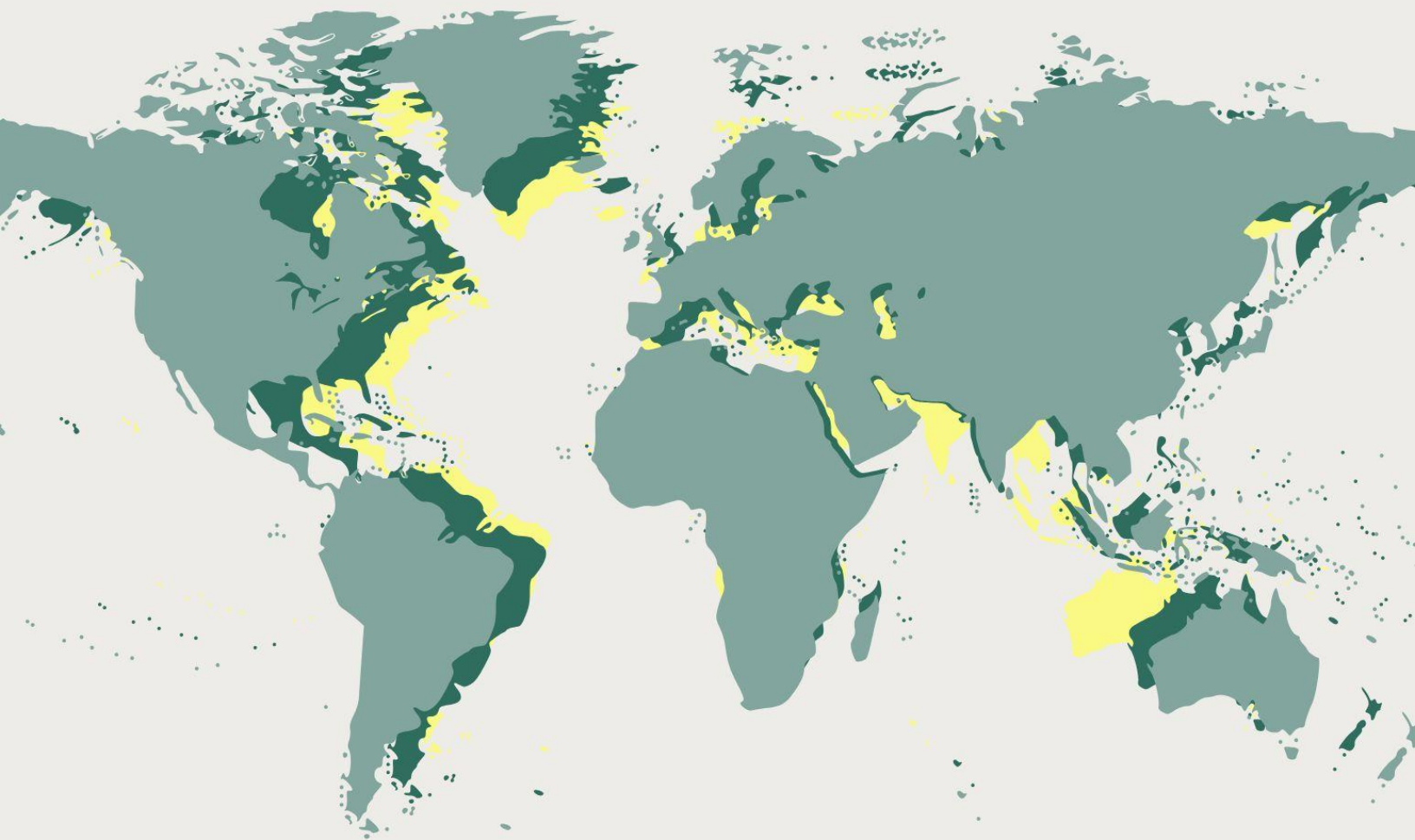


REGIONAL GUIDE AMRO REGION



2025 AMWHO INTERNATIONAL CONFERENCE

Bridging Health and Healthcare Disparities between Low, Middle, and High-Income Countries to Achieve Universal Health Coverage

Since the 1900s, the Americas have increased their attention towards the pressing concerns about healthcare throughout the region. From 1990 to 2020, the under-5 mortality rate dropped by 69%. The probability of death in children aged 5 to 14 years fell by 60%. Figures like the one above are consistent with the advancement of awareness of healthcare issues throughout the Americas region. However, there are still disparities found throughout the region, which were brought to light by the PAHO committee in 2019. The member states agreed to create a new agenda since there was extensive difficulty in promoting public health strategies and making them sustainable. With the advent of COVID-19, they have increased their efforts, but the issue of equity remains.

The immunization scene shows this issue firsthand. In countries across Latin America, like Haiti and Guatemala, only 55% of people were vaccinated compared to Canada which was around 80% by the end of 2021.⁴ Haiti and Guatemala were only 15% above the WHO's vaccination target.⁴ By 2021 there were still 20 countries in the Americas' region that were below the target.⁴ Based on these vaccination rates, we can see the lack of awareness and prioritization the countries had to overcome this disparity. In one week alone, there were 782,000 reported infections and 10,950 deaths in the Caribbean and Latin America, but only a little more than half the population was vaccinated.⁴ These persistent disparities are causing many concerns and issues throughout the region.

Subtheme 1: Inequalities in Infectious Disease Management

Infectious disease control remains a persistent challenge across the AMRO region, with countries like Honduras facing significant obstacles in managing outbreaks like Chagas disease. Despite the pressing nature of the issue, structural barriers such as low income, limited healthcare access, and inadequate infrastructure exacerbate the spread of diseases, particularly in rural and underserved areas. Migration further intensifies the problem, as mobile populations inadvertently carry infections to other regions, highlighting the interconnected nature of the crisis. Climate change, rising temperatures, and an increasing frequency of natural disasters compound the threat, making it even more difficult for countries like Honduras to establish a strong public health foundation. However, recent initiatives have shown promise in reducing disease transmission, though substantial work remains to address these disparities. Efforts by organizations like PAHO, alongside targeted national strategies, have started to shed light on the need for comprehensive approaches to infectious disease control. Through collaborative efforts, there is hope for a future where more equitable healthcare systems can help combat the persistent challenges faced by Honduras and its neighbors.

CASE STUDY 1: INADEQUATE INFECTIOUS DISEASE CONTROL IN HONDURAS

Honduras is situated in the northern region of Central America and is among the poorest countries in Latin America. It consistently ranks near the bottom in key metrics such as economic performance, healthcare quality, and infrastructure development.^{5,6} This combination of limited resources and extreme vulnerability to natural disasters creates an environment that contributes to the proliferation of infectious diseases. For example, after the Hurricane Mitch disaster, much of the entire medical infrastructure was physically and socially destroyed.⁷ Poor sanitation, densely populated urban areas plagued by poverty, and isolated rural communities with minimal access to healthcare from a few of the factors that facilitate the spread of certain diseases.

Infectious diseases are prevalent in Honduras due to various factors, including limited access to healthcare, with 30% of the population lacking healthcare services and 77% without health insurance.⁸ Many individuals, especially those from marginalized populations, cannot receive proper treatment in hospitals, facilitating the spread of diseases, particularly in rural communities where 51% of the population resides.⁸ Rural residents frequently report being “left behind,” with some describing the need to “walk long distances to catch a bus or get a ride,” to get to the closest hospital while battling diseases and injuries.⁸ Even after reaching hospitals, patients face a significant risk of contracting additional infections due to inadequate resources for sanitary blood screening.

A study by the Honduran Red Cross found that 45% of donated blood contained traces of syphilis, 35% tested positive for Hepatitis Core, and 6% for HIV. Many donors are unaware of their health status, leading to untested donations contributing to disease transmission.⁹ This situation demonstrates how inadequate education and limited access to healthcare allow infectious diseases to go undetected, perpetuating a cycle of transmission and worsening the public health crisis.

The number of migrants fleeing Honduras has been increasing at an unprecedented rate, with 253,000 Honduran citizens recorded at the U.S. border in 2019 compared to approximately 76,000 in 2018.^{10,11} Though this migration is driven by various factors, including climate change and poverty, the role of mobile populations in spreading infectious diseases is often overlooked. People who travel on foot are particularly vulnerable to both acquiring and transmitting diseases due to malnutrition, neglect, and the conditions they face while traveling in groups.¹⁰ Diseases can spread through shared food, airways, or sexual contact during their journey.¹⁰ Upon reaching their destinations, many migrants are forced into cramped living conditions, which further exacerbate disease transmission.¹⁰

National policies also play a role in the spread of disease. Many of these people are sent back to Honduras, a process that accounts for over 20% of the country's GDP.¹⁰ This return flow amplifies the transmission of diseases within Honduras which already reports a high prevalence of HIV, with 22,000 HIV-positive adults and children recorded nationally in 2021^{10,12}. While treatments exist, only 56% of individuals complete them, as migration interrupts access to care.¹⁰ These returning migrants contribute to the cycle of transmission, while incoming migrants further compound the issue. For example, in 2022, 165,000 migrants from Nicaragua entered Honduras, bringing not only diseases but also drug-resistant strains of infections.^{10,13} One notable example is *Plasmodium Falciparum*, the parasite responsible for malaria, which is treatable with chloroquine in Honduras.¹⁰ However, migrants from regions with chloroquine-resistant strains risk introducing this resistance into local populations.¹⁰ Additionally, HIV and other sexually transmitted infections are frequently carried by migrant groups, intensifying the public health challenge.

The climate of Honduras creates favorable conditions for insects and vector-borne diseases, with one of the most significant being Chagas disease, transmitted by triatomine bugs. In 2000, Honduras reported an estimated 300,000 cases of Chagas disease, underscoring the widespread impact of this illness.¹⁴ Often referred to as the "disease of the poor," Chagas is closely linked to the living conditions of low-income populations, as the triatomine bugs thrive in the walls of poorly constructed homes.¹⁴ With over 51% of the population living in rural areas or poverty, the disease proliferated across the country during the early 2000s.¹⁴ Many individuals in these regions lacked the financial resources to purchase insecticides and were often preoccupied with other responsibilities. Furthermore, limited awareness of the risks associated with Chagas disease, combined with the inaccessibility of treatment for those in rural communities, allowed the disease to spread unchecked, increasing its impact on vulnerable populations.

In recent years, Honduras has made significant progress in advancing its response to infectious diseases. The first example is the eradication of the Chagas Disease. Through a joint initiative between the Japanese International Cooperation Agency (JICA) and PAHO devised a plan to reduce the number of infections.¹⁴ They established the National Chagas Program and National Chagas Laboratory and wrote the standards and method for Chagas Disease Control. Creating a new survey method, educating the public, and establishing new and improved ministries of health were able to reduce the Chagas cases by 75%.¹⁵ This initiative is only one of the ways that Honduras is trying to reduce the number of infectious diseases ravaging the country. There is still a need for research and development to significantly reduce the pressing concerns.

CASE STUDY 2: INEQUALITIES IN ACCESS TO CHOLERA TREATMENT IN HAITI

Haiti's struggles with cholera reflect the profound inequalities in healthcare access, sanitation infrastructure, and disease management that characterize low-resource settings. The 2010 cholera outbreak marked the start of a public health crisis.¹⁶ The interplay of poverty, inadequate infrastructure, and systemic inequities has perpetuated the disease burden on Haiti's most vulnerable populations. Drawing from recent research and case studies, this analysis explores how inequalities have shaped cholera's impact and management in Haiti. The cholera outbreak in Haiti, exposed profound inequalities in infectious disease management, disproportionately affecting vulnerable populations. Nearly 59% of people in Haiti live below the poverty line, with limited access to necessities.¹⁶

One of the disparities in cholera management in Haiti was the lack of effective disease surveillance and the issue of underreporting. Research showed that in Grande Saline, during the early months of the cholera outbreak in 2010, over half the population showed serological evidence of infection; however, only one-third were clinically reported.¹⁷ In addition, asymptomatic cases in older children and adults were not detected due to limitations in surveillance systems.¹⁷ One of the inequalities that occur is that rural areas lack access to diagnostic tools that identify mild or asymptomatic cholera cases, which makes a large number of cases go undetected.¹⁷ Limited healthcare facilities and testing capacity create barriers to accurate case tracking, particularly in underserved areas.¹⁷

In addition, there are barriers to treatment and advanced care. The majority of cholera deaths occur in patients who do not reach the hospital in time which consequently results in hospitals underreporting the number of deaths caused by cholera.¹⁸ Haiti has limited healthcare resources such as weak governance, geographic and financial barriers to access to healthcare resources, shortage of medical supplies, etc., leading numerous individuals not to receive treatment.¹⁹ A study revealed that some patients who received care so far may not have reached the cholera treatment centers in time or were brought in too late.¹⁹ It was found that even when patients are admitted or arrive at the treatment sites, many do not receive life-saving treatment as there are limited resources at the treatment sites.¹⁹ A significant focus of Haiti's efforts to improve healthcare is enhancing treatment accessibility and increasing medical supplies, as many individuals were falling ill during cholera outbreaks.¹⁸ One method of treatment includes treating dehydration through oral rehydration salts (ORS) or intravenous fluids, and this was an effective method to treat cholera disease as the rehydration salts were needed in times when sanitary water was sparse.¹⁸ This played a significant role in reducing fatality rates in Haiti and, due to its availability, prompted the prioritization of developing ORS stock for future outbreaks.¹⁸ However, this approach would not be effective in severe cases that require antibiotic treatment. Delivering cholera care in urban and rural areas of Haiti presents significant challenges.¹⁸ In densely populated slums, the disease spreads easily through fecal-oral bacterial transmission, whereas in more organized camps, individuals benefit from improved access to case detection, sanitation, and medical care.¹⁸ Rural areas face additional challenges in the delivery of care due to the significant distances to treatment centers, inadequate infrastructure, and a limited number of medical professionals.¹⁸ This poses a critical issue, as the majority of cholera cases were reported in these regions.¹⁸ This shows that there are inequalities in the treatment of care in Haiti.¹⁸

Subtheme 2: Disparities in Access to Quality Healthcare

Disparities in access to quality healthcare are a pressing issue in various parts of the world, where socioeconomic and geographic factors prevent equitable healthcare distribution and outcomes. In Brazil, vast geographic challenges, including the dense Amazon rainforest and sparse infrastructure in the North and Northeast regions, restrict access to essential medical services for millions. Low-income populations, primarily in rural and Indigenous areas, face significant barriers to preventive care, emergency services, and life-saving treatments, such as antidotes for tropical diseases. This limited access has severe consequences, evident in high preventable mortality rates and healthcare delays. Although Brazil has made efforts to improve healthcare access through initiatives like telemedicine and infrastructure investments, substantial gaps remain. Addressing these inequalities requires continued focus on expanding healthcare services, improving supply distribution, and implementing targeted interventions for vulnerable populations.

CASE STUDY 1: GEOGRAPHIC LIMITATIONS OF HEALTHCARE ACCESS AND ITS EFFECTS ON BRAZIL

Brazil, the 4th largest country by land mass, 8th largest economy in the world, and 7th largest population in the entire world, has a serious issue with its allocation of medical resources.^{20,21} The geography of Brazil causes a lack of distribution of important resources, including healthcare-related goods. With the dense, thick rainforest that is the Amazon and poor infrastructure around this region, hospitals and access to medicine are located in population centers inaccessible to low-income rural populations.

Brazil is divided into 5 distinct regions: North, Northeast, Southeast, South, and Center-West.²² The most socioeconomically disadvantaged of these are the North and Northeast, where the majority of the Amazon Rainforest is located.²² The south encompasses 40% of the population and is the wealthiest area in all of Brazil.²² Over 63% of the low-income population in Brazil live in the Northeast region of Brazil. Of these people, 57% live in rural areas.²³ These individuals are far removed from any form of healthcare infrastructure. This not only discourages people from getting care in the first place but once individuals once they realize they need care, there is no way to access a route to get there.²³ Many mothers are likely to use distance as a determinant factor to decide if they are going to get professional care for their infants in life-threatening situations.²³

Even emergency care services are facing numerous challenges. Globally, an estimated 45% of deaths could be prevented with emergency care.²⁴ In Brazil there are 5843 hospitals with medical services. Of those, 2774 are Small Hospitals that have about 50 beds and no emergency care surgeries.²⁴ Nearly half of the hospitals in the country are not suitable to deal with life-threatening situations. The other half are High Complexity Centers which have access to emergency care surgeries and the presence of certification related to emergency care.²⁴ But in the Northern region, there is a shortage of Small hospitals and High Complexity Centers.²⁴ Of the hospitals that are present, the majority are Small Hospitals. Even then, they are over 120km or approximately 2 hours away from the closest high-complexity center which has access to life-saving medical care.²⁴ This equates to a lack of access to emergency surgical care and patients having to be reliant on under-equipped small hospitals to deliver the right care promptly. This compared to the Southern region, which has an abundant amount of resources and access to emergency services, shows a clear disparity in equal access to healthcare around Brazil.²⁵

The distribution of medical supplies is largely impacted by geographical issues. The WHO recognizes snakebite poisoning as a Category A neglected tropical disease. In Brazil, there was a mean of 27,000 recorded snake bites from 2001-2019.²⁶ The North and Northeast combined for 57.7% of the total snakebites over 18 years.²⁶ The two most socioeconomically disadvantaged regions in the country are experiencing the highest number of recorded snake bites and they have the least access to the antidote.²⁶ Even though this is well known, over 9 million people throughout these regions are still over 2 hours away from access to an antidote.²⁶ This disparity is also observed in the distribution of medical supplies during the COVID-19 pandemic. The North and the Northeast have minimal access to healthcare and reported facing the highest mortality rate during the pandemic.²⁵ In these regions, there is less than one ICU bed per 10,000 inhabitants.²⁵ The lack of distribution and access to medical care led to the North becoming the most affected region in Brazil by the pandemic.²⁵ The uneven distribution of medical access led to the deaths of many throughout rural areas, while urban areas had a high survival rate.²⁵

The Brazilian healthcare system has many challenges in addressing the geographic isolation of the healthcare units in the North and Northeast regions of the country. The WHO ranks it 125th out of 190 in healthcare systems around the world.²⁷ However, the Brazilian government is actively trying to fix this disparity.²⁷ They are increasing healthcare spending per capita twofold over the next decade.²⁷ They are planning to enact policies that increase access to healthcare in rural regions by creating telemedicine pathways and building better infrastructure in these regions.²⁷ Creating an electronic medical record system would address the lack of information between small hospitals and high-complexity centers.²⁷ The addition of a focused approach to preventive medicine would decrease the rate of transmission of disease throughout rural regions. There are some solutions to address the large disparity of lack of healthcare throughout the North and Northeast regions of Brazil, but many still need to be developed.

CASE STUDY 2: SOCIOECONOMIC INEQUALITY EFFECTS ON HEALTHCARE ACCESS IN PERU

Significant socioeconomic inequalities continue to limit healthcare access for the majority of Peru's population. According to the World Health Organization, cities such as Lima benefit from more extensive healthcare infrastructure and resources, while rural and remote areas - especially in the Andes and Amazon - face shortages of medical facilities, supplies, and healthcare personnel.²⁸ These disparities disproportionately affect Indigenous communities and low-income populations, who encounter higher rates of preventable diseases and limited access to healthcare services.²⁹ The reliance on public healthcare services among low-income and rural populations is often met with limitations, as these facilities are more likely to experience shortages compared to private-sector facilities available primarily in urban regions.

Socioeconomic status is a crucial determinant of healthcare access and health outcomes in Peru. Research published in the *International Journal for Equity in Health* analyzed inequalities in the use of medical consultation services in Peru, revealing that only 25.4% of people used medical consultations, and this was concentrated among the wealthiest individuals.³⁰ This discrepancy highlights a significant gap in healthcare access and utilization, particularly due to factors like lack of insurance, geographic barriers, and inadequate healthcare facilities in underserved areas. The study emphasizes how the absence of timely diagnosis and treatment for economically disadvantaged groups can lead to worsened health outcomes, with common illnesses potentially escalating into more severe conditions due to delayed or inaccessible care.

Access to essential preventative services also varies significantly across socioeconomic groups. Vaccination coverage is affected by socioeconomic disparities in Peru. A study examining missed opportunities for vaccination found that children from wealthier households were far more likely to receive scheduled vaccinations compared to those from low-income households.³¹ Lower-income families faced obstacles such as transportation costs, limited healthcare availability, and insufficient outreach programs, resulting in decreased vaccination coverage among these populations.³¹ This disparity in access to preventative care not only increases the risk of vaccine-preventable diseases among vulnerable populations but simultaneously creates a cycle of poor health outcomes. Children in lower-income families, who have less access to essential vaccinations, are at greater risk for preventable diseases that may impact their health later on.

Hypertension and other chronic conditions provide further evidence of healthcare inequalities based on socioeconomic status. A study on undiagnosed hypertension revealed that 67% of adults with hypertension in Peru had not received a diagnosis, with undiagnosed cases heavily concentrated in poorer populations and rural areas.³² The lack of diagnosis increases the risk of severe complications, including heart disease and stroke. This study underscores how limited healthcare access among low-income and rural populations leads to disparities in health outcomes, where socioeconomic status directly impacts both the likelihood of diagnosis and access to ongoing management for chronic conditions.

In the Amazon region, socioeconomic factors further shape health literacy and preventive practices, particularly for infectious diseases.³³ Research conducted in Iquitos examined the influence of socioeconomic status on dengue prevention and found that higher-income households demonstrated greater knowledge of dengue transmission and invested in preventive measures, such as using insecticides and installing screens.³³ In contrast, lower-income households had limited awareness of preventive practices and fewer resources to implement these measures, leaving them at a higher risk of contracting dengue.³³ This disparity in disease prevention reflects how lower-income families often lack access to preventive health education, further perpetuating vulnerability to infectious diseases.

To address these health inequities, targeted policies and interventions are essential. Comprehensive Health Insurance (SIS) is a program that provides insurance at a lower cost to those experiencing poverty in Peru.³⁴ Expanding programs like this could help overcome barriers to access to healthcare. This could help bridge healthcare gaps by covering preventive services such as vaccinations and screenings and improve the distribution of healthcare resources and medical personnel in rural areas.

Subtheme 4: Prioritization of Mental Health

Prioritization of mental health is an ongoing issue in the AMRO region. Despite mental health becoming a critical public health problem, many countries neglect the need for mental health services for individuals. In Latin American countries especially, the neglect stems from cultural stigma towards mental health, making it difficult for individuals to get essential treatment.³⁵ Mental health disparities disproportionately impact individuals across various demographic groups, including race, gender, and socioeconomic status. The rise of social media has had a significant impact on mental health, contributing to insecurities and discrimination, particularly in minority populations.³⁶ However, in the past few years, individuals have started to change their perspective and have become more willing to seek help in times of need. PAHO has conducted research to address the disparities in mental health treatment across different communities in the Americas regarding the various stigmas such as public, consumer, family, etc. This research not only raises awareness of these challenges but also sheds light on further research to dismantle these barriers and remove stigmas. In Argentina, efforts to improve mental healthcare have included government policies designed to better support those with mental health disorders. With the policies in place, Argentina was able to transition from institutionalized care to a more community-based approach, making mental health services more accessible to those in need.

CASE STUDY 1: SOCIAL MEDIA AND ITS EFFECTS ON THE MINORITY POPULATION OF THE USA

Social media has become a prominent part of modern society and plays a significant role in shaping the mental health of children and adolescents. The mental health effects of social media are influenced by factors such as the types of platforms individuals use, the content they consume, and the amount of time they spend online.³⁶ In addition, social media affects different groups of people depending on their socioeconomic, cultural, and sexual backgrounds.³⁶ Adolescence, typically ages 10-19, is a critical period as the brain is still developing.³⁶ Social media exposure can be particularly harmful during this period, as adolescents may begin to develop a sense of self-worth from peer and societal pressures.³⁶

Social media can have several positive impacts, including facilitating social connections and interactions with peers.³⁷ Individuals with mental health disorders often find online interactions more appealing, as they may face challenges engaging in face-to-face communication.³⁷ This is significant because many individuals with mental health disorders often experience limited social interactions in real life, which can contribute to feelings of loneliness and isolation.³⁷ While social media can help people with mental health disorders, there is also evidence showing that spending many hours on social media can increase the chance of developmental disorders such as anxiety or depression.³⁶

A study showed that introducing social media to college students contributed to more than 300,000 new cases of depression.³⁶ Based on these results, researchers are concerned about the risk of using social media in younger children as the effects could be far more detrimental.³⁶

With the increased use of social media, racial discrimination has become an issue for minority groups.³⁸ A study hypothesized that an increase in the hours of social media would lead to higher exposure to social media racial discrimination amongst people of color.³⁸ This, in turn, can contribute to the development of conditions such as depression, anxiety, alcohol use disorder, and substance abuse problems.³⁸ During the COVID pandemic, people used social media as a way to stay connected during the quarantine period.³⁹ However, there was an increase in anti-Asian hate, which exacerbated racial discrimination and heightened social tensions.³⁹ Asian Americans using social media at the time, encountered both individual and indirect forms of racial discrimination.³⁹ As racial discrimination worsened, it negatively impacted mental health, resulting in increased psychological distress among affected individuals.³⁹

Despite the many negative impacts of social media on mental health, researchers are exploring potential ways it can be utilized to detect and monitor the progression of mental health disorders. Studies suggest that social media can enhance engagement and retention in mental health services, enable individuals with mental health disorders to connect with care providers and create online support networks for caregivers of individuals with mental health conditions.

CASE STUDY 2: FUTURE OF MENTAL HEALTH IN DEVELOPING COUNTRIES SUCH AS ARGENTINA

The WHO defines mental health as the “state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community”.⁴⁰ Throughout the PAHO region, the differences in the importance placed on mental health are tangible. First-world countries like the United States have been emphasizing mental health since 1908.⁴¹ This importance has gradually been imparted to developing countries throughout Latin and South America. One such country that has been part of this trend is Argentina.

Argentina is still considered a developing country, although it has been gaining steady improvements through the past years in terms of infrastructure and utilization of natural resources.⁴² Though, this was not always the case. In 2007, approximately 25,000 people were stuck in psychiatric institutions with inhumane living conditions.⁴² These individuals faced many hardships, but that was only made worse with the rushed deinstitutionalization of these institutions.⁴² Many of these individuals were placed into community living areas with little to no safety net in place.⁴² They would be thrown into these neighborhoods with no insurance to cover them if anything were to occur.⁴²

The government itself claimed that 53.6% of this population cannot sustain itself in these faulty communities.⁴² By saying this, the government knows there is a disparity between the mental health patients who can afford proper care and those who are low-income and uninsured they will be able to survive.⁴² This changed with the introduction of National Mental Health Law No. 26657 in 2010.⁴³

This legislation laid the groundwork for mental health care in the country by encouraging stable deinstitutionalization with insurance plans for the patients, community-based care, and active user involvement.⁴³ This also led to the establishment of the Interministerial Commission on Mental Health and Addictions Policies (CONISMA).⁴³ The commission coordinates interministerial planning for mental health and addiction policies, focusing on gender and human rights, thereby fostering a more comprehensive approach to care.⁴³ This law advocates for a more effective method of deinstitutionalization compared to the previous government policies by having a proper set of guidelines that lists all the necessary plans.⁴³ Buenos Aires, under the Buenos Aires Free from Asylums program, helped over 50% of individuals previously institutionalized in long-stay pavilions transition to better community living standards.⁴³ Moreover, there has been a significant increase in community-supported housing (a 138.16% rise since 2019) and a substantial growth in discharge subsidies provided by the Ministry of Social Development (a 553.37% rise since 2019).⁴³ These statistical increases show that there is improvement in making sure that individuals have something to back them once leaving these deinstitutionalized asylums.

However, the implementation of this law has faced significant challenges. Many individuals throughout the country argue that it has not effectively addressed the issues, and mental health asylums continue to pose problems for many.⁴² Despite these challenges, Argentina is working to make progress. The country recently introduced the National Mental Health Plan 2023–2027 which aims to strengthen people-centered public policies, improve relationships, and create inclusive and comprehensive care from a global health perspective.⁴³ Argentina is at the forefront of making advancements in its mental health institutions and policies.

Conclusion

The PAHO region has been developing infectious disease control, and mental health facilities, and reducing the gaps of healthcare disparities between income levels at a rapid pace over the last couple of decades. With new diseases like COVID-19 and mental health crises, the PAHO region has to endure and continue to develop methods to tackle these issues to ensure that civilians cannot only survive, but thrive in their respective countries.

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