LATIN AMERICA

ACCESS TO HEALTH - THEMATIC NEWSLETTER

NOVEMBER 2024

ACTION AGAINST HUNGER

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CONTENT

1. FRAGILE HEALTH SYSTEMS AND SOCIAL INEQUITY ARE BAD COMPANY

We present this publication with the purpose of sharing Action Against Hunger´s perspective on access to health in Latin America. As an organization, we promote health as a fundamental right and are dedicated to reducing inequalities in access to health services and opportunities. Our main objective is to contribute collaboratively to the achievement of universal health coverage[1]. In this publication, we present our position and propose solutions based on data collected from the **most recent analyses** in our areas of intervention. In addition, we provide conclusions derived from joint reflection processes with **local administrations** responsible for providing basic health services to their populations. Through this medium, we seek to foster a constructive dialogue on the challenges and opportunities for improving access to health in the region, backing up our proposals with solid evidence and practical experiences in the field.

The advances in health in the Americas region have been remarkable over the years[2]. But these achievements have been crumbling in the last decade, a situation that has been accelerated by the effect of COVID-19 pandemic in practically all countries, returning to situations considered as emergencies is some areas. In 2023, in Latin America and the Caribbean there was a setback of 32% of the targets of the 2030 Sustainable Development Goals, related to areas such as health, poverty, inequality, education, work and nutrition, with the result that the region came to consolidate itself as the most affected by the triple crisis generated by the pandemic. If current trends continue, only 15% of the targets will be met by 2030[3].

In the countries where Action Against Hunger works, the average life expectancy has been reduced in the last years.

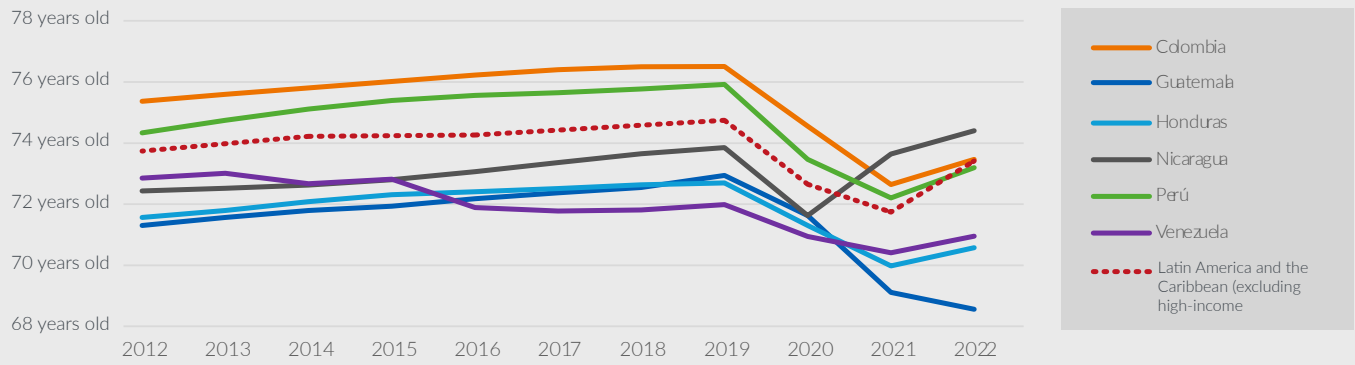


Figure 1: Average life expectancy over the last 10 years in countries where Action Against Hunger has been active in Latin America and the Caribbean: World Bank; Life expectancy at birth, total (years) | Data

The recent setback in health indicators has highlighted the fragility and limited resilience of health systems in Latin America in the face of catastrophic events. These systems have proven incapable of guaranteeing equitable and quality care for the entire population, showing a loss of efficiency in the use of resources and sensitivity to diverse needs[4]. The current structure and financing fail to provide affordable services for different population groups, exacerbating existing inequalities[5]. The seriousness of this situation became more evident during the recent COVID-19 pandemic, when the region recorded mortality rates significantly higher than the global average. Despite representing only 8.4% of the world's population, Latin America accounted for 32.1% of all COVID-19 deaths reported up to August 31, 2021[6].

[1] Universal health coverage means that all people have access to the full range of quality health services they need at the right time, in the right place, and without suffering financial hardship. It is a concept that encompasses the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care throughout the life course. WHO; Universal Health Coverage (UHC)

[2] For example, infant mortality decreased by 35% and under-5 mortality decreased by 46% between 2000 and 2017. Panorama of Health: Latin America and the Caribbean 2020, https://doi.org/10.1787/740f9640-es

[3] Economic Commission for Latin America and the Caribbean (ECLAC), Latin America and the Caribbean Faced with the Challenge of Accelerating Progress towards the 2030 Agenda: Transitions towards Sustainability. Synthesis (LC/FDS.7/4), Santiago, 2024.

[4] According to WHO: the extent to which health care services provided to individuals and populations improve desired health outcomes. This requires that they be safe, effective, timely, efficient, equitable and person-centered.

[5] Source: WHO, Monitoring the Building Blocks of Health Systems, op. cit.

[6] Mortality by COVID-19 and inequalities by socioeconomic level and territory | ECLAC

This disproportionate impact not only reflects the structural weaknesses of health systems, but also underscores the persistent social inequality that keeps a large part of the population in poverty, limiting their opportunities for development and overall wellbeing.

One of the indicators that best demonstrates this situation of inequality and the risk of continuing the cycle of poverty in health care is the percentage of **out-of-pocket** spending as a percentage of total health care spending by families. This indicator measures what proportion of a country's total health expenditure (including public investment) is covered by families through out-of-pocket payments. A high value reflects weaknesses in the coverage and equity of the health system.

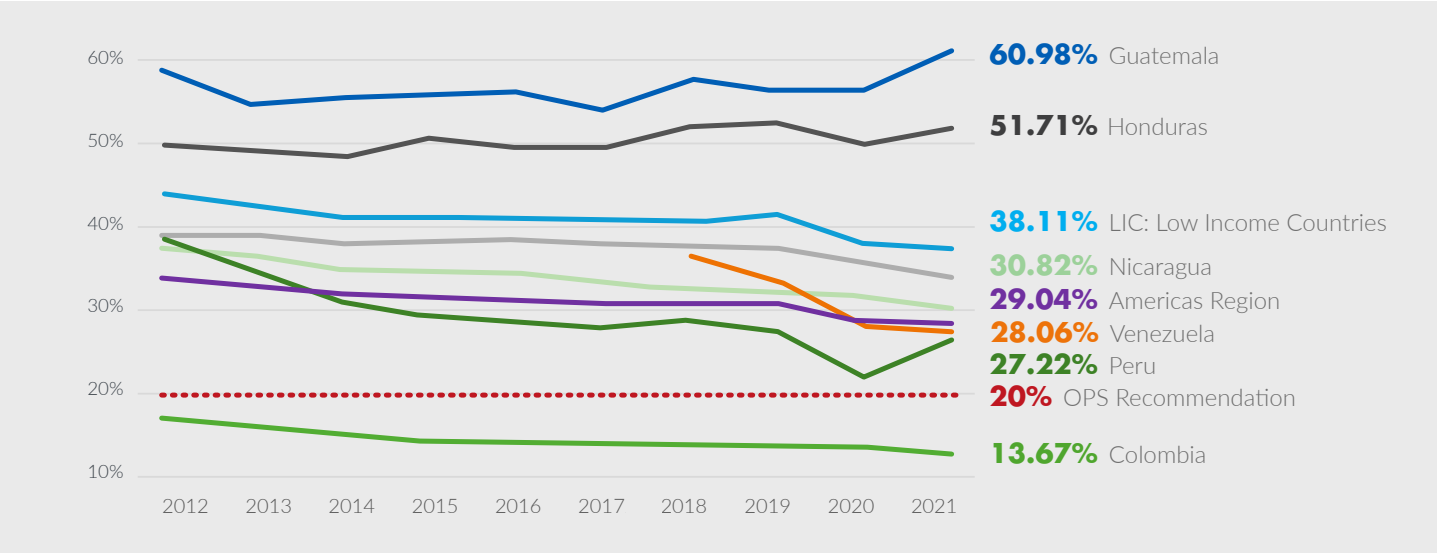


Figure 2: Out-of-pocket spending as % of total health expenditure. Source: WHO. Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%). Global Health Observatory data repository. [Online] 12 05, 2023.
https://apps.who.int/gho/data/node.main.GHEDOOPSCHESHA2011?lang=en

Significant challenges persist in access to health care. Approximately 29.3% of the population does not seek medical care when needed due to various barriers. The main challenges include organizational barriers (17.2%), such as long waiting times, financial barriers (15.1%), lack of resources (8.4%), acceptability barriers (8.0%), such as language problems and distrust of medical personnel, and geographic barriers (5.4%). These difficulties especially affect the most vulnerable groups, exacerbating health inequalities[7].

The health of the population is a fundamental pillar for the sustainable economic and social development of any nation. Failure to invest responsibly in health condemns a society to a cycle of underdevelopment that is difficult to overcome in the short term. This neglect weakens both individuals and systems, perpetuating a vicious cycle of poverty and disease. The most severe effects of poor health are concentrated in the most vulnerable sectors of society: those with lower incomes, lower levels of education, precarious working conditions, limited access to health services, decent housing and basic services. This disparity not only affects individual well-being, but also hinders collective progress, underscoring the urgent need to prioritize investment in health as a key strategy for the comprehensive and equitable development of countries.

In Latin America, comprehensive solutions are being proposed to reform health systems, ranging from the restructuring of their financing to the incorporation of community potential in service delivery. Although these proposals are based on validated and recommended formulas, there is a growing need to emphasize two fundamental aspects: the facilitation of a multisectoral approach and the development of models that transcend traditional health system services. In particular, the importance of fostering synergies with other systems, such as the social health protection system, is highlighted. This broader and more collaborative approach promises to more effectively address the region's health challenges, leveraging resources and capacities from diverse sectors to achieve a more significant and sustainable impact on the wellbeing of the population [8, 9,10].

[7] Rev Panam Salud Publica 44, 2020 | https://iris.paho.org/bitstream/handle/10665.2/52572/v44e1002020.pdf?sequence=1&isAllowed=y
[8] Comparative study of health systems in Latin America, Mariela Sánchez-Belmont Montiel. Inter-American Conference on Social Security. ISBN: 978-607-8088-95-9.
[9] M. .L. Marinho, A. Dahuabe, and A. Arenas de Mesa, "Health and inequality in Latin America and the Caribbean: La centralidad de la salud para el desarrollo social inclusivo y sostenible", Políticas Sociales series, No. 244 (LC/TS.2023/115), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2023.
[10] According to PAHO, the social protection system in health is: the guarantee that society grants, through the public authorities, so that an individual or a group of individuals can satisfy their health needs and demands by obtaining adequate access to the services of the system or of any of the existing health systems in the country, without the ability to pay constituting a restrictive factor

2. NEEDS ANALYSIS

In the **"slow motion crisis"** affecting the region, guaranteeing access to health becomes a challenge and a priority. According to the recently published ECLAC report[11], public spending on health has increased in the region in the period 2020-2021, reaching 4.5% of GDP, but this is mainly due to the extraordinary investment made during the pandemic, and "a slowdown is expected from 2022 onwards". In the same way, out-of-pocket health expenditure and catastrophic expenditure have decreased on average[12], but the coverage of services remains stagnant on average at 80% and with huge differences between territories and collectives. In fact, **"around 295 million people had unmet health care needs in 2022 and 79 million incurred catastrophic expenditures".**

The most vulnerable groups and women are those with the worst health outcomes. "The lowest income quintile has a **maternal mortality** equivalent to **more than seven times** that of the highest income quintile. The same occurs with the mortality of children under 5 years of age; the most disadvantaged group in terms of income has about **4.5 times the risk of dying** compared to the most economically advantaged group. *[...]* The same is repeated for chronic noncommunicable diseases: the most disadvantaged group has a 46% higher risk of dying between the ages of 30 and 69 from these diseases compared to the most advantaged group. Finally, 2019 data indicate that the mortality rate attributed to **unsafe water,** poor sanitation and lack of hygiene is almost **six times higher** in the lowest income quintile, highlighting the effect of living conditions on people's health." **Women** face specific barriers such as "economic difficulties (56.7%), followed by distance to health facilities (36.6%), reluctance to go alone (29.7%) and the need to obtain permission from the head of household to go to the service (13.5%)" (ECLAC).

THE SITUATION IN THE TERRITORIES WHERE WE WORK

This regional situation is particularly acute in some of the territories where we work, particularly affecting certain population groups. In October of this year, we conducted a **needs analysis** in priority territories to assess access to health care. In this analysis, we examined information on the situation of **205 health centers** in Peru (170, Metropolitan Lima); Colombia (6, Putumayo); other countries (22) and Central America (7, El Paraíso, Honduras). In addition, we interviewed 54 key informants, and conducted 17 focus groups, 25 interviews and 94 surveys of community members.

To strengthen our analysis, which we present below, we also compiled information from a multisectoral analysis of Peru and previous surveys of migrants and the local population in Honduras and Guatemala.

[11] The urgency of investing in health systems in Latin America and the Caribbean to reduce inequality and achieve the Sustainable Development Goals - October 2024
[12] Out-of-pocket health care expenses that exceed the threshold of 10% or 25% of household income.

MIGRANTS

The Darien region, on the border between **COLOMBIA** and Panama, has experienced an unprecedented increase in mixed migration flows. The migration experience in the Darien is profoundly influenced by the health status of the people, in addition to economic factors. Long walking distances, climatic variability, uneven terrain, food insecurity, exposure to unsanitary conditions and protection riks, problems maintaining personal hygiene and exposure to vectors are some of the health challenges faced by migrants.

Migrant children are especially vulnerable, as families travel through the harsh conditions of the journey, exposing them to numerous health risks. Lack of access to safe drinking water, the cost of accessing it, and inadequate sanitation contribute significantly to the prevalence of diarrhea and other gastrointestinal diseases. According to UNICEF, In the first 7 months of this year, more than 46,500 children and adolescents crossed the Darien jungle.

As part of the humanitarian response to this emergency, we have implemented various strategies to address these urgent child health needs, providing direct medical care and distributing essential medicines. The evaluations we carried out have revealed that about **12% of the surveyed children were found to be malnourished or at risk of malnutrition.** Forty-nine percent of the children between 0 and 5 years of age were stunted and 26% were underweight. These data underscore the urgency of health and nutritional interventions to reduce the risks in transit through the Darien jungle.

The main gaps we found include the lack of protective spaces for children in the camps at the entrance to the Darien, limited access to easily transportable food for the route, and the lack of hydration points in strategic locations in the jungle. The latter is crucial to reduce the consumption of unsafe water and water-borne diseases, which together with factors such as dehydration due to the climate in the Darien jungle, cause innumerable serious health problems.

The next point of attention in this route in which we operate is the border of entry to **HONDURAS,** where 286,000 people entered in the first 8 months of the year. "When I left the Darien jungle, the Panamanian police threw my medicines in the trash. I begged them not to do it, but they wouldn't let me cross the border with medical treatments." Rosa, 39, is a migrant and takes olanzapine to deal with the bipolar disorder she was diagnosed with years ago. In June, she sold her house and all her belongings, for a total of US$4,500, to travel with her husband and children to the United States, in search of a job that would allow her to pay for the treatment she can no longer get in her country. "A box of generic meds costs around US$12, while the original costs up to US$38. And in my country, we earn about five dollars a month," she explains.

Rosa is sitting in a small doctor's office at the back of the Alivio del Sufrimiento temporary rest center for migrants in the Honduran department of El Paraíso, 11 kilometers from the Nicaraguan border. She has been days without taking her treatment and feels a great relief when she receives a voucher to buy two boxes of pills from the doctors who attended her. There are many testimonies like this one, where people narrate from their experiences of how their health has worsened during the trip. Among the people in transit requesting medical attention, we identified numerous chronic diseases, such as cancer, leukemia, diabetes, cardiovascular problems, respiratory problems, motor disabilities, hernias, psychiatric problems such as depression and bipolarity, people with special needs such as autism in children, injuries due to accidents, bruises and infectious diseases such as malaria, dengue, chikungunya, flu and gastrointestinal problems. Approximately 8.5% of the children served are at risk of malnutrition due to a journey that economically does not allow them to eat the adequate quantity or quality.

In October 2024, we conducted a survey of people in transit in El Paraíso, Honduras, to identify their main needs. We collected 277 responses, in which the majority indicated food, lodging and transportation as urgent needs to continue their route to the United States and Canada. Eight percent expressed a need for medical attention, a percentage that increases to nine percent when asked if anyone in their group is sick or injured, with stomach or intestinal problems predominating. In addition, almost a third of the respondents (29%) have had to make some health expenses (between US$20 and US$30) during the trip. Although 48% reported access to treatment, **40% said they would not stop for treatment,** highlighting the importance of having health care points along the migratory route. More than 50% of those surveyed reported that their **mental health and psychosocial wellbeing** were affected, with symptoms of sadness (57%), hopelessness (35%) and guilt (14%) prevailing. The need for health care services for this type of health problem is clear, but the health structures and systems do not have the capacity to provide this service in the transit points of this population.

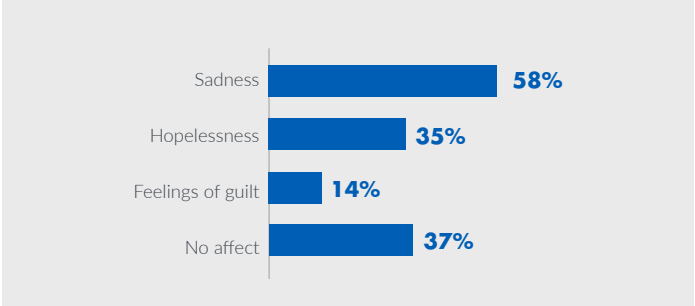


Figure 3: Main mental health and psychosocial effects of the population in transit (n=277. El Paraíso, Honduras)

As part of the coordination with the Honduran Ministry of Health (SESAL), we interviewed personnel from the Health Centers along the migration route in El Paraíso, who reported difficulties in accessing medical care due to the speed of the migrants' transit. The necessary referrals and referrals complicate proper treatment, in addition to the lack of medicines and **language barriers.** The main services provided in these centers are related to basic emergencies and sexual and reproductive health programs. There is a marked lack of mental health and psychosocial support services, as only 2 of the 7 centers surveyed had a minimal service.

Barriers to access to services are also important in places of arrival, such as in **PERU**. The needs assessment that we have very recently conducted in Metropolitan Lima (October, 2024), shows, for example, that 72% of migrants with **chronic diseases** (hypertension, diabetes, asthma, among others) do not receive care or specific treatment for long periods, thus being more at risk the **80%** who do not have the Comprehensive Health Insurance (Seguro Integral de Salud or SIS).

In **sexual and reproductive health (SRH) and mental health (MH),** 85% and 72.7%, respectively, reported barriers to care, such as lack of information, lack of personnel and difficulties in obtaining appointments.

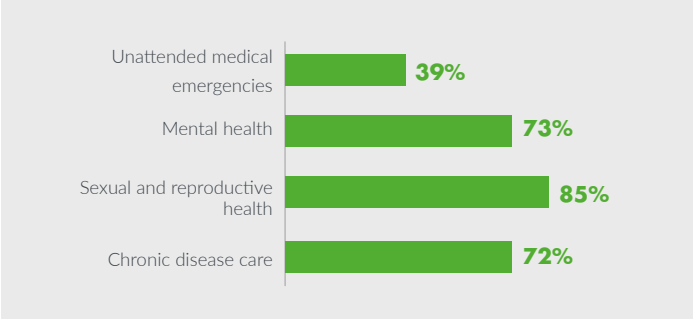


Figure 4: Gaps in health care for migrants in Metropolitan Lima

The number of **medical emergencies** not attended due to lack of resources and documentation is alarming. Thirty-nine percent reported discrimination in access, mainly due to poor care and denial of appointments. We received many expressions of lack of vital access to facilities[13].

The most important barriers are the lack of SIS[14], lack of information, lack of economic resources, lack of cultural relevance of the system, among others, with the aggravating factor of the lack of a family support network which mitigates child labour and neglect.

We have also detected a lack of **sensitivity towards migrant women** with precarious street jobs and care needs for their children, and for people in transit these barriers are exacerbated by limitations of stay and the urgency of the cases.

[13] Statements such as: "I took my son with fever and convulsions, but they did not attend me due to lack of money for the consultation"; "My apartment burned down, ... they did not want to attend my 2 children ..., I could not pay for the hospitalization, ... I did not have the SIS"; "I did not have the SIS".
[14] Medical personnel do not attend or avoid attending to migrants without SIS because they cannot register them as actual consultations, and it is on this basis that they are paid their salary.

COLOMBIA: THE CHALLENGE IN HARD-TO-REACH AREAS

In addition to the situation of migration and/or displacement, social vulnerability is another important determinant of health, which in Latin America is especially evident in rural, dispersed or hard-to-reach areas. Needs assessments conducted in Colombia in the municipalities of Puerto Asís and Puerto Guzmán (**Putumayo**), and Manaure and Uribia (**La Guajira**), in collaboration with health centers, municipal mayors' offices and community representatives,[15] reveal the health access limitations faced by these territories.

In Putumayo, it was identified that, so far in 2024, there have been 5 deaths in children under 5 years of age associated with Acute Diarrheal Diseases (ADD), Acute Respiratory Infections (ARI) and acute malnutrition, and 163 cases of moderate and severe acute malnutrition in children under 5 years of age, mainly in Puerto Asis (27% of cases in the department). In terms of communicable diseases, the department has reported 4,219 cases of Dengue fever, which represents an increase of 275% compared to the previous year, with Puerto Asis and Puerto Guzman being some of the municipalities with the highest increase.

DENGUE CASES REPORTED IN PUTUMAYO OCTOBER 2024		
Municipality	Cases	% Increase
Puerto Asis	504	1838%
Orito	410	900%
Villagarzón	561	835%
Mocoa	1.174	410%
Puerto Guzman	594	175%
Puerto Caicedo	108	157%
San Miguel	271	115%
Guamuez Valley	415	82%
Puerto Leguízamo	182	17%
Departmental total	4.219	275%

Source: National Institute of Health (INS). Epidemiological Bulletin (Oct, 2024).

Access to health services is limited due to mobility restrictions and confinement imposed by non-state armed groups. In the rural areas of Puerto Asís and Puerto Guzmán, some health centers operate on average only 10 hours a day due to security conditions and structural deficiencies, such as lack of medical personnel and supplies. Approximately **38% of households are more than an hour away from the nearest health center** and the health network only offers low complexity care.

The health services offered, although inufficently, are general medicine provision, child health, maternal and neonatal health, family planning, prevention, diagnosis and treatment of non-communicable diseases. Services not offered include specialized medicine, basic surgery, and treatment of tuberculosis and malaria.

It is evident that the constant exposure to violence and the barriers to access to **basic** services **have increased stress levels and affected the mental health of the population.** However, access to mental health care services is limited by the basic care plans in rural areas.

Regarding food security and impacts on nutrition, it was identified that in the municipalities of Puerto Asis and Puerto Guzman, 29% of the households are food insecure, and in the case of indigenous communities 57% of households have serious gaps in their food consumption and access to drinking water is precarious. **Eighty-three percent of rural households in these municipalities depend on surface water sources.**

In La Guajira, we see that the health and nutrition situation continues to be critical, especially for the Wayuú indigenous communities, due to their geographic isolation and difficulties in accessing basic services. It is the department with the highest number of confirmed deaths (31 cases) due to acute malnutrition in children under 5 years of age in the country.

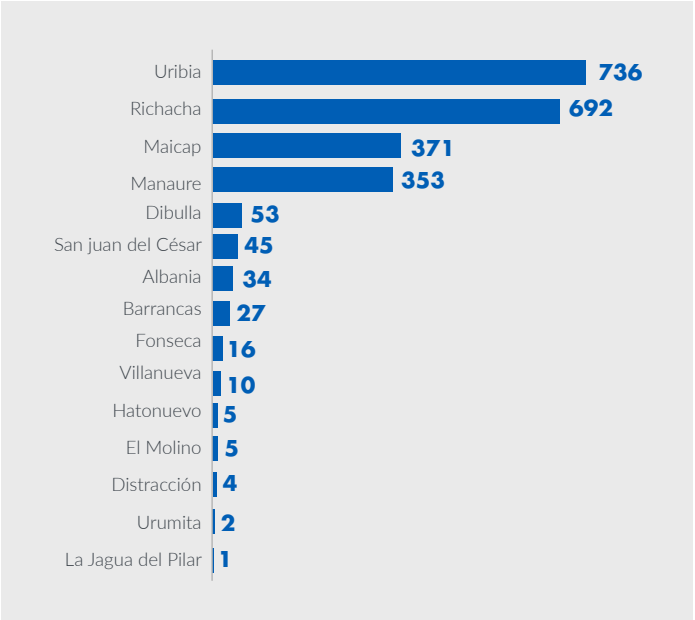


Figure 5: Acute malnutrition in children under 5 years of age - La Guajira. Source: National Institute of Health (INS). Epidemiological bulletin, October 2024.

During 2024, there have been 2,345 cases of moderate and severe acute malnutrition in children under 5 years of age, 76% of which belong to Wayuú communities. In addition, according to data collected by our teams in the municipalities of Manuare, Riohacha, Uribia and Maicao, of the total 389 children assisted by Action Against Hunger, 35%[16] are at risk of acute malnutrition and 9% have moderate acute malnutrition.

The results of the evaluation we have carried out show the absence of health centers and medical supplies in the department's dispersed rural areas, a situation that forces people to travel to populated centers to receive care, generating **additional costs** in transportation and maintenance that represent a considerable economic burden. In addition, they must cover all or part of the cost of medicines, which can reach up to 200,000 COP[17] (US$45), leading many to resort to traditional medicine or self-medication.

[15] Twenty-three qualitative instruments were collected: 10 interviews with health centers, 5 interviews with municipal health secretariats and 7 interviews with community leaders. Epidemiological information was also collected from the 5 prioritized municipalities.
[16] Consolidation of databases ACF Colombia.
[17] Interview with community actor in Sarutsirra, Uribia. Wayúu families working in informal activities such as selling handicrafts (e.g. woven backpacks) or food can earn between 200,000 and 300,000 COP per month.

CENTRAL AMERICA: HEALTH CARE IS EXPENSIVE

Out-of-pocket spending on health is an indicator of inequity, exclusion and impoverishment of the most disadvantaged households, as they face the greatest barriers to access health services. As we have seen, the percentage of out-of-pocket health expenditure in **Guatemala** (61%) is the highest in the region and triples the maximum threshold recommended by the Pan American Health Organization (20%). The values for **Honduras** (51.7%) and **Nicaragua** (30.8%) are also well above the recommended level.

Between September and October 2024, we conducted a survey in Honduras and Guatemala, surveying 2,882 people in both rural and urban areas. In Guatemala, 19% of the households surveyed have at least one member suffering from a chronic disease, mainly arterial hypertension and diabetes. In Honduras, this percentage rises to 25%. In addition, more than 20% of those surveyed in both countries report **not being able to access medical services,** and a high percentage of those suffering from chronic diseases must pay for their own medications; less than half receive care from health centers.

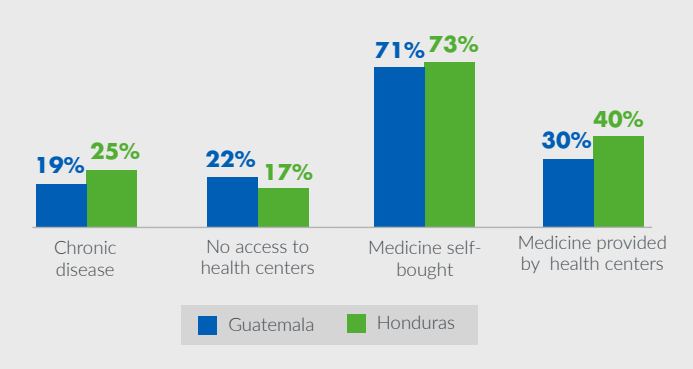


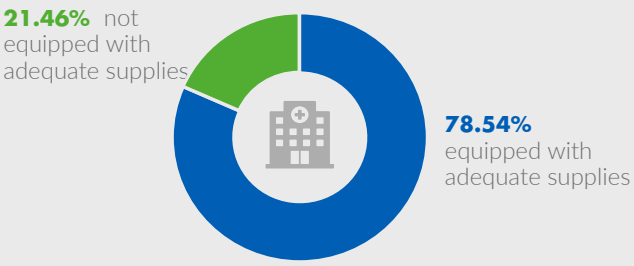
Figure 6: Acess to health care for the population in Honduras and Guatemala

In view of this situation, 64% of the households surveyed stated that they cannot cover their basic needs, and 15% indicated that they cannot afford their medical needs. In addition, more than 76% of household income is spent on food, which limits the ability of families to purchase other essential supplies.

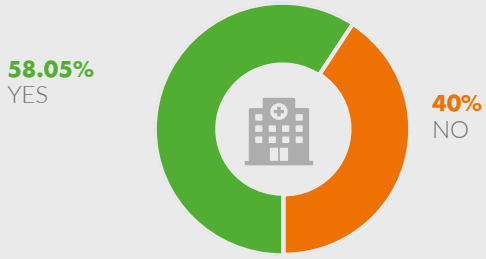
BARRIERS AND COMMON ELEMENTS

CAPACITY OF THE STRUCTURE

- Health facility with **adequate supplies for universal precautions** (measures implemented at the health care (measures implemented in the health care setting to prevent HIV transmission).



- Availability of **clinical treatment of rape survivors**



HUMAN RESOURCES CAPACITY

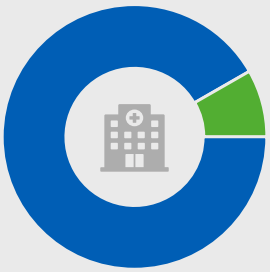
78.05% of the health facilities assessed have at least one provider trained to care for and **refer survivors of sexual and gender-based violence.**

On the other hand, only **10.24%** of the health facilities evaluated have **medical and nursing personnel, or midwives,** available in shifts to ensure 24-hour care, 7 days a week.

Only **77.56%** of the health facilities assessed have **personnel trained to identify mental disorders** and support people with psychosocial and mental health problems.

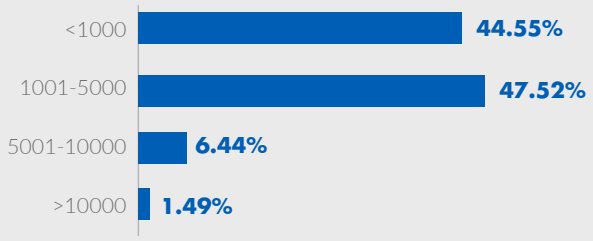
TYPE OF FACILITY

91.71% of the evaluated facilities are in **urban areas.**



8.29% of the evaluated facilities are in **rural areas.**

RANGES OF MONTHLY COVERAGE OF HEALTH CARE STRUCTURES BY PRIMARY HEALTH CARE



COMMON BARRIERS IN THE COUNTRIES WHERE WE WORK

- Costs for services, medications and/or transportation
- Discrimination/ language and cultural barriers
- Deficiencies in infrastructure, services and resources
- Difficult geographic access
- Security problems
- Speed in migratory transits
- Lack of access to information
- Lack of gender focus

COMMON BARRIERS FOR MIGRANTS

- Discrimination/ language and cultural barriers
- Speed in migratory transits
- Lack of access to information

VISIT OUR INTERACTIVE DASHBOARD AND GET THE DETAILS

3. WHAT WE ARE DOING

OUR APPROACH

Our work in Latin America has focused for many years on the detection and treatment of child malnutrition, but in the last 5 years we have expanded the health services we provide mainly due to the urgent needs of the population on the move that we serve, the situation of needs in the communities where we work and the interruption of key services for women and children in all countries during and after the pandemic. Given this situation, the basic health services we have prioritized are those that have evidence of a clear impact on the reduction of malnutrition: **nutrition** services, those related to access to **water and sanitation,** those related to **maternal and child health,** those dedicated to **mental and psychosocial health** and services related to the right to **sexual and reproductive health.**

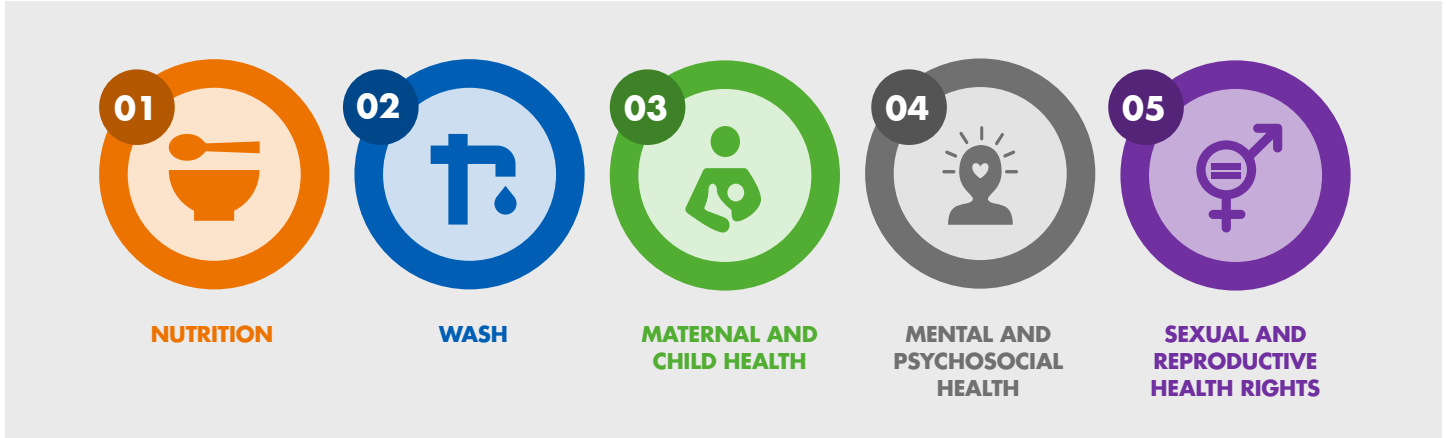
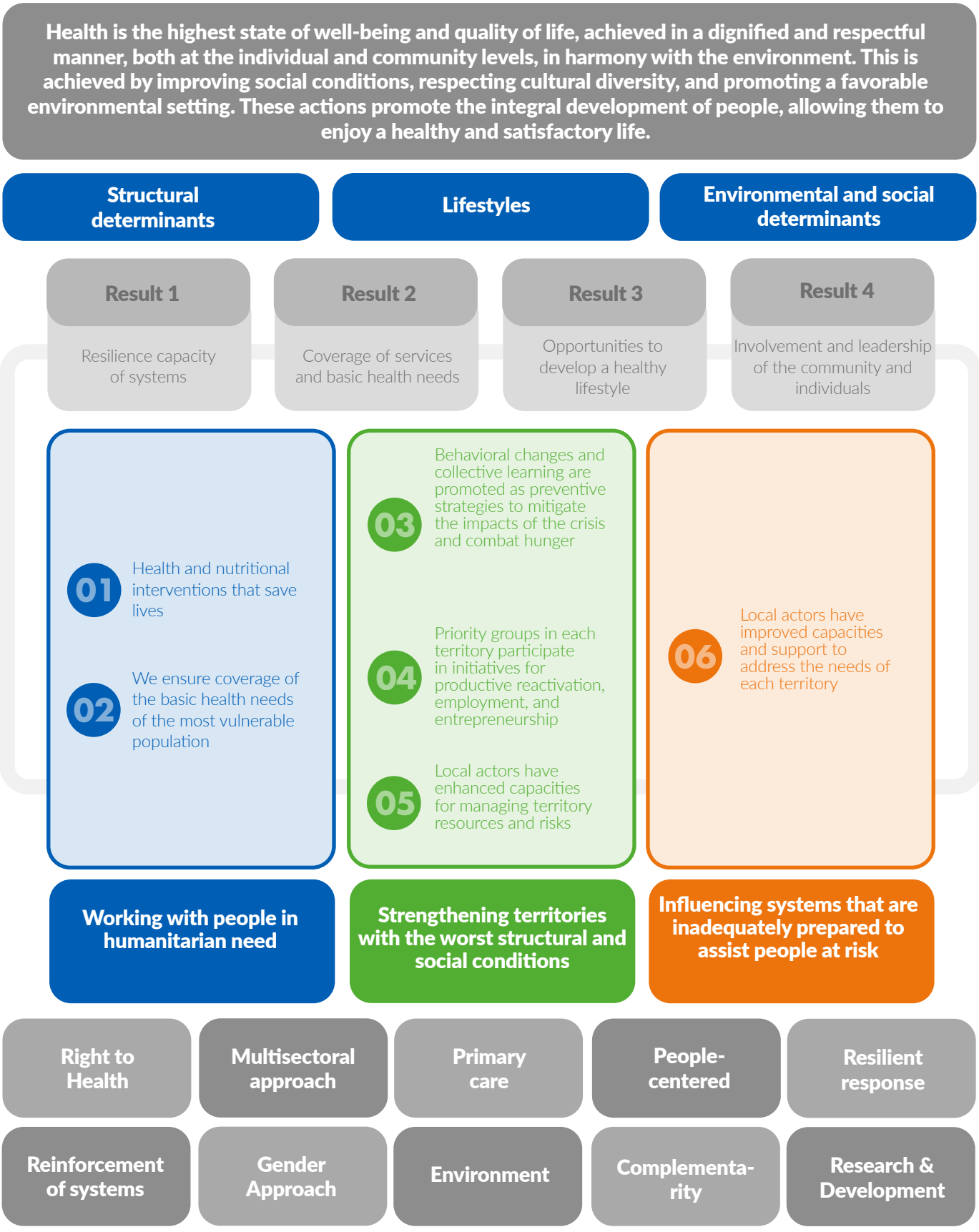


Chart on the types of services within the basic package for Action Against Hunger.

We have defined our framework and the effects that we want to provoke based on this Theory of Change[18]:



Theory of change, health action in Latin America for Action Against Hunger 2024.

[18] Health Framework for the Latin American Context

To measure progress in providing and promoting health for the most vulnerable population, we have defined four key outcomes, which we present below with some examples of the work done so far.

OUTCOME 1

Improved **resilience of the systems responsible** for providing basic health services. Improve their capacity to anticipate, adapt and absorb events that impact their development and responsibility to provide quality services to the population.

In **COLOMBIA**, our health actions are coordinated with health institutions through operational agreements throughout the country, especially in regions with the highest prevalence and incidence rates of mortality and morbidity. This coordination improves and increases the quality of health service delivery in dispersed areas with greater needs.

In the department of La Guajira, we developed an operational model involving people and communities and strengthening the systems through health care in an extramural modality, coordinated with territorial entities and the health care network (ESES hospitals). The work focuses on health risk management, support for adherence to care guidelines and protocols, strengthening the network of community "watchmen" as an essential component of the community surveillance strategy, and the reestablishment of health services. This work model allows the health system to access and maintain assistance at the rural level, resulting in an improvement in the system's capacity to provide qualitative services and anticipating possible negative effects on health, which are aggravated by the contextual changes generated in the different regions, such as extreme climatic events (drought-rain) and victimizing events due to armed conflict (confinements-displacements).

We note that the coordinated actions and institutional strengthening have resulted in a **decrease in mortality rates, especially in cases of malnutrition**, thanks to the active search of the coordinated extramural teams, as evidenced in the figures of the last epidemiological bulletin of Guajira. As of epidemiological week 40 of 2024, a decrease of 4.1% in cases of malnutrition in children under five years of age was reported compared to the cases reported for the same period in 2023. In terms of mortality due to ADD (Acute Diarrheal Diseases), ARI (Acute Respiratory Infection) and Malnutrition, in 2024 there was a decrease of 27% compared to the deaths reported in 2023.

At the community level, a strategy with an ethnic approach was developed, favoring adaptation mechanisms, focusing on prevention and promotion of healthy practices, and absorption of public health events, from the community, and in support of the health system as **Community Based Surveillance called** SUPÜLA ANAÄ; strengthening the community base with training of leaders as community "watchdogs". This has improved the fluidity and effectiveness of care routes, promoting community health management. During 2023 and 2024, more than 300 leaders have been trained by our health teams in coordination with the health secretaries in the municipalities of Riohacha, Maicao, Uribia and Manaure.

For institutional strengthening, our teams have trained (in coordination with the institutional framework) more than 400 professionals from the health secretariats and hospitals of the prioritized municipalities, on topics such as Comprehensive Care of Prevalent Childhood Illnesses (AEPI), Resolution 2350 on comprehensive care for malnutrition, the relationship between gender-based violence and malnutrition, psychological first aid (PFA), sexual and reproductive health, maternal health and breastfeeding. This training ensures adherence to established guidelines and care protocols, improving health quality indicators.

In Central America, improving resilience involves placing health personnel at the center of our actions, supporting them and coordinating efforts to ensure quality care in the communities. In Chiquimula, **GUATEMALA,** we have trained 53 community counselors, mainly **young people,** to drive social and behavioral change. In addition, we have provided health posts with nutritional assessment kits and treatments for acute malnutrition. We have also worked to improve access to safe drinking water in schools and health centers, including strengthening water quality monitoring and control by the Ministry of Public Health and Social Assistance (MSPAS).

In **HONDURAS**, we have trained 1,600 people in eight health regions of the Ministry of Health (SESAL). This training is based on community nutrition and follows the international protocols of PAHO. Thanks to these trainings, we have been able to replicate the knowledge in different health centers, reaching more than 25,000 people trained. We have also provided MUAC (Middle Upper Arm Circumference) tapes and therapeutic food for children evaluated with acute malnutrition.

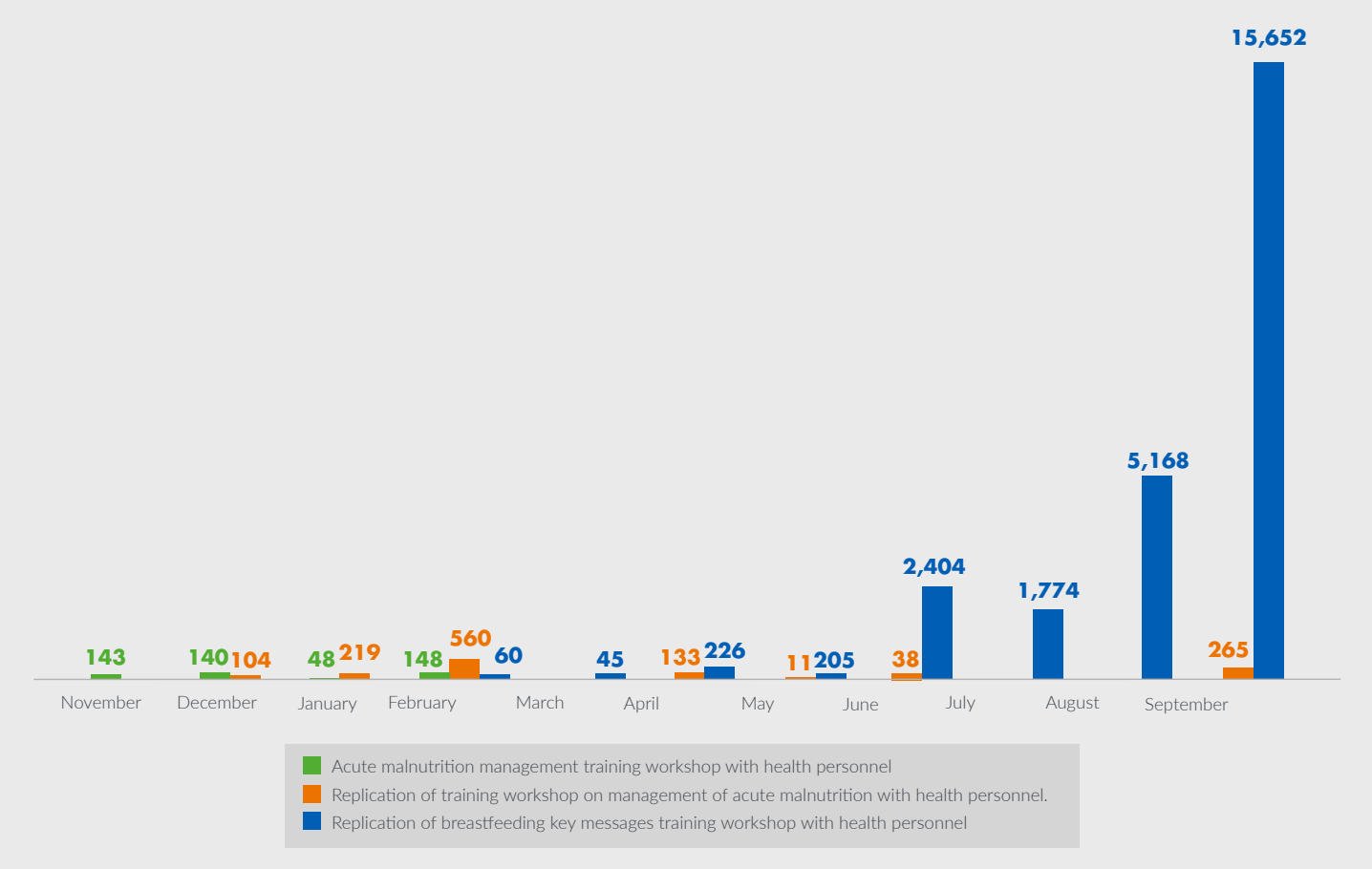


Figure 7: Scope of training activities for Health Centers in Honduras

The capacity-building process has made it possible to evaluate more than 69,000 children as of September 30. To strengthen local health systems and improve their capacity, it is essential that they have the necessary supplies and equipment to care for the population. For this reason, we have donated **medical equipment and supplies for primary care,** as well as for emergency response to dengue in health facilities along the migratory route, both in Guatemala and Honduras. These actions have been coordinated with the authorities of the ministries and secretariats of health, addressing the gaps identified by health personnel.

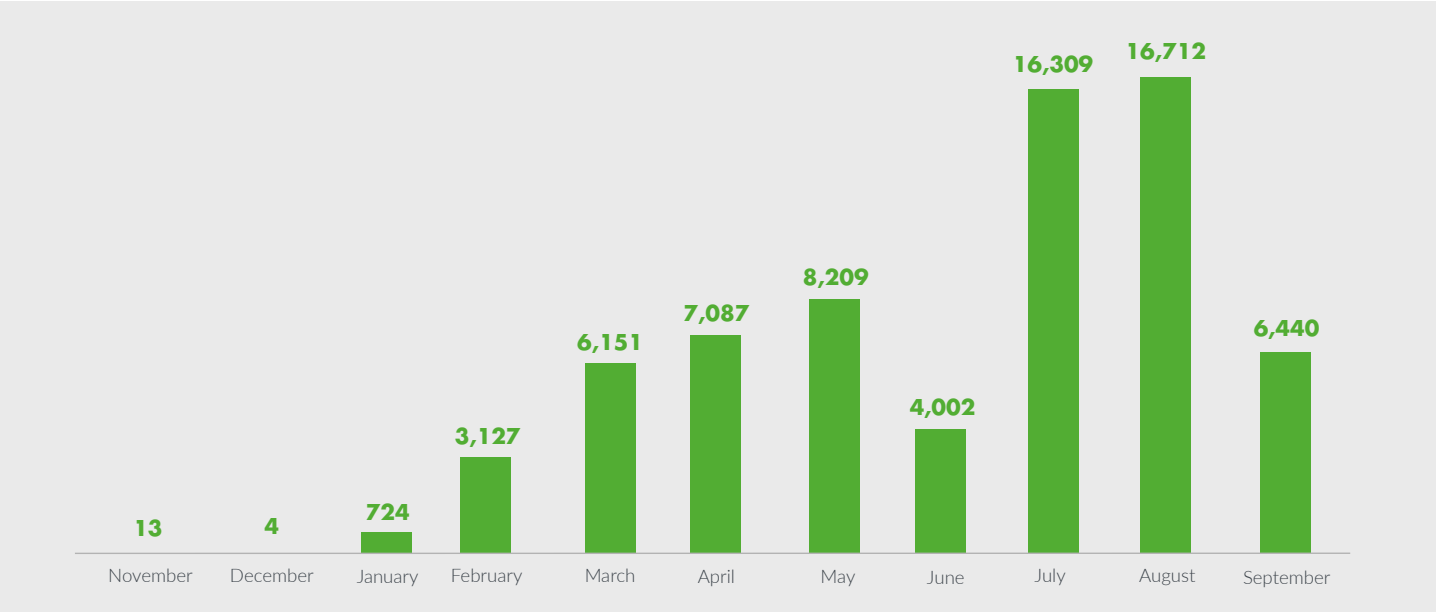


Figure 8: Nutritional evaluation of children under 5 years of age in eight departments of Honduras.

OUTCOME 2

Improved **coverage of basic health services and needs**, including nutrition, water, and sanitation. Promote equitable access to quality services, prioritizing our target populations. We pursue the goal of universal health coverage for the entire population.

In **PERU**, since before the pandemic, we have been addressing the health and nutrition situation of migrants arriving in the country. One of the triggers of migration, after food insecurity, is the lack of access to health care; therefore, when they arrive in Peru many people carry the consequences of poor care before their departure.

As previously mentioned, migrants need access to Comprehensive Health Insurance (SIS) and the financial means to cover emergencies, complementary tests, treatments and medication. To address this situation, we have implemented a scheme of economic support through **cash distributions** for the migrant population settled in Metropolitan Lima, in transit and for refugees. We coordinate with the Ministry of Health (MINSA) to analyze serious health cases of migrants without SIS and in need of priority or urgent attention. The diagnoses are grouped into acute diseases, chronic diseases and disability[19] and are verified with national or foreign diagnoses from health specialists. Cash is distributed through bank transfers, point-of-sale cards (POS, e.g. pharmacies and laboratories) or checks. We also make two follow-up visits to evaluate the evolution of the case, the satisfaction of the participants and provide emotional support.

To date, 52% of the cash distributed has been allocated to acute illnesses, 42% to chronic illnesses and 6% to disability. The benefits include obtaining medical examinations and diagnoses to access treatments (especially for chronic diseases), reinstatement to work or studies, reduction of family stress and the purchase of equipment to improve the quality of life of people with disabilities, such as hearing aids, wheelchairs, glucometers, among others.

In the case of **GUATEMALA** and **HONDURAS,** so far this year we have provided 13,300 health and nutrition services at the main transit points for migrants. Of these, approximately 8,800 have focused on nutrition, targeting children under 5 years of age, as well as pregnant and lactating women. However, at the Guatemalan border, our mobile teams offer nutrition services to people of all ages. Despite our efforts, we have observed that the percentage of children with some degree of **acute malnutrition** remains at around 3% of the total evaluated, with 7% to 10% at risk of malnutrition.

Through September, we have provided 4,383 medical consultations, mostly related to infectious pathologies and dermatological problems. Of these consultations, more than 300 have addressed **sexual and reproductive health** issues, such as HIV prevention and gynecological care for vaginal infections. We have worked in close collaboration with local actors in our coverage area, which has allowed for a more comprehensive response.

[19] The health conditions observed cover a wide spectrum of acute and chronic diseases and disabilities. Acute illnesses include infections such as bronchitis and gastroenteritis, gastrointestinal disorders such as gastritis, endocrine and metabolic disorders such as anemia, and genitourinary problems such as kidney stones. Chronic diseases include respiratory conditions such as asthma, endocrine and metabolic diseases such as diabetes and hypothyroidism, cardiovascular diseases such as hypertension, renal diseases such as kidney failure, neurological diseases such as epilepsy, and various forms of cancer. In addition, disabilities encompassing sensory problems such as severe sensorineural hearing loss, neurological disabilities such as stroke, musculoskeletal problems such as hip dysplasia, and neurodevelopmental disorders such as autism are observed. This diversity of conditions underscores the complexity of the health needs of the population in question.

In addition, we have implemented **mental health** interventions, both individually and collectively. During these interventions, we have mainly identified symptoms of anxiety, acute stress and post-traumatic stress disorder. These actions are fundamental to address not only the physical needs, but also the emotional well-being of the people in our communities.

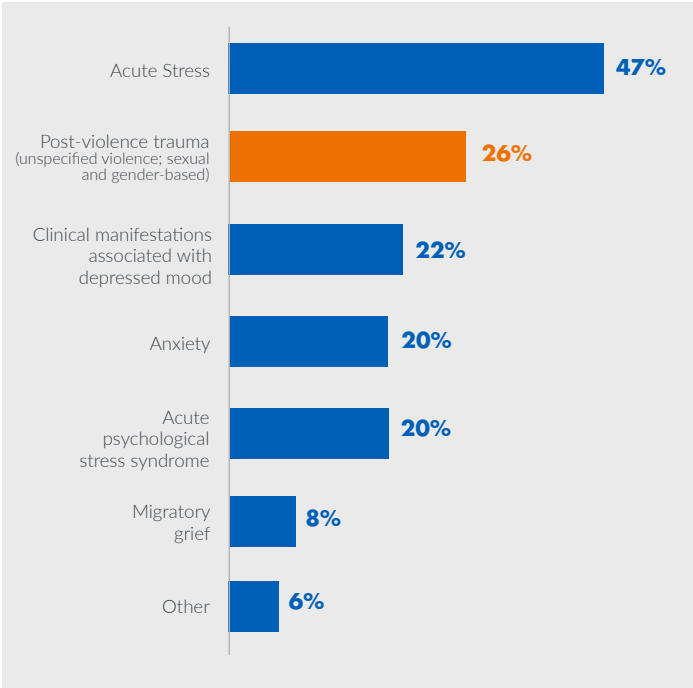


Figure 9: Main mental health diagnoses (Honduras)

Finally, in **COLOMBIA,** during 2024, we have improved the coverage of services and basic health needs for 10,203 people (68% women and 32% men) through our medical and nutritional care, aimed at **pregnant women, infants and children,** that integrates the care of prevalent diseases, the treatment of maternal and child malnutrition, the strengthening of community strategies and health promotion and prevention actions.

We provide complementary mental health care, psychosocial support, sexual and reproductive health consultations, food security and water, sanitation and hygiene actions. We focus our actions on reducing the gaps in access to health care, especially in dispersed rural areas and border zones, through an approach that strengthens institutional and community capacities. To this end, we prioritize the departments of La Guajira, Norte de Santander, Santander and the Darien region, which have limited access due to factors such as armed conflict, migratory crises, corruption, limited access to care by institutions and structural needs. Finally, it is worthy mentioning that in the first impact evaluation we conducted on the ADN Dignidad program[20] (through which more than 371,000 people have been supported with cash transfers), we found an indirect impact on health. Although the evaluation[21] did not directly measure the impact on access to health services, the increase in income and the reduction in food insecurity could have indirect positive implications on the health of the participants.

[20] https://www.adndignidad.co/
[21] httvps://3ieimpact.org/sites/default/files/2023-05/IE137-HCT-ADN-program-Colombia.pdf

OUTCOME 4

Improved **community and individual involvement, participation, and leadership** in health decision-making. The more organized a community is the better it can be involved in the demand and provision of services adapted to their needs and realities.

In **PERU** we have historically worked in health with strong community-based interventions, as is the case in the **rural areas** of Ayacucho. There, health systems were strengthened with community agents and support for the design of plans and programs with local authorities. Thus, in coordination between the staff, the community, the leaders and local authorities, we were able to significantly improve the coverage and quality of primary health care in very remote communities, in highland areas with very poor conditions and extreme climates. The interventions that we facilitated obtained results of great impact, such as the strong reduction of anemia cases in children under 5 years of age , the increase in the coverage of programs oriented to the mother-child binomial and great improvements in the quality of attention of the health personnel considering innovative and digital communication methodologies, with an intercultural approach. However, the most recognized achievement by the communities and the system was to have left communities organized around their own **Community Health Agents,** who were trained for the promotion and follow-up of primary health programs. We have carried out recent evaluations that show that the trained community agents remain active, are part of the local health system and effectively implement comprehensive preventive health promotion strategies for pregnant women and children under 5 years of age,[22] with cultural relevance, and supported by health personnel who now have better technical and methodological skills to do so.

In several territories in **CENTRAL AMERICA**, we have been able to improve people's nutritional status and development opportunities by engaging the community and youth in social and behavioral change actions, with the goal of not only improving health and nutrition, but also empowering people to become agents of change in their own communities. In addition, we have a capacity building program for **youth**, which includes technical training and financial education to improve their decision-making and income.

Our activities include improving the nutrition and health practices of indigenous parents, supporting the training and occupational skills of young people, and promoting healthy behaviors in the communities. In addition, we have provided technical assistance for the implementation of social change and governance actions at the municipal and departmental levels, with the objective of **training authorities and technicians from local and national institutions.** We have been able to strengthen communities through the training of agents of change, with the goal of training community volunteers in the prevention and identification of cases of acute malnutrition. This holistic approach not only addresses immediate needs, but also lays the foundation for sustainable development and continuous improvement in the quality of life of communities.

[22] In some cases reduction of incidence from 50% to 0%.

EMERGENCY RESPONSE

Emergency response is a fundamental part of our work. In the case of a health response, the priority so far this year has been the crisis caused by the increase in the number of dengue cases.

In May, the Central Government of **HONDURAS** declared a dengue emergency in the country and we, as an active member of the Humanitarian Country Network (RHP) and the Health Cluster, activated our response in the second week of July. Our objective was to support the response and establish coordination with governmental institutions, especially with the Ministry of Health (SESAL), taking into account the high incidence and prevalence of cases. Coordination with health authorities allowed us to focus our activities in the areas most affected by dengue. We conducted training workshops on dengue prevention and management for 159 people in the **Cortés** Health Region and provided medical equipment to health centers in this region and in the Central District of **Francisco Morazán**, reaching approximately 850,000 people. We also supported dengue control and eradication actions at the community level, providing vehicles for fumigation campaigns.

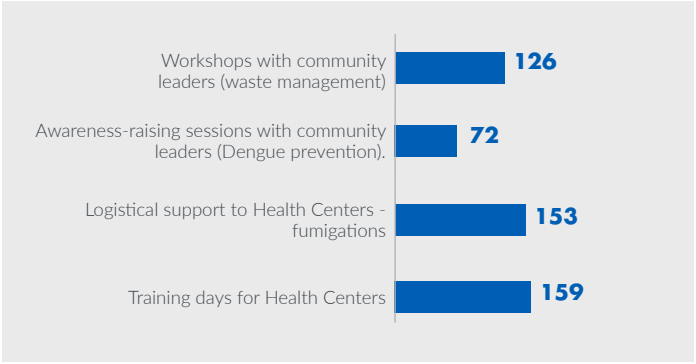


Figure 10. Outreach at the formative level in response to Dengue fever

In this context, we delivered hygiene kits to more than 14,000 families in the two departments, so that they could prepare a mixture called *"untadita"*, designed to prevent the growth of larvae of the *"Aedes aegypti"* mosquito, responsible for transmitting dengue fever. The participation of community leaders in cleaning activities, solid waste disposal and elimination of breeding sites had a multiplier effect, reaching more than 129,000 people.

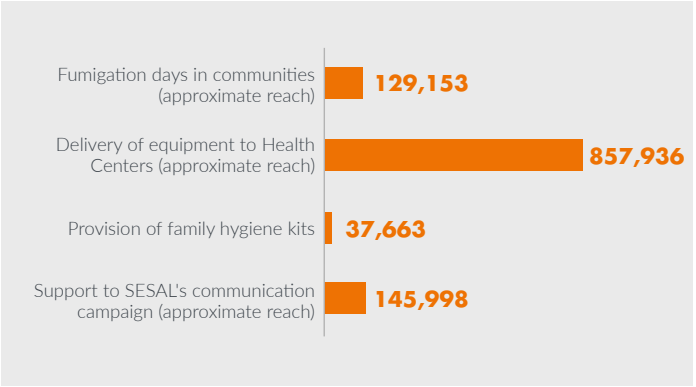


Figure 11: Population outreach in response to dengue fever

It is crucial to mention that, during the state of emergency, the dissemination of **communication messages** was fundamental. For this reason, we supported health centers with communication materials and radio spots nationwide.

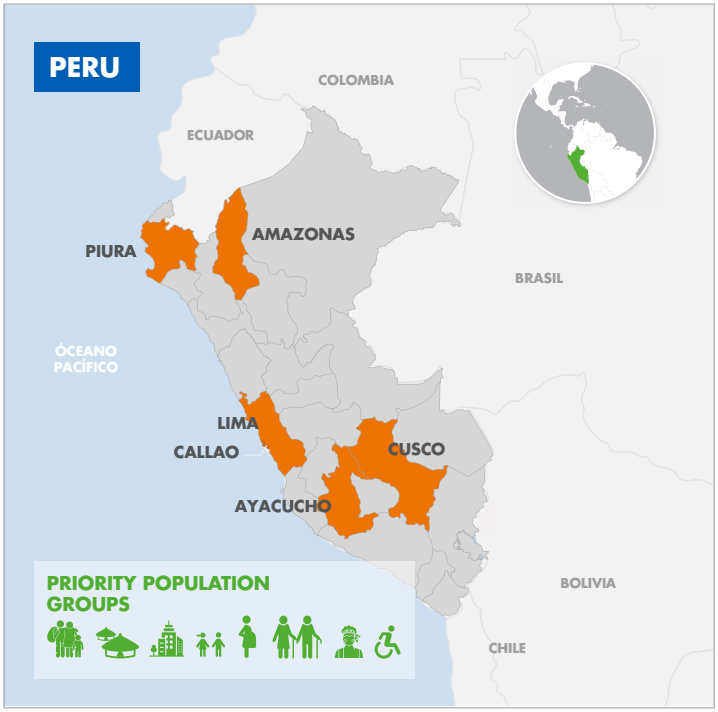
In **PERU**, in the context of the flood emergency caused by the El Niño 2023 - 2024 phenomenon, we provided support to the affected people in coordination with health facilities in the regions of **Piura** and **Lambayeque.** Through this response, we developed a nutritional care strategy aimed at the most vulnerable population of children under 5 years of age, pregnant and lactating women in a situation of acute malnutrition, including treatment with therapeutic nutritional supplements and medical care. At the same time, early detection of at-risk cases was promoted through community-level accompaniment, through organizations and spaces that emerged with the emergency, some of them very important and strategic, such as **soup kitchens.** Considering that the floods and the local climate favored conditions for the development of vectors, particularly the mosquitos that transmit dengue, we worked on awareness raising and training at the household level for the identification and elimination of breeding sites. Likewise, vaccination campaigns were supported with communication actions, logistics and implementation teams. In order to extend and give sustainability to these types of campaigns, appropriating them and making them permanent, we have worked on the training of health agents of the public system and the formation and training of community agents.

PRIORITIES FOR THE NEXT PERIOD

Considering the analyses we have carried out and the needs we have found, we at Action Against Hunger will continue to alleviate the suffering of the population and reduce inequalities in access to health. In all countries, in addition to emergency/epidemic response, we will work at the Primary Health Care level, incorporating the community component and prioritizing the following services:

- Sexual and Reproductive Health
- Nutrition
- Mental Health and Psychosocial Support
- Maternal and Child Health
- Water, sanitation and hygiene

GEOGRAPHIC PRIORITY AREAS



INDEX OF PRIORITY POPULATION GROUPS

- Populations in mobility in border areas.
- Migrant and refugee populations.
- Populations affected by armed conflict.
- Rural populations.
- Urban, peri-urban and rural populations.
- Indigenous populations.
- Children and adolescents.
- Children from 0 to 5 years old.
- Women, pregnant and lactating women.
- Women and teenage mothers.
- Elders.
- People with disabilities.

REGIONAL RESPONSE

TARGET FOR 2024

	REACHED		TARGET
TARGET POPULATION:	285,562	68%	421.800
FINANCIAL REQUIREMENT	€ 54,857,000	91%	€ 60.150.000

PEOPLE REACHED BY SECTOR

75,416	111,255	122,214	5,771	6,019	3,848
FOOD SECURITY AND LIVELIHOODS	HEALTH AND NUTRITION	WATER, SANITATION AND HYGIENE	RISK MANAGEMENT	GENDER AND PROTECTION	SOCIAL PROTECTION

CENTRAL AMERICA

PEOPLE REACHED BY SECTOR

26,749	84,763	84,458	332	2,885

TARGET FOR 2024

	REACHED		TARGET
	189,947	139%	136,800
	€ 12,650,000	94%	€ 13,500,000

COLOMBIA

PEOPLE REACHED BY SECTOR

29,804	10,237	18,593	2,856	1,260	3,848

TARGET FOR 2024

	REACHED		TARGET
	52,907	31%	170,000
	€ 29,100,000	116%	€ 25,000,000

PERU

PEOPLE REACHED BY SECTOR

4,074	1,041	2,358	2,420	236

TARGET FOR 2024

	REACHED		TARGET
	9,731	15%	65,000
	€ 1,225,000	17%	€ 7,150,000

OTHER COUNTRIES

PEOPLE REACHED BY SECTOR

14,789	15,214	16,805	163	1,638

TARGET FOR 2024

	REACHED		TARGET
	32,977	66%	50,000
	€ 11,882,000	82%	€ 14,500,000

285,562 TOTAL PEOPLE REACHED

JANUARY - SEPTEMBER 2024

56.4% ARE WOMEN

43.6% ARE MEN

18.6% ARE CHILDREN UNDER 5

FOR MORE INFORMATION ABOUT OUR OUTREACH, VISIT OUR WEBSITE

STRATEGICS ALLIES

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USAID FROM THE AMERICAN PEOPLE

Suecia Sverige

In partnership with Canada

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Agencia Suiza para el Desarrollo y la Cooperación COSUDE

Cooperación Española

CENTRE DE CRISE ET DE SOUTIEN
Ministère des Affaires étrangères et du Développement international

WFP Programa Mundial de Alimentos

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ACTION AGAINST HUNGER