MIGRATION AND HEALTH IN THE AMERICAS:

A Need and Service Assessment 2021-2023

SHORT VERSION

IFRC

In collaboration with:

Norwegian **Red Cross**

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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)

Contents

Acronyms and definitions

Acronyms

GBV	Gender-based Violence
MMR	Maternal Mortality Rate
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 neighbouring country (R4V, 2023c)

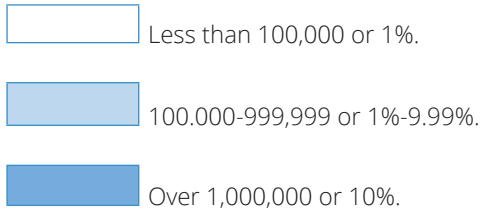
Highlights of migration in the Americas and the Caribbean

Overall, since 2010, the number of international migrants in the Americas grows. In northern America and the Caribbean, the increase is steady. In South and Central America, there is an intensification of the increase since 2015 (Our World in data, 2020)

Zooming in at country level, 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.

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%

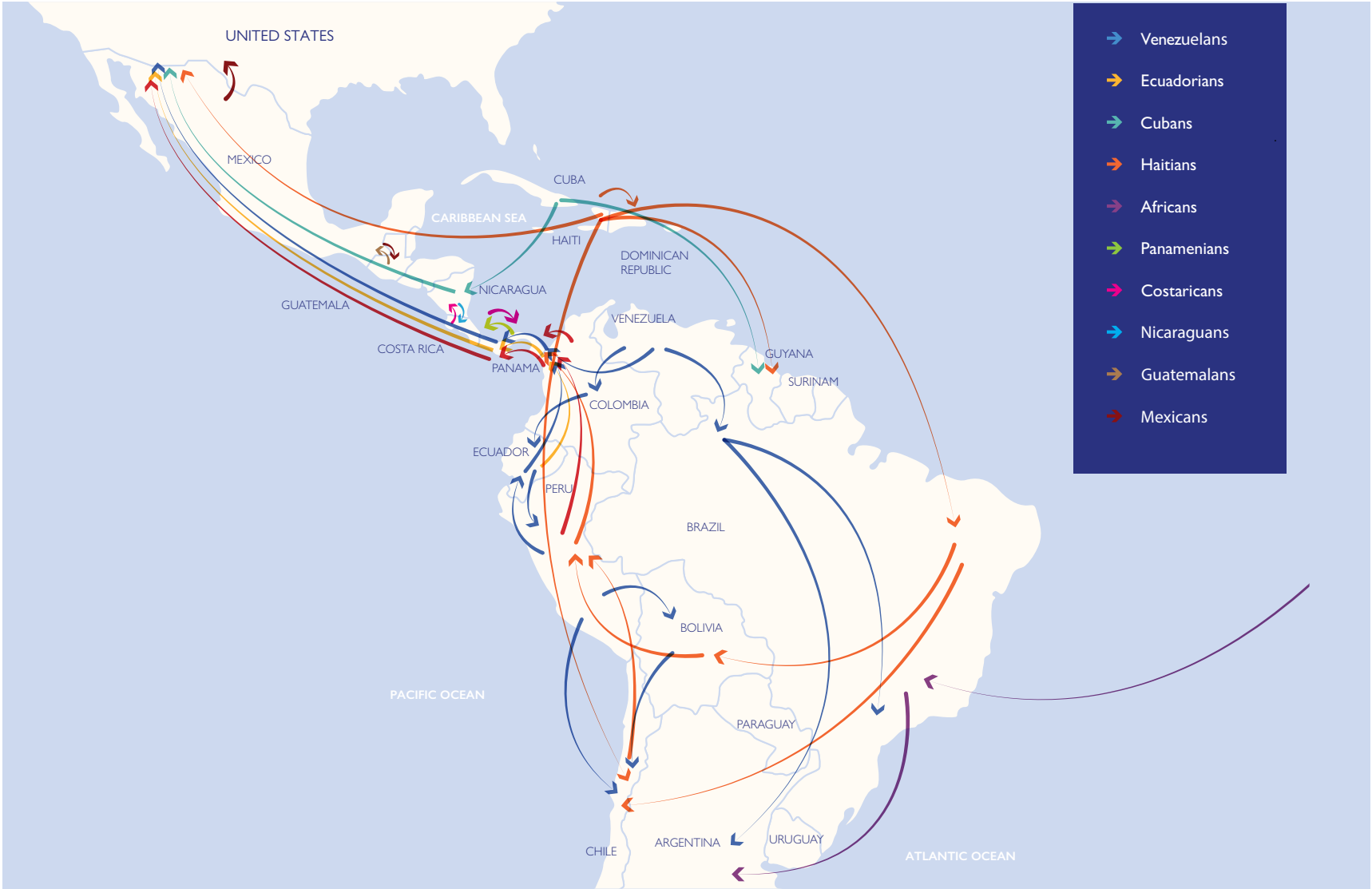


	Countries	Number of international migrants	International migrant stock as a porcentage of the total population
Central America	Belize	62,000	16%
	Costa Rica	520,700	10%
	El Salvador	42,800	1%
	Guatemala	84,300	1%
	Honduras	39,200	0%
	Nicaragua	42,200	1%
	Panama	313,200	7%
Caribbean	Antigua and Barbuda	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 Americca	Canada	8,000,000	21%
	Mexico	1,200,000	1%
	United States	50,600,000	15%

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).

The map below summarizes main migration routes through the continent.

Migrations flows in the Americas (IOM, 2023a)



> *"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 (CICR, 2020)

The flow of irregular migrants along the northern route follows an increasing trend from 2021 to 2023.

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).**

In the adult population in transit, surveys show a higher proportion of men than women. The ratio is roughly 60% men–40% women. **Taking into account minors, the distribution is approximately 16-33% of minors, 24-29% of women, 41-55% of men among migrants in transit.** According to UNICEF (2023), migrant groups include a growing proportion of children. As is, the Americas has a higher proportion of minors among migrants and refugees compared to the world average (25% vs 13%).

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).

Needs and demand

Children under five years

Low birth weight

In Colombia, the proportion of low birthweight to Venezuelan migrants is within the national range (11% vs 10-15%) whereas in Brazil, it is more than double the national average (24% in Boa Vista and Pacaraima vs 5-10%).

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. The world target for exclusive breastfeeding is a rate of 50% by 2025 and 70% by 2030.

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%).

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.

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.

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

Moderate or severe anemia affects as many as one in three or one in five migrant children.

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 children 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 (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.** The recommended vaccination coverage for diphtheria, pertussis, tetanus, Neisseria meningitidis, Streptococcus pneumoniae is 90% (Immunization Agenda 2030, 2021).

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%** (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).

Children and adolescents aged 6-17 years

Nutritional status

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

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).**

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 discussions from the same study, **participants 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 in Brazil and Colombia 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.

Vaccines

A study in Brazil revealed that 70% of children and adolescents 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% of all children and adolescents did not communicate easily; 3% had issues seeing (OIM, 2023; Colchane; 420 surveys).

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. Migrants in

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

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.

Sexual and reproductive health

A survey in Brazil unveils that about 2 in 3 pregnant migrant women (both in destination and in transit) did not want to be pregnant. (Moverse, 2022; all regions but Roraima; 2,000 participants and 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).

> *"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.**

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).

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.

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. 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). 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)

> *"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."*
>
> *"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)

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

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.

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

"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

"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)

Elder people (60+ years)

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%).

> *"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 organisation, 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.

Pregnant and breastfeeding girls/ adolescents/women

Proportion of pregnant and breastfeeding migrants

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

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.

Maternal mortality

In Colombia, the maternal mortality rate (MMR) among Venezuelan mothers is twice the national MMR (125.3/100,000 vs 43,8/100,000). 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.

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 (309/100,000 vs 117/100,000).

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.

Expressed Need by type of care

Ranking needs for different types of healthcare is complex. 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.**

Among in-destination migrants, healthcare needs were substantial (23-74%). 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. One study in Peru states that 30% of migrants required emergency care** (DRC, 2023).

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.

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.

Supply of health services

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.

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.

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 health (R4V, 2023a).

Service coverage

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%). 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.

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 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).

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.

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.

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.

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 (HelpAge, 2021).

> *"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 organisation, Honduras (HelpAge, 2021)

> *"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)

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.**

No information was found on the prevention of chronic diseases.

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.

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).

Humanitarian care

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%). 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 6,391 people). Therefore, out of migrants in transit about to cross the Darien jungle, 16% had received healthcare provided by humanitarian organizations.

Response capacity of the health system

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).

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).

> *"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 adults (Peru - OPS, 2022)

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.

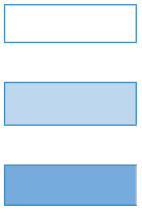
There was no specific findings related to service delivery in community facilities (schools, grassroot organizations, religious buildings, etc.) or temporary infrastructure (tents or mobile units).

Health workforce density

To achieve Sustainable Development Goals 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 Sustainable Development Goals index threshold. Healthworker 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.

Health workforce density by country (WHO, 2023a)

	Countries	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



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.

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).

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).

> *"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)

"Once my grandson was bitten by a dog, and they took him to the 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 centre. 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'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)

"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)

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."

Elder Venezuelan migrant, Peru (OPS, 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).

> *"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] or 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.

[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 and https://espacios.r4v.info/es/map?utf8=%E2%9C%93&country_id=

Quality of health services

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 gray 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).

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

(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

(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.

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.

> *"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)

> *"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)

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 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)

Enabling environment

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 Trinida & 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).

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.

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.

> *"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)

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).

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.

> *"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)

Conclusion

Needs vs services

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.** Concerning 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.

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 gray 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.

Additional information available in the full report

- Tables with country-specific quantitative data on health conditions of diverse age groups differentiated for in-transit and in-destination migrants, with sample size and source of information. These tables contain all sources of information not indicated in this short version.

Example:

Infectious diseases among migrant adults

Countries	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 Venezuelan, an increase of 32% compared to 2021. R4V, 2023[a]		National HIV/AIDS detection rate: **16.5 per 100,000** National HIV/AIDS detection rate among pregnant women: **3 cases/1,000 live births** R4V, 2023a

Countries	In-destination migrants	In-transit migrants	Host communities
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

- Qualitative data
- Country-specific legislation and access barriers to health care for migrants
- Additional factors that affect demand for services
- Additional analyses on migration stocks and flows in the Americas and the Caribbean
- The study methodology
- A full and detailed bibliography

“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)

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network. Our secretariat supports local Red Cross and Red Crescent action in more than 191 National Red Cross and Red Crescent Societies with around 17 million volunteers. Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard-to-reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient places where people can live safe and healthy lives, and have opportunities to thrive.

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