



ACTION PLAN AMAZON TRIPLE BORDER

Colombia-Brazil-Peru

August 2020





***Puerto Nariño, Amazon,
Colombia***

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Rojas/ Umari Journal

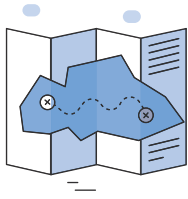
**The region currently
registers the highest
mortality rates from
COVID-19 per 100,000
people in the world.**

The Amazon region is being significantly impacted by COVID-19, threatening the lives and livelihoods of its population and posing an existential threat to its large indigenous communities.

The basin is home to an estimated 30 million people, and includes territory in Brazil, Colombia, Ecuador, French Guyana, Peru and Venezuela. The largest territories in the Amazonas are in Brazil, Peru and Colombia which host more than 400 indigenous communities amounting to an estimated 6 million people. The main channel of the river, which is a vital route for transport in the region, played a key role in the transmission of the disease affecting, in particular, the indigenous population along the border region of Peru, Colombia and Brazil.

As a result, the United Nations Resident Coordinators in the three countries have come together with the support of OCHA to develop an Action Plan to support Government responses to the urgent needs in the area. The plan is initially focused on mobilizing an emergency response to address the most immediate needs of those affected in the area. First level responses in the three countries have already commenced through reprogramed funding but additional resources are needed to scale up the response.

The plan focuses on areas near the so-called Triple Border - between Colombia, Peru and Brazil - home to 208,699 people and where the majority of the population (57%) is indigenous.



WHY A FOCUS ON THE AMAZON TRIPLE BORDER REGION OF BRAZIL, COLOMBIA AND PERU?

COVID-19 is having a devastating impact on the region.

COVID-19 is disproportionately affecting indigenous people.

The Triple Border is an area that has been traditionally neglected.

High infant and maternal mortality rates.

Outbreaks of other diseases further exacerbating the situation.

With fatality rates of 77 deaths per 100,000 citizens in Peru, 50 in Brazil and 29 in Colombia, these three countries have one of the highest fatality rates worldwide. However, the triple border region exhibits ratios that are a multiple of this: the Colombian department's capital of the Amazonas, [Leticia, has a ratio of 234 deaths per 100,000 capita](#), despite having some medical facilities. The absence of medical facilities in the remote parts of the department indicates that these parts exhibit even higher ratios, however, testing is limited or non-existing. The state of Loreto, the Peruvian part of the Triple border, registers over 143 deaths per 100,000 habitants¹ with indigenous people in the district of Mariscal Ramón Castilla exhibiting a mortality twice as high as the average population. The Brazilian state of Amazonas also possesses a mortality rate significantly above the national average, despite limited testing being available in the region. Estimates suggest [indigenous people in the Brazilian part of the Triple Border are 47% more likely to die as a consequence of the disease than the average indigenous population in Brazil](#), indicating their high vulnerability². In comparison, the worldwide highest infection fatality rate (IFS) on a national scale are found in San Marino (123 deaths per 100,000 habitants), followed by Belgium (85) and Peru (77) according to data by John Hopkins University³.

Indigenous communities have voiced their concerns regarding the existential threat COVID-19 is posing. With large parts being located in the most remote locations, where medical facilities are mostly absent, indigenous communities are acutely vulnerable to the disease due to their lower immunity and coping capacity. Those in charge of holding their traditional knowledge and culture are the elderly, who are those most affected by the pandemic. Many fear the pandemic will erase their way of live and traditions.

The Triple Border is an area that has been traditionally neglected - with very poor extension of the state and provision of basic services. Some areas are not even municipalized, meaning they receive no state resources to run services. Many of these areas are hard to reach. As a result, structural poverty can reach over 80% of the population in the region and levels of informality are extraordinarily high, reaching nearly 100% in some rural areas. As such, indicators for those areas - prior to the pandemic - were some of the worst in all countries:

Respiratory infections and acute diarrhea have been the leading causes of child mortality in the region - with indicators significantly above national averages: The incidence of infectious respiratory diseases stood at 57.3 per 100,000 in Colombia's Amazonas compared to 14.7 on a national scale. The incidence of watery diarrhea is of 19.1 per 100,000 in Amazonas compared to 3.0 countrywide. The infant mortality rate is as high as 46.9 per 1,000 births in the region. The region also has the highest maternal mortality rates in country, up to six times as high as the national average, illustrating the general weak health infrastructure and the corresponding logistical challenges in the region. This situation is similar across the border area in the three countries.

Common to each of the countries are also outbreaks of diseases such as malaria, dengue and chikungunya. The department of Amazonas in Colombia witnessed over 2,214 cases of Dengue per 100,000 capita in 2019, which is a multiple of the national average of 257 cases per 100,000 capita. The department of Loreto in Peru is also currently witnessing a Dengue outbreak with more than 7,000 cases registered so far this year compared to 1,500 cases registered during 2019. August and September are usually the months with the highest number of cases so the worst is still to come. Non-COVID services in the area are scarce and are strained by the demand. [70 to 80% of the population has no access to safe water in the region.](#)

¹ The state Loreto, registered an IFR of 53 confirmed deaths per 100,000 capita (143, if suspected COVID-19 related deaths are also considered as the case tracing in the state is significantly below the national average).

² Epidemiological Bulletin of the Secretariat of Indigenous Health.

³ Data as of August 12.

High food insecurity.

In the Amazonas department in Colombia, an estimated 59% of the population faced moderate or severe food insecurity; in the border areas of Brazil this figure stands at 42%, whereas in the border areas of Peru it is estimated at 49%. These values reflect the situation prior to the arrival of the pandemic and are likely to have deteriorated further as a result of the virus and preventive isolation measures. Before the crisis, these areas exhibited a 28% self-supply rate, which means over 70% of goods have to be imported from other parts of the countries, subsequently increasing prices. Chronic malnutrition in children under five stood at 16% and 44% of children under 5 suffered from anemia. The precarious health infrastructure is making it imperative for people to stay at home to avoid contagion, further deteriorating their food security and livelihoods. There are also concerns that pre-existing malnutrition rates are increasing.

Health services in the area are scarce and have almost collapsed by the demand.

ICU capacities are low to non-existent in the region with critical patients being dependent on medical evacuations via air. Non-COVID services such as maternal health and testing for other outbreaks is significantly reduced or absent due to limited resources, exposing the region to the risk of undetected outbreaks of other diseases. The spread of COVID-19 in the region is significantly compounding needs bringing the region to a state of emergency.

Border communities are intrinsically linked and also extremely mobile – which allows the pandemic to spread quickly.

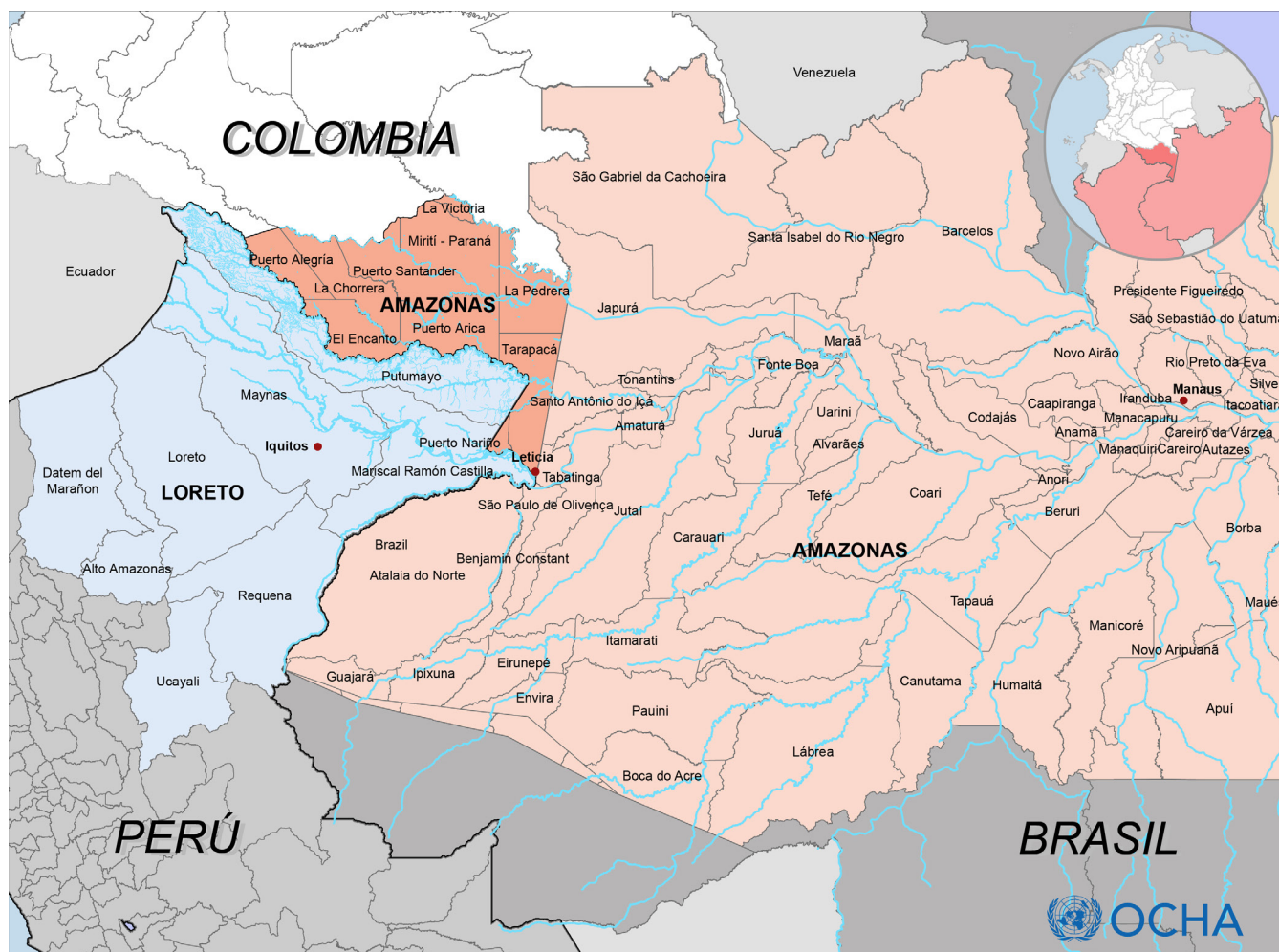
The proximity of communities between the three countries - sometimes only separated by one road and always connected through the Amazonas river - requires coordinated interventions in order to mitigate the impact of the pandemic with a do no harm approach. All communities in the area depend on the river for trade and to obtain up to 70 per cent of their supplies.

The Triple Border is also the most remote area for the three countries and where response capacities have traditionally been limited. Humanitarian actors in Colombia and Peru can only reach the area by plane, whereas colleagues from Brazil would need to travel 6 days by boat from Manaus to reach the area.

Amazon river

Photo credit: Yohana Pantevis/
OCHA





**Map of the Amazon Triple Border action plan
(Colombia, Peru and Brazil)**

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HEALTH:

PRIORITY NEEDS

Based on the information available and the findings of a series of joint evaluation missions carried out by the United Nations, the priority needs identified in the region are the following:

Access to health services is overall deficient due to the low number of health facilities available to the population for emergency situations. There is insufficient personnel, supplies, equipment and hospital infrastructure as well as shortage of personal protection elements. Community health workers are subsequently exposed to contagion. Similarly, there is community exposure to contagion that requires an early detection and community control strategy. At the moment, there is an urgent lack of access to diagnostic tests and capacities for the identification and follow-up of contacts to interrupt transmission, in particular in non-urban areas, as well as the implementation of non-pharmacological measures adapted to the local context and with community participation. There is a need for effective and culturally appropriate risk communication. Epidemiological surveillance and information management require strengthening to be able to take informed strategic health decisions. Since the pandemic, women have stopped receiving sexual and reproductive health care. This is due to both a shortage of hospitals and health posts, as well as community fear and resistance to seek care in health centers in times of pandemic. It is also necessary to improve the transport system for seriously ill COVID-19 patients.



WATER, SANITATION AND HYGIENE:



FOOD SECURITY AND NUTRITION:



EDUCATION:



PROTECTION:



EARLY RECOVERY:

It is necessary to guarantee access to safe water, sanitation and sufficient hygiene elements to prevent contagion. There are community water systems out of operation, hygienic services and water to be repaired in health establishments and educational institutions.

Families in vulnerable situations do not meet their food needs due to the decrease in income in urban areas and limitations in the marketing of products from rural communities. Food assistance is not arriving in a timely manner. Furthermore, the availability of food products in communities and villages is affected by isolation measures.

There is a high risk of an increase in acute malnutrition and a decline in the indicators of anemia and chronic childhood malnutrition that were already significantly unfavorable in Amazonian indigenous communities before the emergency due to the pandemic. Nutritional monitoring services and nutritional supplements have been suspended due to the State of Emergency.

In many areas face-to-face educational services have been suspended. Even when there is an offer of distance education, the absence of connectivity does not allow access to these services to indigenous communities in rural areas.

The risk of gender-based violence has increased, similar to the risk of human trafficking and child labor. There is a need for psychosocial care for emotional containment and the strengthening of coping capacities. It is necessary to strengthen the active participation of indigenous communities in the decisions that affect their lives.

There is a need to establish a consensual strategy between state authorities and representatives of indigenous peoples. The response to the emergency is fragmented and there is a limited capacity for coordination and articulation that generates inefficiency in the use of resources, the opportunity of attention and duplication of actions, as well as loss of opportunities. The connectivity gaps negatively affect the coordination processes.



Amazon river

Pgoto credit: Yohana Pantevis/
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THE 25-POINT ACTION PLAN

The critical context of the current situation made the UN understand the need to build an action plan with a multidimensional vision of the required response, reflecting the key activities required for the region in the three countries. The identification of key partners such as civil society, United Nations System Agencies, other humanitarian partners and donors, will help guide what will be the intervention to help vulnerable communities to face this difficult situation.

Given the logistical limitations of some country teams to reach the area, and the need to harmonize efforts to avoid action with damage, the three countries have joined forces to explore possibilities for mutual support. As a first step to implement the Plan, OCHA Colombia has deployed a field coordinator / information analyst in Leticia, in order to support data gathering, other information tasks and coordinate assessments and response efforts with humanitarian partners and local institutions. Peru is looking for additional resources to deploy two staff to the area and Brazil is envisioning deploying a staff member to Manaus to support the scale up of operations in the triple border.

The Action Plan has an emphasis on the initial emergency response in the sectors of Health, Food Safety and Nutrition (FSN), Emergency Accommodation (Shelter) and Water, basic Sanitation and Hygiene (WASH), identified as priorities by the evaluation mission.

The activities of this action plan are summarized in 25 critical activities for implementation:



SALUD

1. Support the telecommunications network of the Ministry of Health and communities with equipment and supplies, as a tool for referring cases that require hospital management.
2. Coordinate and provide technical assistance to territorial entities and health institutions for the articulation of the response and exchange of information.
3. Provide technical support in the management of information, disaggregation by age, sex, ethnicity and other sociodemographic variables for decision-making and logistics in health. This includes supporting performance evaluations of the public network laboratories that perform COVID-19 diagnosis as well as the implementation of a health indicator monitoring panel, and training in the analysis of these indicators to strengthen health management teams local.
4. Establish mechanisms for the prevention and containment of COVID-19 to protect the community, and for the identification of contacts of symptomatic and positive cases that allow the establishment of isolation and education interventions. To do this, support the hiring of human resources for surveillance and diagnosis actions, follow-up of contacts, including the delivery of supplies for taking samples.
5. Strengthen the risk communication strategy, with an intercultural approach and support in the preparation and implementation of adjustment plans for social isolation measures, based on the local context and with community participation.
6. Establish spaces for prevention and control services for the transmission of COVID-19. (Work with indigenous authorities should be considered in the process, so that they can guarantee sustainability: drinking water, electricity, management of potentially infectious biological waste).
7. Provide elements of personal protection for vulnerable communities and the indigenous population in particular. (It is suggested that the masks be reusable (made of cloth), useful if there is no close contact, this will avoid contamination and be more cost effective).
8. Support the adaptation and implementation of the MSPS guidelines on biosecurity for vulnerable communities.
9. Train health personnel and prison staff in COVID-19 prevention measures, emotional support and mental health for the care of patients with COVID-19.
10. Technical support, with supplies, equipment, basic supplies, personal protection supplies and health personnel for the reorganization of essential services that include guaranteeing maternal health, sexual and reproductive health services, management of infectious diseases and chronic pathologies that have presented before and during the pandemic, articulating Western medicine with the traditional medicine of indigenous peoples. (Strategy for community health managers), through support with supplies for health centers and posts and mobile health units.



FOOD SECURITY AND NUTRITION:

11. Provide food assistance in kind or through cash transfers to the most vulnerable people (mostly indigenous) and most affected by the crisis generated by COVID-19 in urban and rural areas of the Amazon, including those along the river bank.
12. Complement food delivery from existing programs and interventions. Especially complementing and adapting the emergency responses of school feeding programs - even in indigenous and rural areas. This expands social protection capabilities during COVID-19.
13. Support mitigation plans on the effects of COVID-19 and cross-border coordination for the continuation of school feeding programs through capacity development.
14. Coordinate and plan the smallholder food supply and production response across borders as COVID-19 hits the region during the flood period (lean season).
15. Stimulate the coordination and preparation of market access for small farmers. Provide means to increase the availability of food, providing school feeding programs and other complementary food programs and generate income for better access to food for rural families and its consequent improvement in nutritional status.
16. Support the competent institutions for the establishment of local (Colombian, Peruvian and Brazilian Amazon) and cross-border plans for the revitalization of the local economy and the recovery of the sources of income of vulnerable communities, especially indigenous communities dependent on tourism and cross-border trade.



WATER, SANITATION AND HYGIENE:

17. Install hand washing points in strategic places to prevent infection due to COVID-19.
18. Monitor water quality, rehabilitation and adaptation of water supply and treatment systems and storage to improve access to water.
19. Provide hygiene, cleaning and disinfection supplies (surfaces, merchandise or food and hospitalization areas).
20. Repair of excreta disposal systems in vulnerable indigenous communities.



TEMPORARY SHELTER:

21. Complement the epidemiological surveillance and control booths of the indigenous communities of the Amazon with shelter elements to support critical transit spaces and community support.



PROTECTION:

22. Technical support, with human resources and inputs to strengthen prevention and response, in the proper handling of cases of gender-based violence and, within them, of sexual violence; as well as psychosocial care and community participation
23. Implement actions to reduce the transmission of infections at the community and health services level



EDUCATION IN EMERGENCIES:

24. Technical support to the Secretary of Education and indigenous organizations for the Return to School Plan with alternation to educational institutions. Ensure access to distance education and spaces for emotional support.



EARLY RECOVER

- 25.** Technical advice to strengthen multisectoral coordination and intercultural dialogue at all territorial levels, between state actors and indigenous organizations, ensuring the adequate implementation of prioritized response measures in the most vulnerable and affected communities

While this plan focuses on emergency activities for the Amazon Triple Border area, it will be necessary to further prepare complementary strategies that stimulate the development-humanitarian nexus with capacity development programs and a greater reach of direct and indirect beneficiaries. Dialogue and coordination will also be maintained with other countries in the Amazon basin: Ecuador and Venezuela (currently not included in this plan) to harmonize efforts and exchange information on the support that the United Nations is offering to indigenous communities.



FUNDING REQUIREMENTS

	COLOMBIA	BRASIL	PERÚ
 Health (PAHO/UNFPA)	USD 750,000 (health) USD 530,000 (reproductive health)	USD 550,000	USD 1'060,000 USD 220,000
 Food security and nutrition (WFP)	USD 844,750	USD 500,000	USD 2'082,357 (Food security) USD 310,000 (Nutrition)
 Water and sanitation and C4D (UNICEF)	USD 400,000	USD 300,000	USD 875,000
 Protection (UNFPA/UNICEF)	USD 198,000	USD 100,000	USD 351,000
 Education with ethnical focus (UNICEF)	USD 250,000	USD 100,000	USD 201,000
 Early recovery			USD 825,000
TOTAL USD	2'972,750	1'550,000	5'923,357**

** Total funding requirements for Peru reflect a 12 months plan for 4 districts in the region on the triple border.



POPULATION BY COUNTRY, DEPARTMENT AND MUNICIPALITY/ DISTRICT

COUNTRY	DEPARTMENT	MUNICIPALITIES/DISTRICTS IN DIRECT PROXIMITY TO THE TRIPLE BORDER
Brazil	Amazon, pop: 4'144,597 (2019, estimate)	Benjamin Constant, pop: 42,984 Tabatinga, pop: 65,844 Total: 108,828 out of which some 70,000 are indigenous
	Indigenous: 168,700 (2010)	
Colombia	Amazon, pop: 78,830 (2020, estimate)	Leticia, pop: 42,280 Puerto Nariño, pop: 8,519 Total: 50,799 out of which some 30,000 are indigenous
	Indigenous: 38,130 (2018)	
Peru	Loreto, pob: 1'039.372 (201)	Distrito de Ramón Castilla, pop: 19,718 Distrito de Yavarí, pop: 8,366 Pebas, pop: 11,079 San Pablo, pop: 10,449 Total: 49,072 out of which 19,027 are indigenous
	Indígenas: 105,900 (2007)	
Total	Population: 5'262,799	Population: 208,699
	Indigenous: 312,730 (5,9%)	Indigenous: 119,027 (57%)



Amazon, Colombia

Photo credit: Yohana Pantevis/
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For more information, please visit:
www.humanitarianresponse.info/es/operations/colombia

www.unocha.org/latin-america-and-caribbean-rolac/colombia

COLOMBIA:
Claudia Rodríguez
OCHA Colombia Office Chief
rodriguez24@un.org

BRAZIL:
Larissa Leite
RCO Brazil Head of Office
larissa.leite@un.org

PERU:
Ana Maria Rebaza
National Adviser on Disaster Response
rebaza@un.org