



Needs Assessment Report: Venezuela

Assessment findings on the state of health services and urgent humanitarian needs in La Guaira, Miranda, and Distrito Capital following the June 2026 earthquakes.

July 2026

Following the June 2026 earthquakes in Venezuela, Project HOPE and its local subsidiary, Proyecto Esperanza, conducted a needs assessment across 12 health facilities and 160 households in Distrito Capital, Miranda, and La Guaira to evaluate health service capacity, WASH conditions, and community protection needs. The assessment found significant gaps in emergency obstetric care, mental health and psychosocial support services, water quality monitoring, handwashing infrastructure, and protection mechanisms, despite generally strong community knowledge of disease prevention and existing health system capacity. Findings indicate that humanitarian response efforts should prioritize restoring essential health supplies and infrastructure, strengthening WASH systems, expanding mental health and protection services, and addressing barriers that prevent communities and health facilities from translating existing knowledge into effective practices.

Background

On June 24, 2026, Venezuela was struck by a series of major earthquakes, triggering a humanitarian emergency in the north-central region of the country. The earthquakes caused significant damage to homes, health facilities, water systems,

and transportation infrastructure, affecting the response capacity of communities and institutions. The emergency occurred against a backdrop of preexisting vulnerabilities: limited access to health services, deteriorated infrastructure, and shortages of medicines and medical supplies. These conditions exacerbated the impact of the disaster.



Image 1. Project HOPE conducts earthquake response operations in La Guaira, Venezuela on June 28, 2026.

To understand the initial impact on health services, Project HOPE, through its local subsidiary, Proyecto Esperanza, conducted a Rapid Needs Assessment at 16 health facilities in the states of La Guaira, Miranda, and Distrito Capital within 48 hours of the first earthquake. The findings revealed severe impacts: 43% of facilities sustained structural damage, 69% partially or completely suspended their outpatient services, and 81% reported difficulties in getting staff to their workplaces. All facilities reported an increase in demand for care, primarily due to traumatic injuries, hypertensive crises, and psychological stress. Water and electricity supplies were also affected: 63% of facilities reported interruptions in their water supply and 56% in electricity services. Availability of medications was another critical challenge, with 47% of priority supplies depleted. Only 13% of facilities had disaster preparedness protocols in place. The assessment also identified an increase in the need for psychosocial support and protection, with signs of stress and anxiety among the population, as well as concerns about displacement and the loss of livelihoods.

In response, Project HOPE and Proyecto Esperanza launched a multisectoral intervention to strengthen access to health services, improve water, sanitation, and hygiene (WASH) conditions, and expand support for protection and mental health assistance. Based on these areas of intervention, Project HOPE recently conducted another Needs Assessment to guide its response. The remainder of this report details the methods, findings, and conclusions of that assessment.

Methodology and Context

Given the operational need for systematic and up-to-date information on access to essential services, the operational status of health facilities, and community conditions in the intervention areas, Project HOPE and Proyecto Esperanza recently conducted a Needs Assessment to generate sufficient evidence on baseline conditions. These results will guide humanitarian interventions in a timely and effective manner.

This assessment covered Distrito Capital, Miranda, and La Guaira states, prioritizing the usability of the information over absolute statistical representativeness. The results are intended for various audiences — including health authorities, national and international humanitarian actors, and donors — with the common goal of informing Project HOPE's operational planning and response decisions.

Objectives

The purpose of this needs assessment in Distrito Capital, Miranda, and La Guaira states is to generate timely and useful information on the operational status of health services, the availability of critical supplies, the condition of WASH infrastructure, the level of access to clean water and WASH supplies, and protection conditions at the community level.

The specific objectives of this assessment are:

- Assess the operational capacity of health facilities in relation to the population's needs
- Analyze the availability of critical medicines and supplies
- Assess the availability of key personnel in health facilities
- Examine the status of health facility staff and the barriers to their ability to report to work
- Analyze the status of water, sanitation, and hygiene systems in health facilities
- Identify protection risks, especially for children
- Assess the psychosocial impact of the crisis on households and children
- Generate evidence to identify gaps and response priorities

Methodology

This needs assessment was conducted using a mixed-methods design, combining census-style assessments at health facilities with a sample survey at the community level.

Since a census-based assessment was conducted at health facilities, no sampling procedures were applied for this component as all selected facilities were included. Data collection combined direct observation, structured interviews with healthcare personnel, and a review of available institutional records. The assessment covered the availability and capacity of health services, human resources, the availability of medications and medical supplies, mental health and psychosocial support services, care and referral mechanisms for cases of gender-based violence, epidemiological surveillance systems, and community outreach activities carried out by health facilities.

In addition, a comprehensive assessment of WASH conditions was conducted at the same facilities, including direct observation of the infrastructure and interviews with key staff members. This made it possible to gather information on water supply systems, storage capacities, water treatment mechanisms, the availability and functionality of handwashing stations, the availability and condition of sanitation facilities, waste management practices, cleaning and disinfection protocols, and infection prevention and control (IPC) mechanisms.

At the community level, a survey was conducted among households located within the catchment areas of the health facilities supported by the project, with the aim of identifying knowledge, practices, and perceptions regarding health, WASH, protection, gender-based violence, mental health, and child protection. The sample was calculated using a cluster design, with the catchment areas of the health facilities serving as primary sampling units, based on a 95% confidence level, an expected proportion (p) of 0.50, a margin of error of $\pm 10\%$, a design effect of 1.5, and a nonresponse rate of 10%. The sample was distributed proportionally among the three states, and households within each cluster were selected

through community visits and defined accessibility criteria. Based on these criteria, a final sample of 160 households was established.

The data was collected and reviewed by Proyecto Esperanza's Monitoring, Evaluation, Accountability, and Learning (MEAL) team, which verified the consistency, integrity, and quality of the information before cleaning, validating, and consolidating the datasets. Results were analyzed using descriptive statistics to identify the main needs and existing gaps, triangulating information from different sources to strengthen the interpretation of the findings.

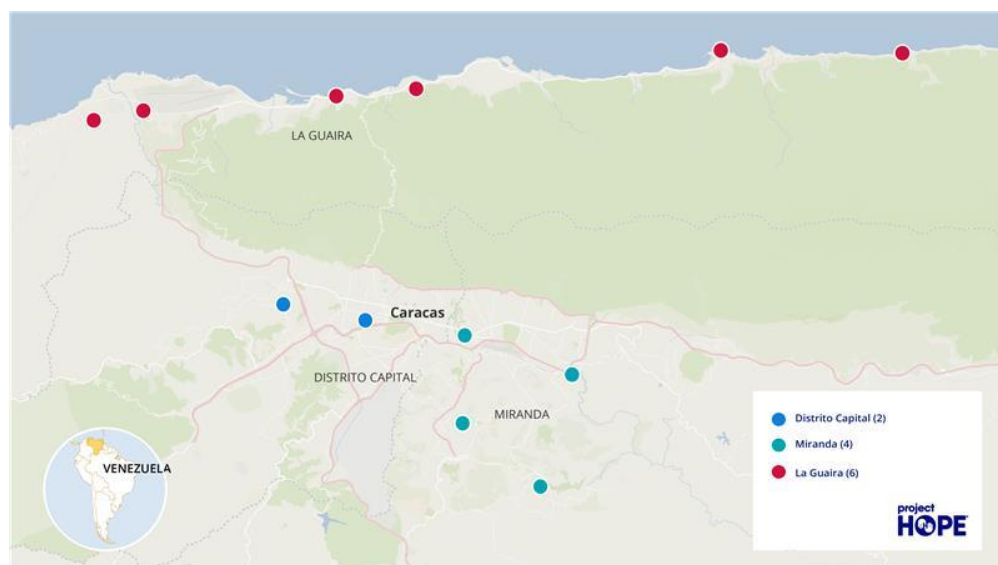
Locations

This study was conducted within 12 health facilities and across communities in the municipalities of Libertador, Chacao, Baruta, El Hatillo, Sucre, and Vargas, within Distrito Capital, Miranda, and La Guaira states. Community surveys were conducted in households located within the catchment areas of the health facilities. The final sample included data from 160 households, including 53 in Distrito Capital, 53 in Miranda, and 54 in La Guaira.

The distribution of health facilities assessed for the health and WASH components is as follows:

- **Distrito Capital:** 2 facilities
 - CLINP II Dr. Pastor Oropeza
 - CPT III Luis Cardozo
- **Miranda:** 4 facilities
 - CPT III Jesús Reggeti
 - CPE Chacao
 - CPT III Dr. José María Vargas
 - Dr. Domingo Luciani Hospital
- **La Guaira:** 6 facilities
 - CPT III Aura Pinto
 - CPT II Anare
 - CPT III Fernando Rísquez
 - Naiguatá Emergency Hospital
 - José María Vargas Hospital
 - CPT III Teleférico

Figure 1: Map of all health centers evaluated for Needs Assessment



Population Context

This evaluation focused on both the service delivery environment and the operational capacity of the health facilities supported by the project. The facilities included in the evaluation serve diverse population groups within their respective catchment areas. In addition, the facilities evaluated encompass different levels of care within the health system, including primary care centers, specialized care centers, and hospitals, which made it possible to characterize and analyze both first-contact services and more complex care within the communities prioritized by the intervention.

Limitations

Since the selection of health facilities was a census-based sample, the results of this component reflect the entirety of the selected centers. However, the results of the community survey were designed to represent the specific conditions existing in the catchment areas of the health facilities and should not be interpreted as representative estimates of the entire population of Distrito Capital, Miranda, and La Guaira states. That data can only be interpreted as pertaining to the communities included within the geographic catchment areas of the selected health centers.

Information regarding community knowledge, practices, and perceptions was obtained through interviews with members of the selected households. Therefore, data integrity and subsequent conclusions are dependent on the responses provided by participants at the time of the survey. Consequently, some results may be subject to recall bias, interpretation bias, or social desirability bias.

Additionally, as part of an ongoing emergency response, the operating conditions of health facilities and communities may change as the emergency evolves, particularly with regard to the availability of services, infrastructure, and access to supplies.

Despite these limitations, multiple measures were taken to strengthen the reliability of the findings: different sources of information (health facilities, community surveys, and key informants) were compared; the data was reviewed daily by the Proyecto Esperanza MEAL team; and key information was triangulated and verified during fieldwork. This made it possible to build a robust picture of the identified needs across the health, WASH, and protection sectors.

Findings

Health Findings

Operational Capacity and Human Resources

This assessment identified a total of 844 healthcare workers at the facilities, 79.1% of whom are women. Nursing staff constitute the largest group with 195 workers, followed by general practitioners with 114. It should be noted that two facilities (Dr. Domingo Luciani Hospital and Jesús Reguetti Outpatient Clinic) did not report staffing information at the time of the survey; therefore, the aggregate figures reflect the situation at 10 of the 12 centers assessed.

The most critical gaps in human resources are among specialized roles. Across the entire network of facilities evaluated, only one psychiatrist, six psychologists, and six social workers were identified.

Emergency Services

At time of data collection, 90.9% of the facilities offered wound prevention and management, the most widely available type of emergency service within the network. However, only 63.6% provided 24-hour care and an observation service, and only 54.5% had the capacity to perform cardiopulmonary resuscitation.

Noncommunicable and Communicable Diseases

The management of noncommunicable diseases shows the strongest coverage in the assessment: 90.9% of the centers manage hypertension and diabetes mellitus, and 81.8% manage bronchial asthma and chronic obstructive pulmonary disease (COPD). However, this clinical capacity does not correspond to the availability of supplies, with salbutamol and ipratropium bromide — first-line medications for respiratory management — only available in 27.3% of facilities.

For communicable diseases, the management of urinary tract infections and the availability of otolaryngological diagnostic equipment was documented at 90.9% of facilities, the strongest coverage area. The management of intestinal parasitic infections was documented as available at 81.8% of facilities.

The gaps among communicable disease services were concentrated in diseases subject to epidemiological surveillance. No facility reports the capacity to manage malaria, only 9.1% have rapid malaria tests available, and only 9.1% have capacity to manage yellow fever. Although 63.6% of facilities have can manage dengue cases, only 18.2% have rapid diagnostic tests, and only 36.4% of staff have received technical training on the subject. Specialized HIV care is available at 9.1% of facilities, and care for sexually transmitted infections at 18.2%. Only 45.5% of the centers are part of the early warning sentinel system for diseases prone to epidemics.

Maternal and Child Health

Management of pregnancy complications and immunizations achieved 81.8% coverage, followed by prenatal care at 72.7% of facilities. Capacity is significantly reduced in childbirth care: only 36.4% of facilities provide childbirth care services, distribute childbirth kits, or have the capacity to manage obstetric complications. There is also a significant time-based gap in the availability of trained personnel to assist with deliveries, which drops from 81.8% on weekdays to 54.5% on weekends. Support and education components show the lowest coverage figures in this category, with just 9.1% of facilities reporting the availability of training in Clinical Management of Childbirth and Newborn Emergencies (MCEPRN), mother-to-mother support groups, and parental education on early childhood development. Across facilities, support for exclusive breastfeeding reached 36.4%.



Image 2. Project HOPE's team operates a mobile medical unit and hygiene kit distribution in Playa Grande, La Guaira, Venezuela. Photo by Gabriela Pérez for Project HOPE, 2026.

Mental Health, Psychosocial Support, and Gender-Based Violence

This service area had the most severe gap across the categories surveyed. Only 18.2% of facilities have a psychosocial support service or program and offer psychiatric care, psychopharmacological treatment, or psychotherapy. The World Health Organization's Mental Health Gap Action Programme (mhGAP) is implemented in just 9.1% of the surveyed

facilities. 54.5% have some form of referral system for patients who cannot be treated locally. Only one facility — CLINP II Pastor Oropeza — offers the full range of mental health services evaluated.

Only 9.1% of facilities have a specific service or program for addressing violence and abuse, and 27.3% report maintaining an active service for addressing sexual violence. 81.8% of the centers surveyed do not have a dedicated office for the clinical management of sexual violence, which limits the privacy and confidentiality required for this type of care. Specialized care for adolescents is available at 18.2% of facilities.

Availability of Medications and Supplies

The average availability of essential indicator drugs is 69.5%, with extreme variations among facilities: one center (CPT III Aura Pinto) reported that all fourteen indicator drugs were out of stock, while three centers achieved full availability. The supplies with the highest availability are Ringer's lactate solution (81.8%) and iron salts with folic acid (72.7%).

Medications for obstetric emergencies were at critically low levels, with an average availability of 12.7%. Hydralazine and methyldopa tablets are not available at any facility in the network, while misoprostol and injectable methyldopa are available at only one facility (9.1%). Only magnesium sulfate reaches 45.5% availability. This situation directly compromises the ability to respond to preeclampsia, eclampsia, and postpartum hemorrhage, in a context where 81.8% of facilities report managing pregnancy complications.

Mental health medications are virtually nonexistent in the evaluated network. Anticholinergics show 0% availability across all facilities; antidepressants average 7.3%; antipsychotics, 10.9%; mood stabilizers, 12.7%; and anxiolytics, 25%.

Nutrition

Among surveyed facilities, 54.5% conduct nutritional assessments to screen for malnutrition risks, but their capacity to manage cases decreases progressively as the severity of the condition increases: 36.4% have capacity to manage moderate acute malnutrition, and only 18.2% have capacity to manage severe acute malnutrition or extreme thinness, meaning that most detected cases require referral outside of the facility where the case is identified.

Physical Infrastructure and Care Conditions

Areas with higher levels of complexity in the care they provide exhibit the widest gaps in availability: 72.7% of facilities do not have an operating room, a labor preparation room, or a recovery room, and 63.6% lack a neonatal unit, an observation room, and inpatient rooms. Spaces dedicated to psychosocial care and the clinical management of sexual violence are absent in 81.8% of the centers.

Regarding the physical condition of existing spaces, evident damage to walls was identified in 62.5% of immunization areas, 57.1% of gynecology clinics, 54.5% of pharmacies, and 42.9% of multipurpose emergency areas.

Physical accessibility for people with limited mobility remains a significant gap: 54.5% of the centers have access ramps. In waiting rooms, 54.5% have sufficient chairs, but only 18.2% have seats properly designated for people requiring priority care, and 45.5% have visible signage identifying the spaces and services.

Community Outreach

Medical care sessions in community spaces and outreach programs on maternal and child health, sexual and reproductive health, and gender-based violence are provided at 63.6% of facilities. Outreach on the prevention of communicable and noncommunicable diseases and on mental health are provided at 45.5%. Health brigades, which have the widest territorial reach, are active in 27.3% of the centers, and the same percentage has visible materials promoting good health practices.

Water, Sanitation, and Hygiene Findings

Status of Infrastructure and Basic Services

All of the facilities evaluated remain functional for medical care. Structural damage to the building was observed in 9.1% of the facilities, while 54.5% showed damage to masonry elements, reflecting a pattern of widespread non-structural deterioration across the network. 9.1% reported blocked access routes at the time of the evaluation.

Regarding electrical service, 90.9% of the facilities have power, although only 54.5% have a backup power system, which exposes nearly half of the network to interruptions in critical services — including water pumping and cold chain storage — in the event of power outages. No exposed wires were identified in any of the assessed facilities.

Water Supply and Storage

The assessment found that 88.9% of the facilities have a main water connection, and the same percentage have storage tanks. 22.2% reported interrupted water service at the time of the survey, and the same percentage report supplementing their water supply with a deep well.

No facility relies on cisterns, rivers, or springs, nor do any extract water manually, indicating that the water distribution infrastructure remains operational even when the supply is intermittent. 11.1% report leaks in their internal piping systems.

Of the 24 tanks surveyed, only 54.2% were functional according to the established criteria — lid, float, absence of visible damage, and connection to the water supply system — while 37.5% were not. 83.3% have a lid and 75% have a float, but only 58.3% have a valve or set of shut-off valves for cleaning, which hinders regular maintenance. Cleaning records indicate that less than half of the tanks have been maintained in the last twelve months, and several facilities reported that their tanks are not cleaned regularly. Additionally, only 20.8% of the tanks are equipped with water pumps, which limits internal distribution capacity in multi-level facilities.

Water Quality

Water quality monitoring is one of the most significant gaps across WASH findings. Only 44.4% of facilities conduct tests to determine free residual chlorine and the same percentage conduct tests for fecal coliforms and apply chlorination treatment to improve water quality.

Water Points and Handwashing Stations

Of the 247 water points evaluated, only 51.8% are functional. The situation is particularly critical at handwashing stations, which represent the most common water point in the network (117 points, 47.4% of the total). Barely 24.8% of handwashing stations are functional. In contrast, 79.1% of latrines and 90.9% of cleaning facilities are functional, suggesting that the deterioration is specifically concentrated in hand hygiene infrastructure.

Compounding this limitation is the lack of supplies: 65.8% of the handwashing stations evaluated lacked soap at the time of observation. Among the identified causes of non-functionality, 19.8% of the stations had broken parts, and 15.4% had missing parts.

Functionality varies markedly among states: Distrito Capital has 81% of stations in working order, while La Guaira has 47% and Miranda has 45.3%. At the facility level, two centers — Dr. Domingo Luciani Hospital (14 stations) and José María Vargas Hospital (8 stations) — reported no functional water stations, followed by CPT II Fernando Rísquez, which reported 9.1% of water stations functioning, and CPT III Aura Pinto, which reported 14.3% of water stations functioning.



Image 3. Victoria, a Project HOPE nurse, provides care to a patient at the mobile medical unit in Playa Grande, La Guaira, Venezuela. Photo by Gabriela Pérez for Project HOPE, 2026.

Restrooms

A total of 63 restrooms were evaluated, of which 47.6% are designated for healthcare personnel, 41.3% for the public, and 9.5% for shared use. Of facilities assessed, 61.9% of the facilities are unisex, while only 19% are designated exclusively for women and 15.9% for men, which limits the gender-based separation recommended in healthcare facilities. A total of 117 handwashing stations, 38 water outlets, 67 toilets, and 24 storage tanks were identified. At the time of assessment, 22% of restroom facilities were not functional due to damaged components. Meanwhile, 74% of handwashing stations assessed did not have soap available.

Accessibility and dignity of use present the most pronounced gaps: 73% of restrooms are not accessible to people with limited mobility — as they do not meet the minimum required dimensions, grab bars, or door width — 92.1% do not have a baby changing table, and 47.6% lack a mirror. Regarding signage, only 6.3% of the facilities are visually identified, and no tactile Braille signage was found. In contrast, basic privacy and safety conditions show that 96.8% of facilities provide privacy, 93.7% have lighting, and 88.9% have a functional lock, latch, or bolt.

Waste Management

During assessment, 55.6% of facilities reported that their staff had not received information on waste management protocols, and only 33.3% had visible materials on the subject. All of the facilities responding to this section have a designated area for temporary waste storage.

Regarding the frequency of waste collection, 33.3% of facilities reported that the last collection of biohazardous waste occurred more than a year ago. For sharps waste, this proportion rises to 44.4%. Only 33.3% of the facilities have biohazardous waste collected two or more times per week. A single facility has an incinerator for final disposal, which is currently out of service due to complaints from the surrounding community about smoke and odors. No facility reported open-air burning or burial of waste.

Infection Prevention and Control & Cleaning Protocols

Only 22.2% of facilities have an established IPC committee, and of these, one reported that its last meeting took place six months ago. Among staff, 44.4% report receiving training on cleaning and disinfection protocols. Only 33.3% of facilities have visible materials on the subject.

In terms of practical implementation, most facilities that reported data apply cleaning protocols daily in restrooms, medical care areas, and common areas, suggesting that the practice is sustained by operational routine rather than by a formal framework of training and supervision.

Hygiene Promotion and Menstrual Hygiene

Among facilities, 77.8% have a supply of bar or liquid soap, 55.6% conduct awareness-raising activities on hygiene promotion and handwashing, and 66.7% have visible materials on the subject. These activities are primarily carried out by nursing and social work staff, with frequencies ranging from daily to monthly depending on the facility.

Menstrual hygiene has lower coverage: 44.4% of facilities conduct outreach activities on the topic, and the same percentage have visible materials available — which represents a significant gap, considering that the evaluated health facilities do not meet the minimum standards for gender-separated privacy in most cases.

Community Findings

Disease Prevention Knowledge

The community survey assessed the population's knowledge on preventing diarrheal diseases, hypertension, dengue, and diabetes, finding, in general, a good level of knowledge regarding the main preventive measures.

Regarding diarrheal diseases, 93% of respondents identified handwashing when preparing food as a preventive measure, 87% mentioned washing fruits and vegetables, and 80% cited the consumption of safe water (boiled, chlorinated, or bottled). Some minor misunderstandings persist, such as considering antibacterial soap or antibiotics as preventive measures (6% and 4%, respectively).

Regarding hypertension, or high blood pressure, 87% recognized reducing salt and fat intake as preventive measures, and 76% mentioned physical activity. Incorrect responses were minimal (less than 4%).

Regarding dengue fever, knowledge was particularly high: 93% identified mosquitos as the vector, 95% mentioned eliminating standing water, and 93% cited keeping water containers covered. However, knowledge about personal protection was lower: only 60% mentioned the use of repellents and 49% the use of mosquito nets.

Regarding diabetes, 92% identified reducing sugar intake as a preventive measure, but only 69% mentioned physical activity and only 58% mentioned eating fruits and vegetables, suggesting that diabetes is primarily associated with sugar and less so with a comprehensive healthy lifestyle.



Image 4. Project HOPE's team distributes hygiene kits to patients at a mobile medical unit in Chacao, outside La Guaira. Photo by Project

Overall, the results show that communities have solid knowledge of the most basic and visible preventive measures, while gaps are concentrated around personal protection practices (dengue) and the lack of a more comprehensive understanding of chronic disease prevention (hypertension and diabetes).

Handwashing Knowledge

Results show significant differences in the recognition of critical times for handwashing. The most frequently mentioned times were before preparing food (69%), after using the restroom (64%), and before eating (55%). However, times related to childcare were significantly less recognized. Only 3.1% of participants mentioned handwashing after changing diapers, and just 1.2% identified handwashing before feeding a baby as critical.

These findings show that community knowledge about hygiene focuses on general self-care practices, while practices associated with disease prevention in early childhood exhibit significant gaps. From a programmatic perspective, this represents one of the clearest needs identified in the evaluation, as it has direct implications for the prevention of diarrheal diseases and other communicable infections.

Community-Level Water Storage

Household water storage is a widespread practice in the evaluated communities. Among assessed households, 69.9% had water storage containers inside or under their homes and 44.2% kept containers outdoors (jugs, buckets, drums, or tanks).

This reliance on storage is partly explained by the fact that the public water system is not the primary source of water for most households: only 31.3% use it as their primary source, while 60.1% rely on other sources and 6.1% rely on water trucks. This forces households to store water to ensure its availability, making it especially important to maintain safe water handling practices.

Although most households had adequate storage conditions, risks were identified in a smaller but significant proportion of the population:

- 11.7% stored water that was visually unfit for consumption or showed signs of contamination.
- 4.3% used containers without a tight-fitting lid.
- 3.7% kept dirty containers.
- 27.6% had potential vector breeding sites in their water storage containers.

Taken together, these results show that water storage is a common strategy for coping with limited and intermittent access to water. Although communities possess basic knowledge of safe water strategies, gaps remain — particularly the presence of vector breeding sites — indicating that the need is not only for access to water but also for strengthening practices that reduce the health risks associated with storage.

Vulnerability to Vector Proliferation

The assessment identified significant risks associated with water storage and vector control. Among households that kept water containers outdoors, only 30.7% reported that these were properly covered, while 11.7% indicated that they were not adequately protected.

Similarly, among households that stored water inside their homes, 52.8% indicated that the containers were properly covered, while 14.7% acknowledged that they were not. These conditions are reflected in the observational findings: potential vector breeding sites or the presence of larvae were identified in 27.6% of households — a considerably high proportion for communities exposed to mosquito-borne diseases.

These findings are particularly relevant when analyzed alongside the health findings, where the population demonstrated extensive knowledge about dengue and prevention measures. The presence of breeding sites in more than a quarter of households highlights a gap between knowledge and practice, primarily associated with structural conditions that necessitate frequent water storage.

Prevention of Violence and Abuse

The assessment revealed a significant gap between awareness of these issues and the knowledge of available response mechanisms. Only 17% of the population adequately understands these concepts. On the other hand, 62% of participants indicated they knew where to turn in the event of a violent situation, while 31% indicated they were unaware of any support options. Previous exposure to educational activities on violence and abuse was relatively low. Only 35% of participants reported having attended talks on the subject, while 55% indicated they had not participated in such activities.

Access to community support mechanisms represents one of the main gaps identified. Only 11% of participants said they were aware of any support groups for survivors of violence, while 84% indicated they were not aware of any. Actual participation is even more limited. Barely 3% of respondents reported participating in activities organized by these groups, which highlights the extremely limited reach of these support mechanisms.

Mental Health and Psychosocial Support Knowledge

Mental health remains a poorly understood topic in the communities surveyed. Among respondents, 53% held incorrect beliefs about its definition and 60% reported never receiving guidance or talks on the subject (only 35% had received such guidance). This reflects limited opportunities to strengthen knowledge about emotional well-being and stress management and highlights the need to increase community awareness of mental health.

Regarding knowledge of support services, 58% of participants indicated they knew where to turn in the event of a mental health problem, but 33% were unaware of any available mechanisms or services. The greatest gaps are found in specific community resources:

- Only 16% are aware of a psychological support group (77% do not know of any).
- Just 14% of participants are aware of counseling groups for mothers and fathers.
- Only 23% are aware of resources that offer information and tools for family well-being.

Finally, the need for psychosocial support is well-recognized by communities: 71% of participants reported that mental health-related situations occur in their community, compared to only 22% who do not identify such situations.

Child Protection and Positive Parenting Knowledge

Perceptions regarding the safety of children and adolescents are mixed: only 33% believe that most spaces in their community are safe for children, 35% indicate that only some are safe, and 28% perceive that most are not safe. Overall, nearly two out of every three participants perceive limitations in safety conditions for children.

Regarding parenting practices, the results are mixed: 39% reported that dialogue and respectful parenting predominate, and another 39% indicated that respectful practices are combined with other disciplinary methods. However, 14% reported that punishment is a common parenting mechanism, indicating that practices persist that could affect children's well-being and that it is necessary to continue strengthening positive parenting.

Child supervision is one of the main areas of concern in this component: only 34% of participants believe that children receive constant and adequate supervision. Among those surveyed, 42% indicated that children are sometimes left unsupervised, and 20% noted that this is common — a situation that increases their exposure to various protection risks.

Finally, situations of family separation and lack of adult care were identified, although to a lesser extent: 28% reported that separation of children from their parents occurs in some cases, and 11% consider it common (54% perceive it as infrequent). Similarly, 37% reported isolated cases of children without adult care, and 6% considered this situation to be very common. Although these are not the predominant phenomena, their presence in a significant proportion of communities warrants preventive actions and early identification mechanisms.

Recommendations

The findings described throughout this report highlight interconnected needs across the health, WASH, and protection sectors, which will require a coordinated response during the coming months of implementation in Distrito Capital, Miranda, and La Guaira.



Image 5. Project HOPE President, Chris Skopec, talks with Project HOPE team members in Caracas, Venezuela. Photo by Emily Morffi for Project HOPE, 2026.

Health Recommendations

The near-total lack of medications for obstetric emergencies — a mere 12.7% on average, with hydralazine and methyldopa tablets completely absent from the entire network — represents the most urgent gap to address, given the direct risk it poses to maternal mortality from preeclampsia, eclampsia, and postpartum hemorrhage. It is recommended to prioritize the provision of obstetric emergency kits in the eleven facilities that currently manage pregnancy complications.

In regards to mental health, the combination of very limited service offerings (18.2% coverage rate) and an almost complete lack of psychotropic medications (between 0% and 25%, depending on category) suggests that the response must be phased: providing a basic list of medications to the centers with the highest volume of care, training general staff in the mhGAP program — currently implemented in only 9.1% of centers —and, while expanding installed capacity, strengthening the existing referral system, which, with 54.5% coverage, constitutes the strongest link in this component. Similarly, care for gender-based violence and sexual violence needs to be expanded: 81.8% of centers lack adequate physical space for the clinical management of these cases. Therefore, it is recommended to establish spaces that guarantee privacy and confidentiality, starting with hospitals and the most complex CPT III centers.

Epidemiological surveillance also needs to be strengthened, particularly for malaria and dengue, for which rapid diagnostic tests are available in only 9.1% and 18.2% of facilities, respectively. Providing these supplies and management protocols in La Guaira and Miranda should be an early priority. Finally, given that more than half of the pharmacies, gynecology clinics, and immunization areas show visible damage to their walls, these interventions should be accompanied by minor infrastructure repairs and the installation of access ramps at the five facilities that do not yet have them.

Water, Sanitation, and Hygiene (WASH) Recommendations

The rehabilitation of handwashing stations should be the top priority for this component: with only 24.8% operational — the lowest rate among all evaluated water points — and nearly two-thirds lacking soap, this is also the intervention with the greatest potential for immediate impact on disease prevention, starting with the two facilities that reported 0% operational stations. At the same time, it is necessary to provide testing kits and train staff so that water quality monitoring — currently practiced in less than half of the facilities — becomes a routine practice and so that staff establish a maintenance schedule for storage tanks, more than a third of which currently fail to meet basic functionality criteria.

The management of medical waste represents another gap that requires attention, in coordination with municipal authorities or service providers. One-third of facilities have not had biohazardous waste collected in over a year and up to 44% of facilities have not had sharps waste collected in over a year. Furthermore, since only 22.2% of the centers have an established infection prevention and control committee, it is advisable to take advantage of these infrastructure interventions to reactivate such committees and expand staff training on cleaning and disinfection protocols.

Community Protection and Psychosocial Support Recommendations

A recurring finding in this component is the gap between what communities know and what they can actually access: most participants know where to turn in the event of violence or a mental health issue, but very few are aware of specific community support groups. Closing this gap requires mapping and actively publicizing existing resources, as well as strengthening or creating support groups in communities where none exist.

The perception of insecurity in community spaces — shared by 2 in 3 participants — along with reports of insufficient child supervision, points to the need to establish safe spaces and structured activities for children and adolescents, prioritizing areas where the perception of risk is highest. Regarding parenting practices, the fact that most households already practice or combine forms of respectful parenting provides a favorable foundation on which to build awareness-raising sessions aimed at reducing the use of punishment, which is still present in 14% of households.

Finally, although family separation and the absence of adult care are not predominant phenomena, their presence in a significant proportion of communities justifies training community and healthcare actors in both early identification and referral.

The findings of this report reveal a pattern common to all three sectors evaluated: there is knowledge and existing capacity within communities and health facilities, but there is a lack of supplies, infrastructure, and the access mechanisms needed to translate that knowledge into effective practice. For example, communities know how to prevent dengue, but breeding sites persist; and health personnel know how to manage pregnancy complications, but the medications needed to do so are lacking. Therefore, the most effective response will not be one that treats health, WASH, and protection as separate components, but rather one that takes an integrated approach to addressing the practical barriers that prevent the application of existing knowledge and prioritizes the facilities and communities where gaps across multiple sectors are concentrated simultaneously.

CONTACT INFORMATION

Latin America & Caribbean Desk
LACDesk@projecthope.org

