment among Venezuelan migrants. **Treatment coverage with adequate frequency was more moderate. Only 22-39% of the Venezuelan adult population with chronic diseases received treatment with the required frequency** (table 34).

Table 34. Treatment coverage for migrants with chronic diseases

	In-destination migrants
Colombia	**64% of internally displaced, migrants, returnees, refugees aged 60+ with chronic conditions were on treatment.** HelpAge, 2021; main cities and towns; 170 participants
	79% of Venezuelan migrants with chronic pathologies accessed treatment. Of the 21% who did not access treatment, 61% were enrolled in the national health system. GIFMM, 2023a; 14 regions; 2,387 households
Ecuador	**63%** of migrants and refugees aged 60+ with chronic conditions were on treatment. HelpAge, 2021; main cities and towns; 187 participants
Peru	**45%** de los migrantes y refugiados mayores de 60 años con Chronic diseases recibían tratamiento. HelpAge, 2021; main cities and towns; 150 participants
	22% of Venezuelan migrants suffering from chronic illnesses received treatment with the required frequency. Another 10% received treatment but not with the required frequency. 68% did not receive treatment. INEI, 2022; 8 cities; 3,680 households

	In-destination migrants
	30% of Venezuelan migrants suffering from chronic illnesses received treatment with the required frequency. Another 18% received treatment but not with the required frequency. 51% did not receive treatment. ACH, 2022a; Lima; 374 participants
	50% of Venezuelan migrants below 5 suffering from chronic illnesses received treatment. **56%** of Venezuelan migrants aged 6-17 years suffering from chronic illnesses received treatment. **22%** of Venezuelan migrants aged 18-59 suffering from chronic illnesses received treatment with the required frequency. Another 18% received treatment but not with the required frequency. 60% did not receive treatment. **39%** of Venezuelan migrants aged 60+ suffering from chronic illnesses received treatment with the required frequency. Another 28% received treatment but not with the required frequency. 33% did not receive treatment. OPS, 2022; Lima; 426 households
	49% of Venezuelan migrants with a chronic illness received treatment. ACH, 2022a; Lima; 374 participants
El Salvador	**65%** of internally displaced, deportees and migrants aged 60+ with chronic conditions were on treatment. HelpAge, 2021; main cities and towns; 82 participants
Honduras	**46%** of internally displaced, deportees and refugees aged 60+ with chronic conditions were on treatment. HelpAge, 2021; principales ciudades y pueblos; 82 participantes

No information was found on the prevention of chronic diseases.

> *"Clinics and hospitals are part of a collapsed public health scheme. In the best of cases some older people can attend medical consultations, but they have to buy medicines pay for their own treatment because the State has no way to pay for them".*
>
> Woman, international non-governmental organization, Honduras

> *"Look, there are days that I buy medicine and I don't buy food, and there are days that I don't buy anything because I've gone three days without medicine and there is no money".*
>
> Elder man on the move, 72, Honduras
>
> (HelpAge, 2021)

3.2.5 Prevention and management of mental health conditions

Information on services to address mental health or psychosocial support is scarce. Multiple types of interventions with diverse timeframes exist. Usually, the type of intervention is not specified and the outcome either.

In Peru, 34% of Venezuelan migrants in need of psychological care received it (CAPS, 2022; Lima and Tumbes; 300 participants). In Guyana, 10% of Indigenous Venezuelan migrants were unaware of any services available to treat anyone who did not feel psychologically well while 90% said such a service did not exist (IOM, 2023b; 4 regions; 162 participants).

Many countries are ill-prepared to provide psychological care in face of the growing demand. In Paraguay only few family health units count with the service (R4V, 2023a). Peru faces a scarcity of professionals and minimal investment in this area of work (Consejo Danés para Refugiados and SJM, 2023). In Guyana there are often no psychologist in hospitals (R4V, 2023a).

No information was found on the prevention of mental health conditions.

3.2.6 Prevention and management of infectious diseases

Information on prevention and management of infectious diseases is scarce. In Peru, 22% of Venezuelan migrants aged 15+ accessed to a test for HIV and other sexually transmitted infections (INEI, 2022; 8 cities; 3,680 households) and 71% of Venezuelan pregnant women had an HIV and syphilis tests (OPS, 2022; Lima; 426 households; 7 pregnant women).

In Peru, half of people living with HIV were on treatment (R4V, 2023a). In Colombia, among Venezuelan migrants living with HIV, 48% were previously diagnosed, 38% were on treatment, 35% were virally suppressed (Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants). By contrast, the global commitments for HIV/AIDS state that by 2025, 95% of people with HIV know their status, 90% are on treatment, 86% are virally suppressed. Other countries, like Brazil and Chile, offer smooth access to HIV/AIDS medicines to migrants (Brazil - Kill Alvim, *et al.*, 2023 and Mocelin *et al.*, 2023; Chile - Obach *et al.*, 2022)

3.2.7 Unspecified medical care

Indicators in this field vary considerably. It is difficult to compare service coverage for migrants in destination. A study in Colombia has "over 5 years stay in the country" as an eligibility criterion. Therefore, migrants in this study had time to regularize their migratory status and gain access to the national healthcare system. Another variation consists in the timeframe of the indicator. It is very different to be able to access healthcare within the past month, the past 3, 6 or 12 months. Most likely the longer the timeframe the higher the probability of succeeding in multiple attempts to access healthcare. The cost of the services also matters. Migrants may manage to get access to required medical care but at a high cost. One report in Peru indicates the cost of the service received. Of those who accessed needed healthcare, 40% did not have to pay (table 35).

For Venezuelan migrants in transit in Colombia, 62% of those who required healthcare were able to access it. This figure was higher for Venezuelan migrants in pendular movements (87%). Perhaps migrants who come and go benefit from an improved access to information as they are not itinerant. In addition, many humanitarian organizations provide medical services in border areas. On GBV, in the specific context of

the journey through Darien, 37% of the 172 cases of sexual violence in 2022 were managed timely (within 72 hours) (table 35).

Two studies in Colombia comment on the reach of humanitarian aid. For Venezuelan migrants settled on the Atlantic coast and near the capital, 17% accessed humanitarian services. Regular migrants had better access than irregular migrants (22% vs 15%) (table 30). For migrants in transit about to cross the Darien jungle, 39% had received assistance in the past 30 days. Among these beneficiaries, healthcare was the most common type of assistance received by 40% (GIFMM, 2023b; 1,874 traveling groups, representing a total of 6391 people). Therefore, out of migrants in transit about to cross the Darien jungle, 16% had received healthcare provided by humanitarian organizations.

Table 35. Migrants 'access to unspecified medical care

	In-destination migrants	In-transit migrants
Brazil	**26%** of primary health care in Boa Vista was delivered to Venezuelan migrants. It reached 45% in some health facilities. UNICEF, 2022, shelters and spontaneous settlements of Boa Vista and Paracaima	
Chile	**80%** of Venezuelan households who required a health service in the past month accessed them. R4V, 2023a	
Colombia	**70%** of Venezuelan migrants who required a health service in the past three months were able to access it (66% for 15-24 old; 67% for 25-54; 86% for 55+) DANE, 2023; 23 cities, 3605 households of migrants with over 5 years of stay	**62%** of Venezuelan migrants in transit who required healthcare accessed it; **87%** for Venezuelan migrants in pendular movement. GIFMM, 2022; 13 regions; 717 participants in transit and 648 participants in pendular movements
	17% of Venezuelan migrants and refugees had accessed humanitarian services. Among those who utilized services, health care-related services included support for accessing national health services (33%); healthcare (28%); psychosocial support (10%) and support for GBV (4%). People with irregular migration status were less likely to access humanitarian services than migrants with regular status (22% vs 15%). Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants	

	In-destination migrants	In-transit migrants
Ecuador	**86%** of Venezuelan households that required medical attention in the past 6 months were able to access it. GTRM, 2023; 23 provinces; 2,541 households	
	Among Venezuelan families who tried to access healthcare since their arrival (average stay of 2 years), 73% received services. Of the services received, 40% were completely free, 20% were partially free, and 39% were provided at cost. The majority of those who were not able to receive services were either seeking to see a specialist (39%) or a primary doctor (36%) IIRC, 2021; Lima and North Peru; 870 households	
Panama	**54%** of migrants who required healthcare in the past three months were able to access it. UNHCR, 2022; 400 households	**37%** of the 172 cases of sexual violence in 2022 after the Darien journey were managed timely (within 72 hours). R4V, 2023a
Trinidad and Tobago	**81%** of Venezuelan migrants accessed needed health services in the past year. UNHCR, 2023c; 12 regions; 1,286 households	

3.3 Availability of essential commodities/inputs

Migrants have difficult access to healthcare. In several countries, access is also strenuous for citizens from the country with national health systems under unbearable strain. The literature on migration in the continent reports lack of medicines in Mexico and Central America (IFRC, 2022a), Honduras (HelpAge, 2021), Ecuador (HelpAge, 2021), Guyana (R4V, 2023a) as well as shortage of medical supplies in border areas of Bolivia, Argentina, Uruguay and Paraguay (R4V, 2023a).

In Peru, a study refers to the technological and logistic constraints that affect the provision of services to the general population, especially vulnerable population (Consejo Danés para Refugiados and SJM, 2023). Often the pharmacies of health facilities and hospitals manage a reduced stock of drugs or lack basic inputs for healthcare. As a result, patients need to source the inputs externally as out-of-pocket expenses (OPS, 2022).

> *"I have a foreigner's card and SIS (Seguro Integral de Salud). But the issue is the following: it is a SIS, but only in the system because the only things I have not paid for are the consultations, but I have had to buy everything from gauze, adhesives, everything"*
>
> Venezuelan migrant, Peru (OPS, 2022)

In Peru, it seems specialized hospitals benefit from better investment. Migrants from Lima demonstrated appreciation for hospitals offering specialized care (neoplastic diseases, rehabilitation, maternal-perinatal and pediatric care) noting their equipment and modern infrastructure. These hospitals are seldom accessed by migrants as they require referrals from general hospitals. In addition, they usually involve long distances and hence transport fees (OPS, 2022).

3.4 Access to adequately staffed services, facilities and information

3.4.1 Infrastructure

In some cases, the condition of the infrastructure jeopardizes the safety and the quality of services. In Bolivia, in border areas, health facilities lack running water hampering safe service delivery for both population in transit and host communities (R4V, 2023a). In Colombia, maternal and perinatal services have been disinvested due to their low profitability. The inadequate infrastructure result in long waiting times for women to be admitted, lack of intimacy for women in labor during vaginal examination, premature discharge of women and their infants, denial of companions despite being recommended by WHO (Mercado Romero, 2021).

In Honduras (HelpAge, 2021) and Peru (ACH, 2022a; Lima; 374 participants), **the number of health centers is insufficient** to cater for a high and growing demand for services.

In many countries **rural areas are not well served in terms of health facilities/healthcare services.** In border areas of Colombia, Ecuador, Chile, Argentina, Uruguay, Paraguay, Guyana, Panama, infrastructure is deficient, and services limited (R4V, 2023a; Panama – ONU-Habitat, ACNUR and OIM, 2021). Likewise, **provision of services to GBV survivors is often sparse outside urban areas** (R4V, 2023a). Conversely, in Brazil, a report mentions that health centers are too crowded in cities and that appointments are more feasible in rural health centers. Thus, Venezuelan households residing in capitals faced more difficulties in obtaining medical assistance (40%) than those residing in the countryside (28%) (R4V, 2023d).

A qualitative study in Peru indicates that **migrants in Lima found local health centers very convenient due to their proximity.** Time spent at the health facility is an opportunity cost. It is not used to income-generate activities or in caring/domestic duties. Proximity also entails saving transportation costs. Women with caring duties were particularly appreciative of proximity as it allowed them to go to the health facility with their children (OPS, 2022).

Too much proximity has, however, some drawbacks. It may expose service users to social norms and deter use of services. In Tijuana, Mexico, it was observed that some migrants, especially women, would refrain from using

sexual and reproductive services delivered in shelters to avoid social sanctions by family members (Llanes-Díaz *et al.*, 2023). Integration of health or multisectoral services may easily counteract this limitation of proximity.

There was no specific findings related to service delivery in community facilities (schools, grassroot organizations, religious buildings, etc.) or temporary infrastructure (tents or mobile units).

3.4.2 Health workforce density

To achieve Sustainable Development Goals (SDG) targets, an indicative minimum density representing the need for health workers was set at 4.45 nurses, midwives and doctors per 1,000 population (WHO, 2016). It is known as SDG index threshold. Health worker density for countries in the Americas provides an overview of the capacity of national health systems to respond to more demand. It remains an indicator among others. It provides no information on geographic distribution of the workforce within countries or on the contribution of other health cadres such as community health workers.

In South America, Bolivia, Venezuela, Colombia, Peru do not reach the SDG index threshold. By contrast Paraguay and Uruguay have more than twice the recommended density of health workforce.

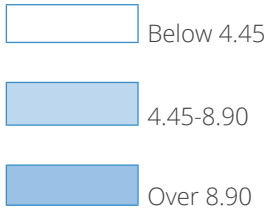
In Central America, Honduras, Nicaragua, Belize and Guatemala have limited health staff for their population.

In the Caribbean, most countries are above the threshold but Haiti, Jamaica, Dominican Republic and Saint Lucia.

In North America, Mexico has the lower workforce density but still above the threshold (table 36).

Table 36. Health workforce density by country (WHO, 2023a)

	Country	Nursing and midwifery personnel per 1,000	Year	Medical doctors per 1 000	Year	Total health personnel (nurses, midwives, doctors) per 1,000
South America	Argentina	5.4	2020	3.9	2020	9.34
	Bolivia	1.5	2017	1.0	2017	2.53
	Brazil	5.5	2021	2.1	2021	7.66
	Chile	4.6	2021	3.0	2021	7.57
	Colombia	1.4	2021	2.4	2021	3.81
	Ecuador	2.5	2018	2.2	2017	4.75
	Guyana	3.5	2020	1.4	2020	4.89
	Paraguay	9.0	2021	3.2	2021	12.27
	Peru	2.6	2021	1.6	2021	4.26
	Suriname	3.8	2019	0.8	2018	4.60
	Uruguay	11.6	2021	6.2	2021	17.75
	Venezuela	2.0	2018	1.7	2017	3.67
Central America	Belize	2.3	2018	1.1	2018	3.43
	Costa Rica	3.1	2021	2.8	2021	5.83
	El Salvador	2.6	2021	2.9	2021	5.55
	Guatemala	2.3	2020	1.3	2020	3.59
	Honduras	0.7	2018	0.5	2020	1.20
	Nicaragua	1.5	2017	0.7	2018	2.19
	Panama	3.5	2020	1.6	2020	5.17
Caribbean	Antigua and Barbuda	9.6	2019	2.9	2017	12.48
	Barbados	3.1	2018	2.6	2017	5.69
	Cuba	7.6	2018	8.4	2018	15.99
	Dominica	6.5	2018	1.1	2018	7.63
	Dominican Republic	1.4	2019	1.4	2019	2.87
	Grenada	5.7	2018	1.3	2018	7.06
	Haiti	0.4	2018	0.2	2018	0.64
	Jamaica	1.0	2018	0.6	2018	1.53
	Saint Kitts and Nevis	4.5	2015	3.0	2018	7.55
	Saint Lucia	3.2	2017	0.7	2017	3.88
	St Vincent and the Grenadines	7.3	2018	0.9	2012	8.29
	The Bahamas	4.4	2018	1.9	2017	6.24
	Trinidad and Tobago	3.7	2019	3.4	2021	7.15
North Americca	Canada	10.3	2021	2.5	2021	12.73
	Mexico	3.0	2020	2.4	2020	5.40
	United States	12.5	2020	3.6	2020	16.03



3.4.3 Healthcare timeliness and health system navigation

Unavailability of care or substantial delays in accessing care were major barriers in multiple countries. Unavailability of care may refer to the absence of health facilities, the absence of medical staff, the unwillingness of staff to receive patients, the unavailability of appointments, full facilities, etc. Delays may refer to delays in getting appointments, waiting times at the health facility, etc.

Both unavailability of care and delays constitute more acute barriers in countries with a policy of universal access to healthcare such as Brazil, Chile and Ecuador. In countries with no universal access, upmost barriers are related to affiliation to the health system and subsequent costs of care (Colombia, Panama, Costa Rica among others) (refer to section 3.1 on access to the national health system).

In Brazil, according to a study among Venezuelan in-destination, the main reason for not accessing care was delays in services (70%). Another reason was the lack of staff or specialists (21%) (R4V, 2023d). Another study mentions staff absence (19%), the difficulty in getting an appointment (17%) (Moverse, 2022; all regions but Roraima; 2,000 participants).

In Ecuador, 43% of Venezuelans migrants were not able to receive health care in the health centers they visited, 24% said medical appointments were unavailable, 6% mentioned the absence of specialists, medicine and/or equipment (GTRM, 2023). Another study found that 58% of Venezuelan families were denied care by doctors at least once (IRC, 2022). Another study adds that hospitals were always full (HelpAge 2021).

Canada also suffers from lack of appointment, long waiting times, delays in access at each point of contact with the healthcare system (Pandey *et al.*, 2022a).

> *"Out here it is easy to make appointments. But there is a long wait. First, wait at the doctors', then at the pharmacy, and time is a factor. I had to wait for 2 months to get an ultrasound for the stomach and was feeling very sick".*
>
> Migrant, Canada

> *"Last year had gallstone went to emergency 3 times they gave medicine and sent home. I waited for 5 months to get surgery. The wait time is too long for surgery and in the emergency, I was in pain. I was feeling like I was going to dying I tried to show by my body language. I have to wait for my ultrasound for too long I was upset and sad".*
>
> Migrant, Canada
>
> (Pandey *et al.*, 2022a)

Aside from the unavailability and delays of services, **a recurrent issue in many countries is health system navigation which refers to the multiple administrative procedures patients must follow to receive healthcare – or not – and time consumed**

in these processes. Some authors coin it bureaucracy (Peru – OPS, 2022), others "institutional maze/laberinto institucional" (Mexico – Llanez-Diaz *et al.*, 2023). Migrants have expressed the feeling of "being ping-ponged/ peloteados" during hours and days (Peru – OPS, 2022) or overwhelmed by the health system (Canada – Pandey *et al.*, 2022a). **They report facing an inhumane health system where processes, requirements, paperwork and money matter more than assistance to humans** (Colombia - Mercado Romero, 2021; Peru - OPS, 2022). To make it worse, staff raise arbitrary administrative barriers (Colombia - Consejo Danés para Refugiados, 2022b; Chile – Obach *et al.*, 2022) and/or charge irregular fees (Chile - Obach *et al.*, 2022; Peru – OPS, 2022). **These hurdles to navigate the health system undermine trust in the system** leading to preferences for self-medication (Peru – OPS 2022; Canada – Pandey *et al.*, 2022a) or private care (Peru – OPS 2022) or delays in accessing healthcare until urgent (Canada – Pandey *et al.*, 2022a). In Canada, migrants fear services will be unavailable when required (Canada – Pandey *et al.*, 2022a). In Mexico vulnerable host populations shared similar experiences and feelings (Mexico – Llanez-Diaz *et al.*, 2023).

The feeling of "being ping-ponged" applies to humanitarian organizations. In Peru, out of 25 humanitarian organizations, only six had a doctor sometimes or always. Other organizations provided medical referrals. **Multiple official and unofficial referrals contribute to the feeling of "being ping-ponged" and dent the concepts of patient-centered services and service integration.**

> *"Health is too much of a protocol."*
>
> Venezuelan migrant, Peru (OPS, 2022)

> *"It has happened on occasions that one has to resign oneself, I went there and they didn't accept it, they gave me the document, another document, then here, another document, so I know this, one takes it as a pulling leg game, from here to there from there to here, and, that is a bus fare, to any place it is a bus fare that comes out of your pocket, you resign yourself that you will never be attended."*
>
> Migrant, Colombia (Ariza-Abril *et al.* 2020)

> *"My husband and his mother kicked me out of the house. When I told him I was going to report him, he threatened not to let me see my children. A friend told me to file a complaint with the prosecutor's office, when I went they didn't help because I didn't have documents, at the council, they gave me a ticket, but they couldn't do anything for my children. A woman recommended that I go to the Montecristi council, where cases of Venezuelan women and children were attended to. I spent a week going back and forth, since I didn't have money for the tickets, I walked three hours every day."*
>
> Indigenous Venezuelan migrant woman, Ecuador (ACNUR and HIAS, 2022)

The bureaucracy of the health system takes place during health emergencies (Peru – OPS, 2022). There was no assistance in the absence of payment (Colombia, Peru). In Chile, women at a late stage of their pregnancies had to walk long hours to reach facilities where they are denied care due to the absence of documentation.

"I arrived at the hospital with an order that said the delivery was urgent and that they had to get the baby out quickly. Upon entering they asked for documents: SISBEN (subsidized health scheme) and medical insurance and a deposit of 200 thousand pesos to be able to assist me, if not, they would not do it, I gave about 150 thousand and with that they assisted me and my mom simply made the deposit and while she was filling out the information, I was admitted to the waiting room, even though the document said it was urgent, they did not attend me until the deposit was made."

Venezuelan migrant woman, Colombia (Mercado Romero, 2021)

"Once my grandson was bitten by a dog, and they took him to a Hospital. They asked him if he had SIS. At that time he had just got enrolled in SIS, they checked his SIS and told him that it was only good for service at the health center. And since the health center only works from Monday to Saturday, and I think it was a Sunday, they charged him there for stitches and everything. Not even emergencies, and he was a six to seven year old child."

Elder Venezuelan migrant, Peru (OPS, 2022)

"I have had cases of families who go to emergency, and an emergency consultation costs 12 soles, which is between 3 and 4 dollars. If you do not have the money, they do not attend to you in an emergency, they just give you a consultation. So if you need a medicine, you have to buy it, and if you are hospitalized, well, I have had cases where they do not discharge the person until they pay."

Woman, grassroots organization, Peru (HelpAge, 2021)

"I'm 35 weeks pregnant, I'm in a camp, and I don't know what's going to happen, because since I'm from Ecuador they don't want to help me, so they haven't helped me or given me any solution. Approximately two months ago I was able to get a check-up with the doctor, but it was also difficult because twice I had complications to arrive on time and then they wouldn't accept me. I had to walk the entire beach of Iquique to a Health Center that is very far away, the last time we walked five hours to get there, and they did not attend me because I did not have a temporary ID and I was told I need a provisional ID to receive good care, and that's the way it is."

Ecuadorian migrant woman, 20, Chile (Obach *et al.*, 2022)

3.4.4 Information about health services

The bureaucracy is difficult to navigate due to information gaps on the side of workers and patients. Workers do not have a clear understanding of regulations that govern migrants 'access to health services. A study on access to HIV/AIDS treatment for migrants in Colombia showed that public workers were unaware of regulations about the right of access to healthcare for migrants and added unlawful requirements (Consejo Danés para Refugiados, 2022b).

"I get the impression that there is a lack of accurate information in those who have to execute the health policies, who are the health workers of the CESFAM. I think there is little preparation for health staff to give this first information; they give the first answer that occurs to them and if they don't want to attend migrants, they don't."

Member of a migrant organization, Chile (Obach *et al.*, 2022)

On the side of migrants, lack of information and misperceptions are common reasons not to approach services. Often migrants do not understand the health system. In countries where access is free, they are unaware of the absence of costs for patients and refrain from looking for healthcare (Chile – Obach *et al.*, 2022; Chile – R4V, 2023a; Dominican Republic – R4V, 2023a). Sometimes migrants believe their irregular status at the health facility can result in detention (Chile – R4V, 2023a).

Aside from lack of knowledge about general access to health services, migrants are often unaware about the existence of specific health services. In Canada, migrants were in the dark about the role of family physicians in managing mental health conditions (Pandey, M., *et al.*, 2022b). In Chile, 64% of women were not aware of services available in their city to GBV survivors (R4V, 2023a). In Colombia, lack of information about their right to abortion was the main reason for which Venezuelan women did not access this service (Quintero *et al.*, 2023). In Peru, 69% of people living with HIV did not know where to get assistance in case of emergency (Consejo Danés para Refugiados and SMJ, 2023) despite NGO and grassroot organizations offering guidance, psychosocial support and free medication.

"Information is necessary. We have realized that foreigners think that they must have their ID in order to get access to health care, and this is not the case. In primary care, the passport is enough. Sometimes young people get sick and it's over a year and they don't seek care because they don't know that they have the right."

Midwife, Chile (Obach *et al.*, 2022)

Several platforms – web and social networks – have been created to provide information to migrants on services available. Some of them provide two ways communication with response guaranteed within 24 hours. In light of the number of migrants throughout the continent, the number of followers on Facebook remain moderate: 13,000 for Info Palante in Colombia; 2,800 for InfoPa'lante in Ecuador; 10,000 for Cuéntanos Honduras; 13,000 for Cuéntanos Guatemala; 3,700 followers for InfoDigna México; 362 followers for ImportaMi USA. The website versions display quite generic healthcare information, not specific to the local context and to local access to services. Some platforms go beyond countries but are limited to service points provided by an organization or a consortium of organizations, for instance HIAS[1] o R4v safe spaces[2], respectively.

It is usually complicated to know if the information displayed on a website is updated. In addition, websites are not always well referenced by Google. A google search on health services available to migrants in a specific country ranks government migration institutions or programmatic pages of humanitarian organization webpages first.

3.4.5 Culturally appropriate care

The most recurrent cultural barrier is language. This is more acute for some migrant origins (Haitians or Indigenous migrants) or in some host countries (Brazil, Guyana, USA and Canada).

> *"There it is very, very different (...) there are specialized places where you go and can get condom without paying, without passport, without tax number, without anything. But here it is different... to get condom one has to make an appointment with a midwife, and then if the person doesn't speak Spanish she doesn't go and she gets pregnant."*
>
> Haitian migrant woman, Chile (Carreño *et al.*, 2022)

In Brazil, 69% of Venezuelans in destination understand Portuguese well or perfectly (Moverse, 2022; all regions but Roraima; 2,000 participants). This proportion is 24% for Venezuelans in transit (Moverse, 2022; Roraima; 682 participants from shelters). In three studies on access to HIV/AIDS and syphilis services for Venezuelan/Latin American Caribbean migrant, language was identified as a barrier (Brazil – Mocelin *et al.*, 2023 and Kill Alvim *et al.* 2023; USA – Ramírez-Ortiz *et al.*,2021).

In Guyana, a scholarship program between Guyana and Cuba means some Guyanese doctors speak Spanish and were able to understand Spanish-speaking Venezuelan migrants. However, communication with Indigenous Venezuelan Nationals is much more challenging as only 8% of them speaking Spanish (IOM, 2023b; 4 regions; 162 participants).

In Canada, migrants with language constraints were more likely to suffer from medication errors, delays in diagnosis and suboptimal care (Pandey *et al.*, 2022a).

[1] https://app.mapahiaslac.org/

[2] https://www.r4v.info/es/document/gifmm-colombia-mapa-de-puntos-de-atencion-en-la-para-refugiados-y-migrantes-en-bogota-y https://espacios.r4v.info/es/map?utf8=%E2%9C%93&country_id=

Aside from linguistic barriers, **cultural differences may result in mistrust and a feeling of incompetence of the health system**. Enhanced cultural competence is desirable (Salami *et al.*, 2022). For instance, **certain migrant groups may have expectations as to the gender of the healthcare providers**. When these are not fulfilled, they may take distance with the health system (Canada – Pandey *et al.*, 2022a).

With regards to sexual and reproductive health, a study in Tijuana, Mexico among migrants in transit points to the heterogeneity of services offered to migrants. A mismatch between the range of contraception methods demanded and offered was reported. In addition, the lay orientation of services providers was identified as a facilitator to access contraception. (Mexico – Llanez-Diaz *et al.*, 2023). The preference for lay providers in sexual and reproductive health applies in Colombia. In this country access to abortion is a right. At least one humanitarian religious organization retained information and did not refer women who expressed desire for abortion to nearby organizations that would provide these services to migrant women at no cost.

3.5 Country-specific barriers

The table 37 below presents the results of country-specific surveys.

Table 37. Country-specific barriers

	In-destination migrants	In-transit migrants
Brazil	Reasons for Venezuelans not accessing care: delay in services (70%); cost of services (23%); lack of specialists (21%); distance (17%); lack of transportation (11%); language barriers (9%); lack of info (8%). R4V, 2023d	
	Reasons for Venezuelans not accessing care: other (documentation, discrimination, bad service) (44%); staff absence (19%); difficulty getting appointment (17%); opening hours (7%); COVID restriction (5%); discrimination (3%); no drug supply (2%); cost (2%); lack of access to information (1%). Moverse, 2022; all regions but Roraima; 2,000 participants	Reasons for Venezuelans not accessing care: other (documentation, discrimination, bad service) (40%); staff absence (16%); difficulty getting appointment (31%); opening hours (3%); COVID restriction (2%); discrimination (1%); no drug supply (4%); cost (1%); language (1%). Moverse, 2022; Roraima; 682 participants from shelters

	In-destination migrants	In-transit migrants
Chile	Reasons for Haitians not accessing care: 51% could not attend during opening hours; 46% experienced language barriers; 39% were far from a health center Luengo Martinez *et al.*, 2021; Chillan; 41 Haitians	
Colombia	Reasons for Venezuelans not accessing care: 56% had no documentation; 15% lacked information; 15% in process, 10% had no formal employment; 3% were unemployed; 2% felt healthy; 2% judged care too expensive. DANE, 2023; 23 cities; 3,605 households of migrants with over 5 years of stay	
	Reasons for Venezuelans not accessing care: lack of money to pay consultation (9%); lack of money to pay for treatment/medicine (4%); lack of money to pay for transport to health center (4%); long waiting times (6%); no nearby health center (4%). GIFMM, 2022; 13 regions; 3,295 households	Reasons for Venezuelans not accessing care: difficulty in obtaining insurance (40%), economic barriers (24%), access to transportation (11%) and availability of the service (11%). R4V, 2023a
Ecuador	Reasons for Venezuelans not accessing care: inability to receive treatment or not being treated at health centers they visited (43 %); unavailability of medical appointments (24 %); lack of money to cover specialized medical and related transportation expenses (10%); lack of specialists; medicine and/or equipment (6 %); lack of knowledge about access to medical services (4%); assumption of failure to get care (3%); and preference for self-medication (2%); health center closed (1%). GTRM, 2023; 23 provinces; 2,541 households	
	38% of Venezuelan families considered they faced barriers to access services: 58% mentioned that doctors had refused to assist them at least once and 24% could not afford medical care. IRC, 2022	

	In-destination migrants	In-transit migrants
Peru	74% of Venezuelan participants noted that there were barriers: cost (68%); migration status (40%); refusal to assist (10%); lack of medicines (4%); lack of staff (4%); lack of equipment (3%). Six of the service providers interviewed noted that they always, or sometimes had a physician available on site for consultations with Venezuelans. 23 reported that they provide medical referrals. IRC, 2021; Lima and North Peru; 870 households; 31 service providers from 35 organizations interviewed	
	Main reasons for Venezuelans not accessing care: lack of information (35%); documentation (34%); lack of money (15%); discrimination (8%); distance (7%) Consejo Danés para Refugiados and SJM, 2023	
	Reasons for Venezuelans not accessing care: the issue was deemed not serious enough (37%); lack of money (32%); no health insurance (19%); lack of time (11%); self-medication (9%); long waiting times (4%). INEI, 2022; 8 cities; 3,680 households	
Panama	Reasons for Venezuelans not accessing care: lack of money (27%); no health insurance (18%); lack of information (16%); service required unavailable (7%) UNHCR, 2022; 400 households	
Trinidad and Tobago	Reasons for Venezuelans not accessing care: lack of money (65%); turned away for being a refugee (24%); other (21%), language barriers (15%); turned away because facility was full (4%); facility too far (3%). UNHCR, 2023c; 12 regions; 1,286 households.	

CHAPTER 4:
Quality of health services

4.1 Adherence to quality standards

All government facilities and providers of healthcare should have in place quality norms and processes to fulfill. For most of them, migrants represent a small proportion of their users. Only some humanitarian organizations take care of migrants exclusively.

This literature review was focused on migrants. It seldom referred to quality of healthcare. The focus is more on coverage of services. It is very rare to find quantitative quality indicators. Academic papers tend to analyze quality more in depth than grey literature. Most of the content of quality of care among migrants revolves around maternal care and sexual and reproductive health. Most of the findings come from qualitative research.

In Colombia, Peru and Chile, breaches in maternal care leading to obstetric violence, have been reported among migrants.

In Colombia, pregnant migrant women irrespective of their status are entitled to integral care related to their pregnancy and delivery including pre and postnatal care. Clinical norms exist but in practice legal norms and clinical guidelines are not always abided by. Several women who participated in the study spent most of the labor in waiting rooms instead of delivery rooms. Women and their infants are discharged too early. There are accounts of unconsented and multiple vaginal examinations (Mercado Romero, 2021).

> *"What I didn't like afterwards was that in the early morning the students arrived and one is in pain and they were asking and asking. They are given explanations with oneself. They can't do it that way! and they ask the same questions over and over again, that was really bad, and on top of this, the residents, who were missing about two years, repeated the vaginal examination again".*
>
> Venezuelan migrant woman (Mercado Romero, 2021)

In Peru, qualitative research with 13 women who had recently given birth in Peru pointed to deficiencies in maternal care quality. Several recalled the insensitivity and carelessness of medical and nursing staff. All mothers referred with disgust to unconsented vaginal examinations sometimes conducted in front of groups or medical students. Three of them described that they underwent cutting, draining and stitching procedures without anesthesia. There was a fear that babies would be stolen and exchanged at the hospital. These perceptions are fueled by separations of the mother and newborn at the hospital and scarce information by health staff.

> *"The only thing that bothers is the examination. I had eight vaginal examinations in less than an hour. Do you know what is really bad here? : when the interns are there, each and everyone of them would start to look and it's like they've never seen a Venezuelan vagina before, I don't know. And they would tell me: 'no, ma'am, we need to do it again', and they would open me again, they would touch me again and everyone would look there. "It shouldn't be, it shouldn't be"*
>
> Venezuelan migrant woman, Peru

> *A mother gave birth at dawn. Until the evening no one would tell her where her baby was. They only gave the baby to her after she made insistent complaints to a doctor on duty "I recognized my son because I took him out on my own, carried him, put him to my breast and breastfed him. And I believe that, for a mother, that face will never be forgotten. When they brought the two babies to me, and the nurse has the nerve to ask me which of the two is my son, because neither had the identification bracelet (...) My son was born with a red mole, it looked like a little wart on the back. I lifted up the shirts of both babies and managed to identify him, automatically when I saw the mole I said 'this is my baby."*
>
> Venezuelan migrant woman, Peru

> *"I believe that Peru's health system is very fragmented and does not work as it should. I speak from my experience: the attention was lousy, from one to ten, I would not give it even one; what s more, I asked for a complaints book and they didn't t want to give it to me at the hospital, they told me the manager was not there, that the director was not there, they put many obstacles in my way. They almost changed my son. They did not attend the birth well, they stitched me up, denying me anesthesia. My contractions didn't hurt, I didn't feel any pain at all. nothing. I cried and screamed when I felt the eight stitches. I can't imagine the size of the cut, but there were eight stitches and three layers of skin."*
>
> Venezuelan migrant woman, Peru
>
> (OPS, 2022)

In Chile, testimonies from women who gave birth show breaches in infection and prevention control protocols, mistreatment and abuse. A generalized perception among young migrants that woman can suffer obstetric violence from health staff prevails (Chile - Obach *et al.*, 2022)

"In the emergency room at the hospital, the cloth that they gave me to cover myself was stained with fresh blood from a woman who had given birth, it was full of blood, it was even slimy, like mucus. I told the doctor and she said I should put it back on, and fast. Then she examined me and told me to wait, sitting in the corridor. I was sitting for three hours. This was like a punishment, it happened when I didn't have my ID. Now that I have a provisional ID, they treat me a bit better".

Venezuelan migrant woman, 20, Chile

"When I went to give birth to my daughter, they treated me badly, I was 17 years old at the time. The midwife was very tough, she told me that if I had liked making a baby, I had to put up with it, and if I made noises or yelled, they would tell me to shut up . . . I think that it was mostly because of my age and because they were racist".

Ecuadorian migrant woman, 24, Chile

"Now with the pregnancy, they have told me that I have to be very strong because here in Chile they say very ugly things to women".

Colombian migrant woman, 21, Chile

(Obach *et al.,* 2022)

In the field of nutrition, in Honduras, children suffering from acute malnutrition were given substandard treatment by humanitarian organizations. Typically, a treatment takes 8-10 weeks and requires several units of ready-to-use therapeutic food a day. Children were given only one unit and were counted as beneficiaries. Transit does pose serious challenges for the continuity of treatment. Nevertheless, a balance must be struck between quality and coverage of the intervention.

4.2 Users' satisfaction

By contrast with previous testimonies on maternal care, some migrant women who gave birth in host countries had very satisfying experiences (Colombia – Mercado Romero, 2021; Chile - Obach *et al.*, 2022). They reported humanized and free care.

The radical variations with regards to the experiences of the provider-patient relationships in maternal care put forward that the quality of the experience very much depends on the

> *"Well, it went well for me and I even feel very grateful that I did not have to pay for anything during my entire stay at the hospital."*
>
> Venezuelan migrant woman, Colombia (Mercado Romero, 2021)

> *"They were very attentive because of the tachycardia, and I didn't feel half my body, so they asked me all the time how I was feeling, they were very attentive to me and to two other women who were also there, if I had to go to the bathroom they always accompanied me, they would always be there at the time I had to bathe and eat."*
>
> Venezuelan migrant woman, Colombia (Mercado Romero, 2021)

> *"They treated me wonderfully. They even gave me anesthesia. I remember that doctor very much; she treated me very well, everything was fine. So maybe not all of them are bad."*
>
> Venezuelan migrant woman, Chile (Obach *et al.*, 2022)

> *"The quality of care is appreciated. In Haiti, check-ups are only done with a gynecologist... if there is no complication, they is no consultation with other specialties (...) here, they see midwives, a dentist and also a nutritionist, a social worker... not in Haiti".*
>
> Haitian migrant woman, Chile (Carreño *et al.*, 2022)

health staff in charge or perhaps the health institution. As such, there are serious caveats in national quality processes: quality standards are not enforced. A study in Colombia suggest that shortage of staff and insufficient remuneration of health staff are some of the reasons behind obstetric violence (Mercado Romero, 2021).

In Lima, Peru, migrants appreciated the quality of care in specialized hospitals highlighting good treatment and skilled staff. Likewise, there was a high level of satisfaction with regards to the growth and development program for children (OPS, 2022).

> *"At the health center they assist very well, when I took my small children they checked them. They themselves ask you if they already had a check up and tell you which vaccines are missing. They rule out anemia and deworm."*
>
> Venezuelan migrant woman, Peru (OPS, 2022)

CHAPTER 5:
Enabling environment

5.1 Legislation/Policy

The right to health care is universal and is captured as such in many constitutions in the region. In practice, health systems in the Americas and Caribbean are not so generous with irregular migrants. **According to the literature reviewed, Argentina, Brazil, Ecuador, Uruguay, Nicaragua, Dominican Republic and Trinidad & Tobago grant a free access to both regular and emergency care. Some of the countries only grant access to emergency care (Chile, Colombia, Paraguay, Mexico, USA) and some only cater for vulnerable populations – pregnant/lactating women and children under 5 (Bolivia, Peru, Costa Rica, Guatemala, Panama)** (table 38).

Table 38. Access to healthcare for migrants with irregular status

		Access to emergency and regular healthcare	Access to emergency healthcare only	Access to healthcare for pregnant/lactating women and children under 5.	Legal text
South America	Argentina	Yes			Ley 25,871
	Bolivia	No	No	Yes (Women can also access sexual and reproductive health)	
	Brazil	Yes			*Nueva Ley de Migración en* Brazil 2017
	Chile	No	Yes		Circular A 15 no 4; Circular letter 6232
	Colombia	No	Yes	Yes	Decreto 1288 (2018); Constitutional Court of Colombia Judgement T-760/08; T -210/18; T-348/18 superseded by T-025/19; T179/19; T-452/19; T246/20; T-496/20; T-517/20

		Access to emergency and regular healthcare	Access to emergency healthcare only	Access to healthcare for pregnant/lactating women and children under 5.	Legal text
	Ecuador	Yes			Art. 3, 9, 43 y 362 de la Constitución; art 52 de la Ley Orgánica de Movilidad Humana
	Guyana	Yes			
	Paraguay	No	Yes		
	Peru	No		Yes	Decreto legislativo 1350
	Uruguay	Yes			Ley del Sistema Nacional Integrado de Salud 2007; Ley de Migración 2007; Decreto 394/009
Central America	Costa Rica	No		Yes	Directriz No 057.2017; Decreto de la Caja Costarricense de la Caja de Seguro Social para el aseguramiento temporal de refugiados, solicitantes de refugio y migrantes en condición de extrema vulnerabilidad como niños y embarazadas
	Guatemala			Yes (Women can also access sexual and reproductive health)	Decreto 44/2016
	Honduras				Legal gaps
	Nicaragua	Yes			
	Panama	No		Yes	Art 109 y 110 Constitución Art 5 Código Sanitario
Caribbean	Aruba	No	No		
	Curasao	No	No		
	Dominican Republic	Yes			Case of Nadege Dorzema *et al.* Judgment of Oct 24, 2012. Series C No. 251
	Trinidad and Tobago	Yes			

		Access to emergency and regular healthcare	Access to emergency healthcare only	Access to healthcare for pregnant/lactating women and children under 5.	Legal text
North America	Canada	No	Yes - only in Ontario and Quebec		Interim Federal Health Program
	Mexico	Yes		Yes (Women can also access sexual and reproductive health)	Ley de migración, artículo 8. Reforma a la Ley General de Salud 2019 Comprehensive Health Care Plan for the Migrant Population (PIASM)
	EE.UU.	No	Yes	No	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 Emergency Medical Treatment and Active Labor Act (EMTALA)

5.2 Budget/expenditure

5.2.1 Projected and actual costs per person for health/nutrition/GBV interventions

For year 2022, the R4V platform reported on the projected cost and the actual cost of interventions in different sectors including healthcare/nutrition/GBV (table 39).

For health, the overall budgeted cost per person (USD 85) is almost twice the actual cost per person (USD 48). All countries/subregions but the Southern Cone have a lower actual than budgeted cost. The range for projected costs and actual costs per person is broad: USD 63-478 and USD 9-328 respectively.

For nutrition, conversely to health, the budgeted amount per person is almost half the actual cost (USD 46 vs USD 81). In Peru and the Caribbean, interventions ended up 4-5 times more expensive than budgeted. Similar to health, ranges are broad: budgeted USD 28-268/person vs actual USD 22-1,408 per person.

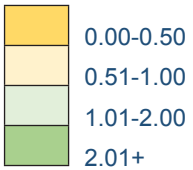
GBV follows the pattern observed in nutrition with an average budgeted cost of USD 86 and an actual cost of USD 148. Most countries exceeded their budget per person. Again, very broad ranges are observed: USD 51-677/person targeted, and 5-24,581/person reached.

Two figures are very eye-catching: USD 1,408 per person reached in the Caribbean for nutrition and 24,581 per person reached in Central America & México for GBV. Reporting mistakes may occur especially when data is consolidated from multiple actors.

This analysis is useful from a donor perspective. It is, however, an uneasy task to interpret these data in the absence of additional information on the nature and success of the interventions. For instance, should a very low individual actual cost be interpreted as an intervention of very high efficiency, of poor quality or a result of good access to free public services? It is important to remember that R4V reports on the platform´s achievements and leaves aside the sizeable contributions of national governments to migrants´ health assistance. In addition, not all partners report all migration-related activities to the R4V platform as some of their activities are funded by other donors.

Table 39. Budget and cost analysis of R4V interventions in three sectors (R4V, 2022a)

	Health			Nutrition			GBV		
	Estimated cost per person targeted	Actual cost per person reached	Actual cost/ estimated cost	Estimated cost per person targeted	Actual cost per person reached	Actual cost/ estimated cost	Estimated cost per person targeted	Actual cost per person reached	Costo real / costo proyectado
Total	**85**	**48**	**0.57**	**46**	**81**	**1.77**	**86**	**148**	**1.71**
Brazil	191	9	0.05	144	70	0.49	96	5	0.06
Chile	478	9	0.02						
Colombia	76	51	0.67	35	22	0.65	52	213	4.13
Ecuador	78	30	0.38	70			51	134	2.64
Peru	63	23	0.37	28	140	4.93	205	37	0.18
Caribbean*	177	178	1.00	268	1408	5.25	334	321	0.96
Central América and Mexico	210	45	0.21				597	24,581	41.19
Southern cone***	178	328	1.84	35			677	6	0.01



*Caribbean includes Aruba, Curaçao, Dominican Republic, Guyana, Trinidad and Tobago
**Central America includes Costa Rica y Panama
*** Southern cone includes Argentina, Bolivia, Paraguay y Uruguay.

5.2.2 Corruption

In the literature reviewed, there were a few reports of corruption. **Corruption took place at different levels.**

In Honduras, several actors referred to a collapsed health system unable to respond to a high and growing demand with a limited number of health centers, shortage of staff, equipment, medicines and other inputs. One key informant put forward that **the lack of resources of the social security system is partially due to corruption** (HelpAge, 2021).

Corruption also takes place at the level of the health facility to get healthcare workers to perform the tasks they are responsible for. In Peru, children under 5 regardless of their status have the right to health care. Yet in the account below, the mother had to pay the healthcare workers to register the child. Other accounts from Peru give testimonies of **professionals from the public health sector referring patients to their own private practice** (OPS, 2022). In Chile, **migrants are charged irregular fees (Obach *et al.*, 2022).**

"Living in San Juan de Lurigancho, I had to come to vaccinate him here in La Victoria, because I paid the admission girl fifty soles to open a medical file and give the vaccines to my son."

Venezuelan migrant woman, Peru (OPS, 2022)

"The doctor who was treating me at the hospital told me 'you can do some tests, you can go to a certain laboratory, it's safer', like he was selling me a package. And when I had the problem that I couldn't find someone who could change my catheter, he told me 'look, call my secretary', when I called the secretary the first thing I had to deposit was eighty soles".

Elder Venezuelan migrant, Peru (OPS, 2022)

"I entered with my passport, I had to pay. At that time, I did not know that care should be free, and I was having the fear that I could be sent back to my country [deported]. They do not tell you in the health center that it is free. They attend and that's it, they don't give you that option or that basic knowledge. Now I have more knowledge".

Ecuadorian migrant women, 19, Chile (Obach *et al.*, 2022)

5.3 Management/coordination

There are several coordination mechanisms in response to migration across the continent.

Established in 2017, **the MIRPS (Marco Integral Regional para la Protección y Soluciones/comprehensive regional framework for protection and solutions)** is a government-led response for a regional and national coordination and response to forced displacement in Central America and Mexico. Belize, Costa Rica, Guatemala, El Salvador, Honduras, Mexico and Panama are members of the framework.

Since 2018, **El Proceso de Quito** is a government - led initiative gathering 13 countries to exchange experiences and develop a regional response to the Venezuelan refugees and migrants' crisis. Country members are Mexico, Costa Rica, Panama, Guyana, Dominican Republic, Colombia, Ecuador, Perú, Brazil, Chile, Uruguay and Argentina. The Proceso de Quito tackles two health-related areas of work: COVID-19 and HIV/AIDS.

The R4V is a coordination multisectoral platform created to coordinate the response to the Venezuelan crisis, led by the United Nations High Commissioner for Refugees and the International Organization for Migration. Established in 2018, it gathers 200 organizations of diverse type – UN agencies, civil society, religious organization, NGO, among others – in 17 countries of Latin America and the Caribbean (Mexico, Costa Rica, Panama, Aruba, Curaçao, Trinidad and Tobago, the Dominican Republic, Guyana, Colombia, Ecuador, Peru, Brazil, Bolivia, Argentina, Chile, Paraguay, and Uruguay). At country level, partners work to produce strategic information, plan, implement and report to avoid duplication and overlaps. Despite these efforts a visit to the platform does not allow program officers and/or migrants to easily grasp who does what where when and for whom. R4V partners are bounded by donors´ interests and priorities, short-term funding, beneficiaries´ eligibility, and other constraints. The multisectoral assistance offered to migrants by R4V partners is fragmented and difficult to keep updated.

Although participation of government officials in coordination meetings is frequent, **the valuable contributions of national governments are not included in the R4V platform**. The breach between some coordination mechanisms and the public sector is noticeable in multiple platforms that aim to inform migrants or program officers on service availability[3]. They do not feature government services: healthcare, helplines for mental health, services for GBV, among others.

5.4 Social norms: discrimination

A relevant social norm to this study is discrimination. **The general xenophobia and discrimination towards migrants prevalent in society gets expressed in the health sector by service providers, administrative staff, guards, among others who abuse their power.** The literature reviewed mentions discrimination in South and North American countries and most of Central countries. Literature on the Caribbean is scarcer.

The surveys below quantified the Venezuelan experience of general or health sector specific discrimination (table 40).

[3] *Cuéntanos Honduras Guatemala El Salvador; IInfo palante Ecuador y Colombia; GIFMM Colombia 4W; ImportaMi USA includes government services in its mapping.*

Table 40. General and health sector specific discrimination

	In-destination Venezuelan migrants	In-transit Venezuelans
Brazil	**26%** reported being victims of discrimination. Moverse, 2022; all regions but Roraima; 2,000 participants	**20%** reported being victims of discrimination. Moverse, 2022; Roraima; 682 participants from shelters
Colombia	**47%** of experienced stigma/discrimination a few times per year or more. 90% believed stigma and discrimination were targeted on the basis of their migration status. Red Somos, 2022; Bogota, Soacha, Barranquilla, Soledad; 6,221 participants	
Ecuador	**58%** mentioned that doctors had refused to assist them at least once. IRC, 2022	
Peru	**18%** Venezuelans identified acts of discrimination and xenophobia as barriers to accessing health insurance or receiving care. GTRM, 2022; Lima, Tacna, Trujillo, Tumbes: 255 participants	
	61% felt discriminated against. **22%** reported being discriminated in health facilities. OPS, 2022; Lima; 426 households	
	28% experienced discrimination and xenophobia. CAPS, 2022; Lima and Tumbes; 300 participants	

Discrimination acts against migrants at health facilities follow a gradient. The most direct form of discrimination is mistreatment by healthcare staff with references to patients' origin. Studies in Peru and Chile found that young women were particularly often victims of this direct discrimination and experienced strong judgements on their sexual behavior (Chile – Obach *et al.*; 2022 Peru – OPS, 2022). Obstetric violence may also be an expression of discrimination (refer to section 4.1 on adherence to quality standards).

"I went to the hospital with pain, they told me that I only had the sack without a baby, they had to take it out. And I remember, I will never forget it, a nurse said 'oh, so young? this shitty Venezuelan having an abortion'. What they didn't know was that I had been trying to get pregnant for two years and I couldn't, and it wasn't a baby, only the sac. And they kept me for two days and I was losing a lot of blood, and that I had to wait, that there were priorities".

Venezuelan migrant woman, Peru (OPS, 2022)

"The treatment was horrible, because he came and asked me if I was from Venezuela, I obviously said yes and then he started to speak ill of all Venezuelans that we were taking jobs away from Colombians, that we had come to displace them and all those things, that if I was pregnant why didn't I stay in my country, he is supposed to be a professional and he was pretty rude."

Venezuelan migrant woman, Colombia (Mercado Romero, 2021)

On the other end of the gradient, subtle forms of discrimination consist in denial of care citing diverse excuses or making up requirements or refusal to provide information. They may be difficult to detect. According to a study conducted in Ecuador, 38% of Venezuelan families considered they faced barriers to access services. Fifty-eight per cent of these mentioned that doctors had refused to assist them at least once (IRC, 2022).

"They have been turned away from immediate emergency care. Many Venezuelans have died seeking help. Access to a hospital is not necessarily a decision made by doctors, nurses or the director. Access is decided by staff of private security companies who discriminate against Venezuelans and do not allow them to enter. That's why it's a problem to get medical care from a hospital."

Man, national public entity, Ecuador (HelpAge, 2021)

In between mistreatment and subtle forms of discrimination, there is an array of discriminatory practices such as keeping migrants longer in queue and successive rescheduling of appointments.

Conclusion

Epidemiologic profile and service coverage

Migrants have a poor nutritional status. While minors suffer mostly from low weight, adults and elder people suffer from overweight. **According to international classifications, depending on surveys and countries, the level of acute malnutrition in migrant children under the age of five ranged from low to very high. For chronic malnutrition, it goes from moderate to high.** By contrast, over half of adults and a vast majority of elder people were overweight or obese. As to anemia, 18-36% of children under 5 and 32-37% of pregnant women suffered from moderate or severe anemia. **Nutritional status is an issue across the continent for both migrant and host communities. In Central and South America, the percentage of people in need of nutrition interventions is constant across both communities.** In Colombia, there is no evident disparity between the nutritional status of migrant and host community.

The response to poor nutritional status falls short. The most common nutrition interventions among migrant children under 5 were: nutritional assessment (42-57%), deworming (21-36%), micronutrients (12-30%). There seems to be a marked preference for quick, one-touch and inexpensive activities. More complex, longitudinal and costly activities such as management of acute malnutrition had an extremely low coverage (1-4%). For pregnant women, only 60% of Venezuelan and Colombian pregnant women were taking an iron supplement. **Achieving an optimal nutritional status among pregnant mothers and children is a key prevention strategy to reduce vulnerability to acute and chronic diseases, in addition to many other benefits.**

The maternal and sexual and reproductive health status of the migrant population is very concerning. With regards to maternal health, an analysis of maternal mortality rate in Colombia and Brazil suggests that **mortality among migrants is twofold the national mortality rate.** In Colombia, in 2022, every week, 73 notifiable events of extreme maternal morbidity were reported. **Obstetric violence has been documented in several countries. C**oncerning sexual and reproductive health, **one out of ten pregnancies in the Venezuelan migrant population was from a girl.** A survey in Brazil unveils that about **2 in 3 pregnant migrant women did not want to be pregnant.** Four data analyses or studies related to sexually transmitted infections (HIV/AIDS, syphilis, herpes (VHS-2)) showed that **the prevalence among migrants was about twofold the national prevalence. In Colombia and Peru, HIV treatment coverage among migrants was approximately 38% and 50%.**

No study on other infectious diseases among migrants was identified. Surveillance data in Colombia suggest ongoing spread of dengue, malaria, varicella, tuberculosis.

The burden of chronic diseases is substantial and only a fraction of patients receive treatment with the required frequency. Between 62 and 78% of Venezuelan migrants aged 60+ had a chronic disease. The proportion was 13-15% among adults, 8% for school age children and 4% for children under the age of 5. In Peru, only 22-39% of the Venezuelan adult migrant population with chronic diseases received treatment with the required frequency.

Disability affected 16%-66% of elder migrants and 2-26% of adult migrants. No information was found on interventions to address disability.

Mental health issues are prevalent in the migrant population with 21-90% of adults suffering from moderate to high anxiety and/or depression as well as 18-56% of elder people presenting mental health issues. Children and adolescents are also affected although no range of magnitude was found in these age categories. **Neither information on coverage of mental health conditions nor description of treatment were found. Many countries stand ill-prepared to face this problematic.**

Violence is part of migration. Migrants are exposed to diverse types of violence: physical, psychological, sexual. Among migrant men and women in transit, about 13-18% had experienced violence. This proportion was 5-13% for settled migrants.

Migrants in displacement had conditions specific to their displacement such as wounds, dehydration, joint injuries, insolation.

The elderly migrant population is overlooked. Aside from a couple of reports, their specific needs are not portrayed.

Expressed needs for healthcare

Among in-transit migrants, the need for healthcare was high (59-69%). Most required a general practitioner. With regards to sexual and reproductive health 6-41% were in need. Main needs were contraception, STI prevention and management, and maternal care.

Among in-destination migrants, healthcare needs were considerable (23-74%). The percentage varied depending on the country and the timeframe under consideration. The most needed type of care was a general practitioner. Other types of care required were maternal and pediatric care, exams and tests, medicines, chronic diseases management and specialized care, mental health. With regards to sexual and reproductive health, 22-36% of migrants in destination required these services.

While in-transit migrants require humanitarian health care, in-destination migrants require integration to the healthcare system in order to access a broader range of health services.

National health systems

The response to migrants' health needs depends heavily upon national health systems. The analysis of migrants' health-seeking behaviors shows that migrants tend to turn to public health facilities and hospitals in the first place. The reach of healthcare provided by humanitarian organizations was found to be limited. For instance, in Colombia, the country with the largest stock of Venezuelan migrants, about 17% of migrants in destination accessed some kind of humanitarian services (multisectoral). For migrants in transit about to cross the Darien jungle, 16% had received humanitarian healthcare.

According to the literature reviewed, Argentina, Brazil, Ecuador, Uruguay, Nicaragua, Dominican Republic and Trinida & Tobago grant a free access to both regular and emergency care to irregular migrants (universal access). Other countries only grant access to emergency care (Chile, Colombia, Paraguay, Mexico, USA) and some only cater for vulnerable populations – pregnant/lactating women and children under the age of 5 (Bolivia, Peru, Costa Rica, Guatemala, Panama).

The irregular status or the lack of documentation of migrants is one of the major barriers to access health care: migrants are denied access to national health insurances because they do not fulfill eligibility criteria; professionals from the health sector use the absence of documents/insurance to deny care even to patients in life-threatening conditions; in countries where they have access to healthcare regardless of their status, migrants often have the misperception that they are not entitled to services and fear being deported. **In the region, more than one in three refugees and migrants was in an irregular situation.**

The lack of capacity and coverage of national health systems is a major hindrance to healthcare. It is a hindrance for migrants and also population from host countries. Infrastructure is insufficient: urban health centers and hospitals are collapsed, rural areas are underserved, facilities lack running water. There are reports of shortages and stock-out of essential commodities and inputs in many countries. Patients are left with no choice than sourcing medicines and commodities externally as out-of-pocket expenses. **In terms of health workforce, close to half the countries in the region are below the minimum density** to achieve Sustainable Development Goals targets set at 4.45 nurses, midwives and doctors per 1,000 population. **From Canada to Chile, healthcare timeliness is a major challenge with unavailability of care, substantial delays, a heavy bureaucracy qualified as "inhumane" by users.** Users feel overwhelmed and ping-ponged in the midst of multiple procedures and referrals, which erodes trust in the health system.

Health systems are under severe pressure to respond to the needs of their own and immigrant populations. In Honduras, there is such an excess demand over offer that humanitarian organizations made multiple calls in 2023 for international solidarity. In Guatemala, the nutritional status of children is worse than that of migrants. One out of two children suffer from undernutrition. The country has the third-highest rate of chronic malnutrition, worldwide.

Quality of healthcare

Diverse breaches of quality have been described: non-respect of clinical norms and of infection prevention and control protocols; incomplete treatment unaligned with evidence-based recommendations; non-consensual medical procedures; discriminatory and demeaning treatment; obstetric violence and harmful delays.

On the other hand, **the search for better health services in host countries is a motivation for migration** especially for population with more intense health care needs such as pregnant girls/adolescents/women and elder people. Some migrants provide laudatory testimonies of their experience.

A crucial observation emerging from the review of reports by organizations and platforms is the absence of indicators on quality of healthcare. Most indicators were on coverage. Possibly, this is partially due to the monitoring challenges posed by dynamic populations. Yet simple satisfaction surveys could be used for some of the activities. For medium- and long-term treatments required for chronic diseases, malnutrition, mental health, among others, a reflection is needed as to whether the observed measurable one-touch first stage of a medium or long term treatments with minimal impact is preferred over bolder interventions more multisectoral, more effective, but with a high risk of no routine measurement as migrants will resume their journey with more than an initial dose of their treatments. The second option will require more financial resources. As the cost analysis in this report reveals some very high costs per person, a higher unit cost may not be a major constraint. It may be justifiable on the grounds of more quality interventions.

Substantial quality issues were also observed in strategic information presented in grey literature on health and migrants. Some examples are figures are not well transcribed from their original source; survey questions and their responses from the original source are misinterpreted to magnify an issue; there are mismatches between the narrative and the figures; statements are not supported by data presented. From a methodological angle, a shortcoming in the analysis of maternal care is the focus on prenatal care and silence on critical indicators such as coverage of skilled birth attendance and post-natal care. It is well known that most maternal deaths occur in the intra and post-partum periods. For mental health, the use of standardized measurement tools would produce more meaningful and comparable data.

Multisectoral and integrated response

It is important to reiterate that part of the prevention and solutions to many health conditions observed lies beyond the health sector. Poor water and sanitation practices due to resources constraint led to diarrhea. Some of the mental health conditions can be resolved through -non-healthcare- assistance. Nutritional status is strongly dependent upon livelihoods. Migrants face concomitant needs. More impact will be achieved through a more integrated and multisectoral response.

"We see many cases, aggressive people, without self-control. In childhood care, we can handle a lot of stress, a lot of anxiety, and we try to understand but also to take care of ourselves".

Scarlet Chirinos, psychologist, Honduran Red Cross (Danlí, Honduras, 2023)

"What has had the greatest impact on us is looking after babies who are only days or months old; children who don't even know how to speak. We welcome them at the centre and give them the loving treatment they deserve until we can hand them over to their waiting family members".

Gabriela Oviedo, Honduran Red Cross (Honduras, 2023)

"I spent seven days trying to save water from a bottle I bought before starting the journey (...) You can't climb the mountains of Darien without drinking water".

Adiel, Haitian (Darien, Panama, 2021)

"Arriving in Panama was one of the happiest moments of my life, it is very hard because I had to fight for it. The Red Cross was the first to help us and for me it was a blessing. In pursuit of our dream for a better life, we lost everything. So, three meals a day, soap, a towel, a bath, being able to talk to someone or be cared for, that means everything".

Francis, Sierra Leonean (Darien, Panama, 2023)

"Every day of the year we go out in the racer to look for migrants who need help. Although there are even more arid areas, here in Nogales during the summer, the temperatures are extreme. Heat stroke, dehydration and animal bites are common. But in the winter, the desert is also a deadly threat".

Lupita González, emergency medical technician, Mexican Red Cross (Nogales, Mexico, 2023)

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