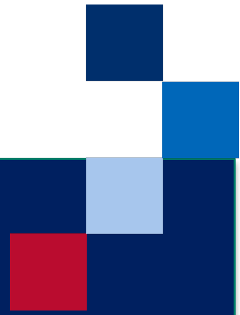
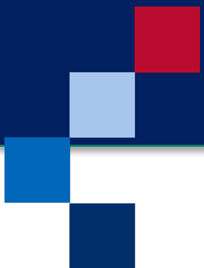


# Expanding Social Health Protection for Women at Risk of Migration in Honduras

## Desk Review and Regional Stakeholder Engagement Report

Local Health System Sustainability Project
Task Order 1
USAID Integrated Health Systems IDIQ

March 2022



USAID
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**Local Health System Sustainability Project**

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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**Submitted to:** Scott Stewart, Task Order Contracting Officer's Representative, USAID Bureau for Global Health, Office of Health Systems

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# Acronyms

| | |
|---|---|
| CCT | Conditional Cash Transfer |
| FSPSRP | Solidarity and Social Protection Fund for Extreme Poverty Reduction (Fondo de Solidaridad y Protección Social Para La Reducción de la Pobreza Extrema) |
| GDP | Gross Domestic Product |
| GoH | Government of Honduras |
| HBP | Health Benefit Plan |
| IDB | Inter-American Development Bank |
| IHSS | Honduras Social Security Institute |
| IOM | International Organization for Migration |
| LAC | Latin America and Caribbean |
| LGBTQI | Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex |
| LHSS | Local Health System Sustainability Project |
| NGO | Non-Governmental Organization |
| OHCHR | Office of the High Commissioner for Human Rights |
| PAHO | Pan-American Health Organization |
| PBS | Basic Health Package (Paquete Básico de Salud) |
| PBVM | Bono Vida Mejor Program (Programa de Bono Vida Mejor) |
| PRAF | Family Allowance Program (Programa de Asignación Familiar) |
| RUP | Unique Registry of Participants (Registro Único de Participantes) |
| SHP | Social Health Protection |
| USAID | United States Agency for International Development |

# Executive Summary

The USAID Local Health System Sustainability (LHSS) Project helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support high-performing health services. The LHSS Latin America and the Caribbean Bureau Activity is providing technical assistance in Honduras to support the development of capacity to adapt, finance, and implement strengthened social health protection (SHP) to provide adequate and equitable coverage for women migrants and those at risk of migration.

This report presents findings from a desk review conducted by LHSS to inform increased understanding of the Honduran context for expanding SHP to women at risk of migration, including LGBTQ+ populations. This study is a first step designed to inform LHSS project engagement with Honduras stakeholders to collaboratively map the landscape to inform a feasible approach to develop a roadmap to strengthen SHP for this priority group in Honduras. This desk review included peer-reviewed and gray literature on SHP, health financing, and migration in Honduras. This process was supplemented by key informant interviews with subject matter experts working on migration and/or SHP issues to substantiate and validate findings related to gaps in the coverage, integration of migrants into the health system, and current and potential financing strategies, as well as gender-based violence, human trafficking, and other relevant social determinants of health.

Key findings include the following:

- The main drivers of migration for Honduran women discussed in this report are violence and lack of public safety, economic conditions and unemployment, food insecurity, family reunification, government instability and corruption, and emerging drivers such as climate change and the COVID-19 pandemic.
- Access to health and health costs can greatly influence women's decisions around migration, but motivations to migrate are complex and multi-faceted, requiring a systems-thinking approach to developing solutions.
- There is less access to health care in rural areas as opposed to urban locations.
- The health needs of women at risk of migration are various and often interconnected: access to maternal health services, reproductive health services, mental health services, and violence prevention and reduction programs.
- The lack of investment on health care generates difficulty in accessing health care services (and thus meeting the above needs) due to high costs for users, lack of access due geographical location and limited transportation, and facility overcrowding and lack of trained health staff.

Existing efforts to strengthen SHP that were found in the review and that are discussed in the report are: Conditional Cash Transfer programs, the role of non-governmental organizations and foreign aid, and the government's response to violence against women. Continuing to expand existing programs in Honduras such as Conditional Cash Transfers for women living in extreme poverty and those not receiving social pensions helps to bolster already existing SHP. Additional benefits can be seen through expanding programs that create employment opportunities, especially for at-risk youth, rural youth, and youth living in extreme poverty, and by increasing gender equity in access for beneficiaries to social services such as health services, education, and vocational training.

There are several approaches at the government level that could be considered to expand financing mechanisms for SHP. Suggested strategies include reforming regulatory policies and procedures to facilitate expansion of health coverage under existing law. Another strategy would be improving planning for pension schemes to cover those living in extreme poverty along with increasing long-term sustainability. In 2021, an LHSS landscape analysis of SHP protection in the region found that there is some potential to use blended and non-traditional financing to support strengthened health protection in countries of origin of migration, including Honduras. The desk review conducted for this report did not find any evidence of engaging the public, non-governmental, or commercial private sectors in these types of financing schemes for SHP in Honduras[1].

In addition to informing LHSS project interventions and contributing to the broader knowledge base on these topics, the key findings will be disseminated as described in the LHSS LAC Bureau work plan. These dissemination methods include a webinar with participation of national and regional actors such as Mesa Interinstitucional, Interagencial de Salud y Migración, and the International Organization for Migration (IOM) and a publicly disseminated blog referencing the findings.[2]These review findings will inform collaboratively developed initial recommendations to the Government of Honduras and other key stakeholders for strengthening SHP for women at risk of migration in Honduras.

1 The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. March 2021. *Social Health Protection in High Migration Areas Landscape Analysis Report*. Rockville, MD: Abt Associates.

2 The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. October 2021. *Local Health System Sustainability Project LAC Bureau Activity Year 2 Work Plan: October 1, 2021-September 30, 2022*. Rockville, MD: Abt Associates.

# Introduction

## Honduras Context

In Honduras in 2019, the percentage of the population living in poverty was 59 percent and extreme poverty was 37 percent (INE 2019). As of March 2021, at least 2.9 million people faced high levels of acute food insecurity (Integrated Food Security Phase Classification 3 or above) (IPC 2021). Honduras has one of the lowest labor market participation rates in Latin America and the Caribbean (56 percent), with considerable inequality regarding female participation as 74 percent of jobs are held by men (CABEI 2016), as well as a high level of informal labor that persists across all sectors including agriculture, industry, and service (World Bank 2019). From 2005 to 2012, Honduras' homicide rate rose until it reached one of the highest rates in the world at 86 per 100,000. Between 2005 and 2018, 5,730 women were murdered, with the rate reaching 14.6 for every 100,000 women inhabitants by 2013 (MESCLA 2020). Even though Honduras' overall homicide rate saw a reduction between 2013 and 2018 (OSAC 2020), the violent deaths of women have continued to rise in recent years. Recent estimates illustrate that the rate is once again rising to one comparable to that of 2013, which can be attributed to the prolonged COVID-19 pandemic and its effects on gender-based violence (ECLAC 2021). Additionally, for LGBTI+ Hondurans, insecurity and social exclusion based on sexual orientation and/or gender identity is cited by the International Migration Observatory of Honduras as one of the main causes of migration; particularly for trans women, who face a life expectancy of less than 35 years due to hate crimes and transfemicides (OMIH 2021). Lastly, people with disabilities are often among the most disproportionally vulnerable migrant demographics. According to Human Rights Watch, people with disabilities not only face infrastructure challenges that hamper quality of life; they are often deprived of full legal capacity and institutionalized or can face threats and extortion by criminal gangs (HRW 2021). Decades of violence, insecurity, and lack of job opportunities have driven a large wave of out-migration from Honduras primarily northward to the United States.

## Health System in Honduras

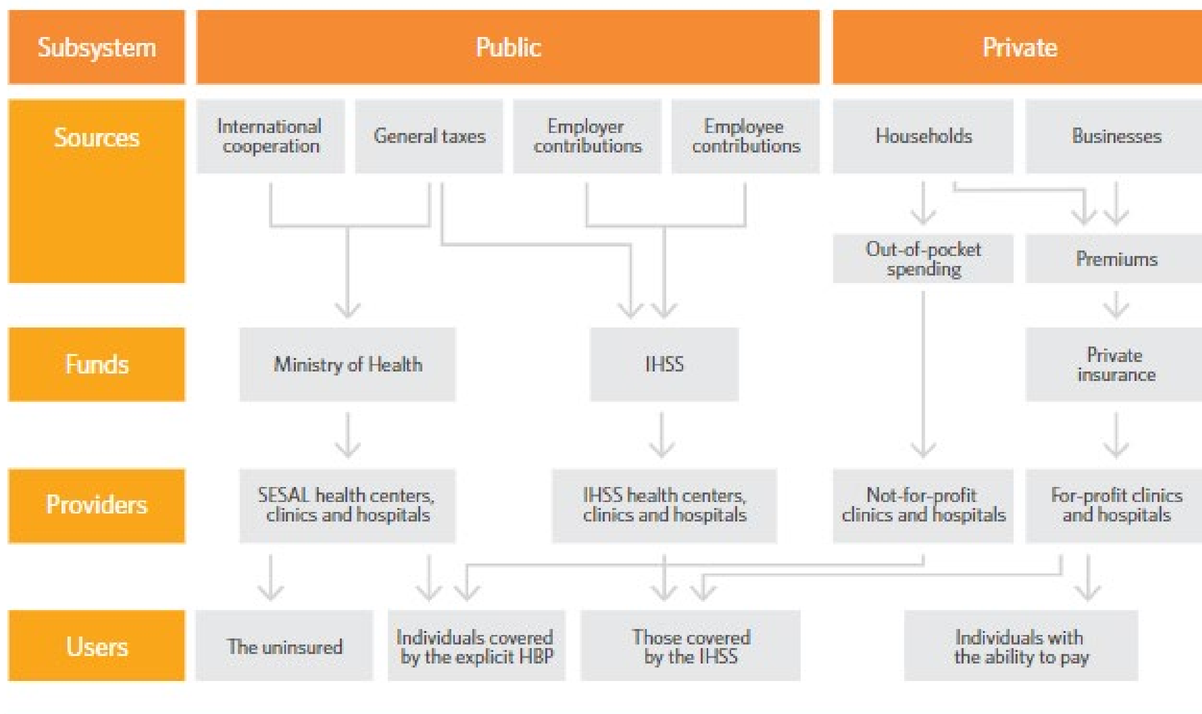
In Honduras, the Executive Branch, through the Ministry of Health (MOH), coordinates the health system through a national health plan. In 2005, when the initial National Health Plan was prepared and agreed upon for implementation, Honduras focused on health sector reform that included the decentralization of health care services provided by the MOH, maternal and infant health and nutrition, promotion of health and prevention of risks, communicable disease control, and chronic non-communicable diseases (PAHO 2009). In the plan, Honduras' stated goals were to ensure access to basic health services for at least 95 percent of the population, for at least 60 percent of the population to be affiliated with an insurance system, and for 100 percent of public and private health establishments to be properly licensed and accredited (GoH 2005). However, Honduras is still far from achieving these goals, which will require investment in infrastructure modernization, human resources, and budget increases (Carmenate-Milián et al. 2017). Likewise, the country has several important national policies focused on health issues, but insufficient implementation of these policies have contributed to only minimal improvements in the health of the population (PAHO 2017a).

The National Health Plan 2010–2014 included the adoption of a model of comprehensive and community care, creation of a national quality system, strengthening surveillance, reinforcement of the evaluation system, and mapping of a health information system (PAHO 2017a). The 2014–2018 National Health Plan aimed to improve the health profile of the entire population

using a risk management approach (CABEI 2016). This plan guided the implementation of 500 primary health care teams made up of a physician, a nurse, and a health promoter that serve rural areas of the country. These teams prioritize communities living in extreme poverty and, as of 2015, 367 teams were working in rural areas and serving 1.4 million people (PAHO 2017a).

The Honduran health system's public sector includes the Ministry of Health and the Honduras Social Security Institute (IHSS), and a private sector made up of for-profit and non-profit institutions. In theory, Ministry facilities provide services to the entire population, however, in practice, only around 50 percent to 60 percent of Hondurans regularly use these services (PAHO 2012). The IHSS provides services to approximately 12 percent of the population, using both its own and contracted facilities. The IHSS charges, collects, and manages fiscal resources and compulsory contributions from workers and employers (Carmenate-Milián et al. 2017) and grants coverage benefits in the areas of illness, maternity, workplace-related accidents and illnesses, disability, old age, death, and involuntary unemployment to both public and private sector workers (Social Security Administration Research 2019). Private sector coverage serves around 10 percent of the population, specifically those who can afford to pay for private insurance (Carmenate-Milián et al. 2017). It has been estimated that 17 percent of Hondurans have no regular access to health services (Bermúdez-Madriz et al. 2011). Note that more recent information and data was not found in the literature review, indicating a need for further study of access to health care. Figure 1 illustrates an overview of the Honduran health system.

**FIGURE 1: THE HONDURAN HEALTH SYSTEM**




*Source: Bermúdez-Madriz et al. 2011*
*Secretaria de Salud (SESAL) – Ministry of Health*

## Overview of Migration Trends in Honduras

Honduras is a country with a high migration flow, and emigrants outnumber immigrants. The Honduran migrant population most frequently favors destination countries such as Mexico, Spain and particularly, the United States (Canales, Fuentes, and Escribano 2019). While difficult to quantify exact numbers of irregular and regular migrants out of Honduras, recent reports from the U.S. Customs and Border Protection show that in FY2017, CBP agents apprehended 47,260 Honduran citizens at the U.S. southwest land borders (U.S. Customs and Border Protection 2017), and in FY 2021 that number rose to 308,931. Between FY 2017 and FY 2020, there was a 38% decrease in asylum receipt for Hondurans (either affirmatively or defensively) (DHS 2017-2020). Individuals involved in irregular or undocumented migration are predominantly male, with 118 men migrating for every 100 women, whereas those who participate in regular migration are predominantly female, with 76 male migrants to every 100 women for (MESCLA 2020). However, of the total number of irregular Honduran migrants (male and female) reported at the border of the United States between 2013 and 2020, roughly 41 percent were women. While women are increasingly migrating in search of decent and sustainable work, the IOM and OECD attribute underrepresentation to biased recruitment processes that prioritize production sectors which skew towards men over other professions such as health, education, etc. that tend to hire women (IOM OECD 2014). The average age of Honduran migrants was 20.9 years in 2018, with children and youths up to 17 years of age typically migrating irregularly more than other age groups. From 2016 to 2019, 79 percent of returnees from the U.S. were men averaging 26.8 years of age, indicating the average returnee is older than the average migrant from Honduras. Reports from U.S. Customs and Border Control show that this increases to 88 percent when specifically considering the proportion of males returned from the United States (DHS 2019). As discussed further below, individual motivations to migrate vary across socioeconomic status; level of educational attainment; region of origin; gender; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) identity; or ethnic or indigenous identity.

## Study Objectives and Methods

The objective of this report was to conduct a desk review of existing social health protection (SHP) platforms, needs, and challenges in Honduras to better understand the link between SHP and migration behaviors, and to identify promising practices and lessons learned from Latin America and the Caribbean (LAC) and globally with SHP platforms in high-migration contexts. The research was guided by the following sub-objectives:

- Describe the health needs of women at risk of migration, and gaps in SHP coverage for those women
- Identify and describe drivers of irregular migration, including how access to health care and health costs influence women's decisions around migration
- Understand the existing or previous efforts to strengthen SHP and how these could be leveraged, expanded, or complemented
- Describe potential mechanisms to sustainably finance expanded SHP coverage

The desk review was supplemented with key informant interviews with stakeholders working on migration and/or SHP issues in the LAC region. Organizational stakeholders of the Local Health System Sustainability (LHSS) project for the USAID LAC Bureau were contacted, informed of the project, and invited to participate. Interviews were scheduled and completed based on the capacity and availability of the organizations. The goal of the qualitative data collection was to

clarify the context for expanding SHP for women at risk of migration in Honduras, understand key challenges that women face when trying to access SHP, and identify promising initiatives to improve the opportunities for health and safety within Honduras for women at risk of migration. Organizations that participated in the key informant interviews are listed in Annex A

# Literature Review Findings

Literature reviewed for this study included recent publications from peer-reviewed academic journals, as well as gray literature such as conference papers, government reports, donor/implementing partner publications, webinars, and blogs from organizations with experience in migration/SHP. Publications reviewed were published, in English and Spanish, and discuss barriers to access to health services and social health protection for women at risk of migration.

## Characteristics of Women at Risk of Migration

The International Organization for Migration (IOM) defines a migrant as any person who is moving or has moved across an international border or within a state, away from their habitual place of residence, regardless of the person's legal status; whether the movement is voluntary or involuntary; the cause of the movement; or the length of the stay (United Nations 2021). A recent study about Honduras shows that women account for 52.4 percent of individuals prone to regular migration and 44 percent of irregular migration (Quijada and Sierra 2019). Female migrants apprehended at the US Southwest land border are more likely to come from urban, rather than rural origins and the majority tend to fall into the age ranges of 6-12 years old, followed by 20-24 years old, respectively (DHS 2020). It is important to consider intersectionality in analyzing the characteristics and drivers of women at risk of migration. Intersectionality refers to the interconnected nature of social identifiers such as race, class, and gender, and the way these dimensions may converge to compound discrimination or disadvantage. For example, women of working age with low levels of education in Honduras may be more likely to decide to migrate. In Honduras between 1996 and 2010, around 5,000 health professionals emigrated to more developed countries including the U.S. in search of better work opportunities (Carmenate-Milián et al. 2017) Generally, younger individuals with lower educational attainment and lower income are more prone to irregular migration as opposed to those who participate in regular migration. Additionally, for those in Central America and Mexico, women who have directly experienced an act of violence, or report that violence has affected their family, whether it be kidnapping, robbery, sexual violence, or murder, are more prone to migration than women who have not experienced such violence (UNHCR 2015)[3].

### Health Status of Women at Risk of Migration

Maternal and child health indicators reflect the overall health systems performance. Despite health services coverage expansion in Honduras over the years, certain areas still lack progress, such as maternal mortality during pregnancy, childbirth and the puerperium which is one of the four leading causes of death in women in the age group of 20-24 years old accounting for 65 deaths per 100,000 live births (PAHO 2017b) along with chronic malnutrition which affects 25% of children younger than 5 years old (IDB 2014). It would be important to study other health indicators for women's health, however these are not easily available, and the sources of information are often unreliable. Health care access is especially difficult in rural areas of the country, resulting in worse health outcomes. For instance, the current maternal mortality ratio in rural areas, 75 per 100,000 live births, is much higher than the 39 per 100,000 live births in urban areas (IDB 2018). The rate of adolescent pregnancies in Honduras is one of

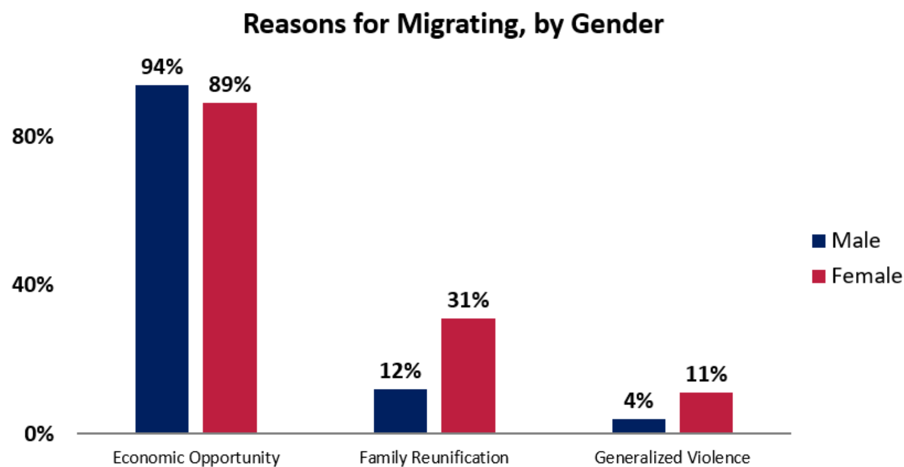
[3] Most sources reviewed refer to irregular when referencing "migration." Regular migration is far less available to vulnerable populations given requirements for achieving that status.

the highest in the LAC region (17.2 percent) ranking fourth out of 31 and probably related to the unmet needs for contraceptive (17,7 percent) (FP2030, 2020). Early unions in Honduras are associated with adolescent pregnancies which lead to school dropout, lower rates of labor force participation as adults, greater risk of suffering domestic violence, and reduced autonomy or agency in decision-making.

## Main Drivers of Migration for Women

From all Honduran migrants, 43% are women (Pulte Institute 2020) from which 96.6% are in the age range of 18-65 years (CEMLA 2017). Regarding unaccompanied minors, the average age is 15.5 years for girls, compared to 14.3 years for boys (REDODEM 2018). However, between 2016 and 2017, there was a 72 percent increase in migration by unaccompanied girls, highlighting the need to consider gender and age when examining the gendered drivers for migration among Hondurans. There is a range of influences and stressors that contribute to the decision to migrate and understand these reasons and how they intersect and compound each other is critical to guide the improvement of SHP programs. Many Honduras do not migrate voluntarily, but rather are involuntarily displaced due to various structural and contextual factors beyond their control. The most frequently reported reasons to migrate are income loss due to unemployment, (Corson and Hallock 2021), lacking economic prospects and opportunity, family reunification, and generalized violence (CENISS, 2020).

**FIGURE 2: REASONS REPORTED FOR MIGRATION BY HONDURAN MIGRANTS, BY GENDER**




*Source: CENISS 2020*

### Economic Conditions and Unemployment

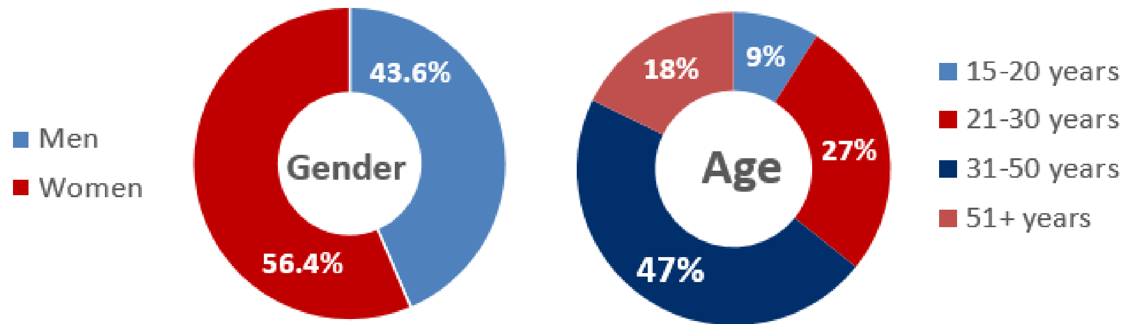
As of 2017, approximately 82.6% of the Honduran population is employed in the informal sector (Statista 2021). This creates increased conditions of vulnerability among women due to lower salaries, the potential for working in unsafe conditions, and limited benefits, such as social security and employer-provided health care (MESCLA 2020). The COVID-19 pandemic brought national health measures to attain the control of infections, some of which impacted the local economy— especially in the informal sector, causing loss of income, work, and social benefits (Pulte Institute 2020). The pandemic has intensified widespread forms of discrimination in the labor market due to greater the widening gap between supply and demand of workers. Although hard to quantify, LGBTQI populations in Honduras experience markedly more difficulties in

securing employment in the formal labor market due to their gender identity (Asegurando La Educación/USAID 2019).

Some employers discriminate against women and LGBTQI applicants based on their appearance or the possibility of pregnancy and in some cases, the belief that women are not capable of carrying out certain functions. Many employers require women to take pregnancy tests as a condition of applying for a job, and all applicants (male and female) must submit an approved, negative COVID-19 test, which is prohibitively expensive (Britt and Morgan 2021). Workers in the informal economy are often the most vulnerable to COVID infection, the first to lose their jobs, and the least likely to have access to social security and health care services (Britt and Morgan 2021). The pandemic has also accentuated already existing gender inequalities and harmful social norms that perpetuate occupational segmentation, limiting the scope of talent and career options, increasing wage gaps for equal work, which affects worker performance, and normalizing gender-based violence (Britt and Morgan 2021). As economic recovery from the pandemic is underway, younger workers may be deprioritized in hiring, leading to inactivity, and accepting of dangerous or precarious work (Britt and Morgan 2021).

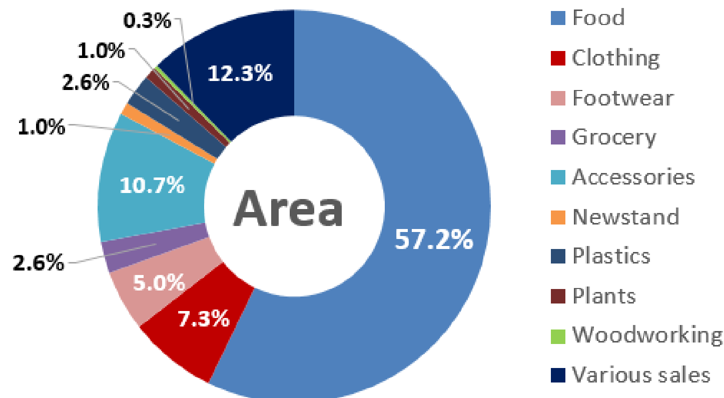
When women are able to participate in the formal economy, this not only benefits their own quality of life and that of their families, but also the social and economic development of a country. Studies have shown that there is an association between increased formal economic participation by women and a decrease in poverty levels (MESCLA 2020).

**FIGURE 3: PARTICIPATION IN THE HONDURAN INFORMAL LABOR SECTOR**




*Source: Raudales and Alvarenga 2017*

**FIGURE 4: COMPOSITION OF HONDURAN INFORMAL LABOR SECTOR, BY AREA**




*Source: Raudales and Alvarengo 2017*

## Violence and Public Safety

Persistent violence, and with it increased perceived levels of insecurity, continue to be a challenge and push factor for migration in Honduras. Despite a 50% decrease in the homicide rate in Honduras from 86 per 100,000 inhabitants in 2013 to 43 homicides per 100,000 in 2019, it remains one of the highest in the world as of 2019 (Meyer 2021). Violence against women continues to be especially high. Domestic violence, femicide and sexual violence, and the impunity of perpetrators are among the root causes of the emigration of women from Honduras (OHCHR 2016). In 2019, Honduras had the highest rate of femicide, defined as the killing of a woman because of her gender, in LAC with 6.2 out of 100,000 women being killed by femicide (CEPAL 2019). This compares to the world average of 2 per 100,000 women (Testimony of Ariel G. Ruiz Soto 2021). Other types of less-visible violent crimes are major push factors for Honduran migrants, including extortion, organized crime, and domestic and sexual violence. One in five Honduran residents report being the victim of a crime, and one in 10 residents reports experiencing extortion annually (Montalvo 2019). Organized crime related to drug trafficking, gang violence, and political conflict continues to be a common migration push factor.

Women in Honduras face high levels of gender-based violence which continues to be a frequently cited push factor for migration. Gender-based violence has severe social and health consequences and impedes country development and poverty alleviation efforts by imposing large medical expenses and reducing productivity and income for affected families. The increased use of health services also generates an additional financial and logistical burden on the health system at the national level. Gender-based violence manifests itself in various forms including, but not limited to: femicide, sexual violence, domestic violence, and violence against marginalized groups. In a study on gender-based violence commissioned by USAID, forty percent of women reported suffering at least one incident of gender-based violence (physical, psychological, emotional, sexual) and statistics are often underreported (Reisman and Martinez 2015). Although the homicide rate for women is less than the rate among men, a greater percentage of women than men die from causes linked to violent incidents involving drug trafficking and organized crime (IUDPAS 2019). While violence affects the country overall, certain subpopulations—youth, women, LGBTQI+ populations, individuals with disabilities, and indigenous groups—are often targeted more frequently than others (MESCLA 2020). Honduras has the highest rate of LGBTQI+ homicides in the LAC region stemming from transphobic and

homophobic violence that is systemically entrenched and reinforced through various social structures. Very limited quantifiable information is available related to migration of the LGBTQI population; however, traditionally conservative sectors and widespread stigma suggest that this community suffers a disproportionate impact of discrimination and violence (Ramos 2019) which impedes them from accessing employment, health services forcing them to migrate. (Pulte Institute, 2020) Additionally, specific ethnic and indigenous groups are often the target of violent acts linked to access and control over land and resources (Irías 2018).

Violence against women, especially physical violence by their partners and sexual violence, is a serious public health problem and a violation of women's human rights. Gender violence is fostered by women’s lack of freedom of expression and a patriarchal culture that empowers men; within families, men are the ones who usually control decision making. Women at risk of migration usually are living in extreme poverty, deprived of basic resources such as land, education, or access to health care. Without a sustainable livelihood, women are often unable to leave a home where they experience violence. However, often the alternative to having a better quality of life and escape from violence, is to migrate.

The government of Honduras (GoH) has passed several laws and policies aimed at protecting women from violence and discrimination. These include a law against domestic violence in 1997, a law for equal opportunities for women in 2000 and a femicide law strengthening penalties for the murder of women in 2013 (Menjívar and Walsh 2017). The GoH also outlined many of its efforts toward gender equity in the Second Gender Equality and Equity Plan of Honduras for 2010-2022, which identified several priority areas to promote gender equality: discrimination in the family, restricted physical integrity, restricted access to productive and financial resources, and restricted civil liberties (OECD 2019). Yet due to an often-unresponsive justice system and weak systemic response to violence against women, more than 96 percent of incidents of violence against women goes unpunished. Additionally, in April 2013, the addition of femicide to the Criminal Code came into force. However, the records of the Public Prosecutor’s office only began reporting femicides in 2017 and only 30 cases were prosecuted by 2019. This contrasts with the 7,041 complaints of murder, infanticide, parricide, and homicide filed between 2008 and 2019 in which the victim was a female. (CDM 2020).

In a United Nations High Commissioner for Refugees study, 40 percent of women interviewed who fled the country due to violence did not report these incidents and abuses to the police because they felt it would be useless to do so. Whereas overall rates have decreased during the last decade, persistent violence continues to affect families and communities while governmental gaps in assistance and protections contribute to an increase in Hondurans migrating abroad (UNHCR 2015).

The Pan American Health Organization prioritized in 2020 the implementation of safety measures and improvement of health centers located in areas with highest prevalence of violence in Honduras. This initiative was called “Hospitales Seguros” (Safe Hospitals) (PAHO 2020). In this year it was also implemented the third phase of the project named Fortalecimiento del acceso a los servicios de salud seguros y resilientes en zonas propensas a la violencia en el Triángulo Norte de Centroamérica (TNCAM). Based on surveys that evaluated the health services in the context of violence, the findings were used to develop intervention plans that include safety protocols in for centers of attention for migrants and other hospitals. (PAHO 2020)

## Food Insecurity

One of the main sources of work and family subsistence for populations in the Central American region, including Honduras, is agriculture. However, currently 15.3 percent of the Honduran population is undernourished, thus ranking the country as having the fourth highest level of undernourishment in Latin America (MESCLA 2020). The prevalence of moderate or severe food insecurity in the Honduran population increased from 40.9% in 2018 to 45,6% in 2019 (World Bank 2020c). Honduras is one of the Latin American countries located in a region termed the "Dry Corridor," which is known for its lengthy dry spells and droughts that negatively affect agricultural crop yields for many rural families. Challenges such as high unemployment, limited/seasonal labor demands, and low or inconsistently paid wages are all characteristics of the Dry Corridor region (Salvador 2017). Additionally, climate change and the increased frequency of natural disasters negatively impacts food security in this already agriculturally fragile region as it will be explained later in this review in the section" Additional Drivers: COVID-19 and Climate Change".

The inability to provide enough food to feed a family can become an important emigration push factor but can also be a consequence of emigration when a family lacks key members to contribute to household earnings, especially among families who are agriculturally employed. Studies from the World Food Programme show that households from the Dry Corridor area of El Salvador, Guatemala, and Honduras with a recently emigrated family member are more likely to experience increased food insecurity at a 43 percent rate among these families—rising to 47 percent after several consecutive failed crop seasons post-emigration (Salvador 2017). While many households hope that recently emigrated family members will be able to contribute to improving their socioeconomic situation through remittances, this is not always the case depending on the outcome of the individual's migration attempt. At least in the short to mid-term, remittances often cannot recoup the acquired debts of emigration as funds do not start flowing until the emigrant finds gainful employment (Salvador 2017). Once the origin household does receive remittance payments, this income usually goes towards basic food consumption; however, if debt repayment cannot be maintained then even families that receive remittances on a regular basis will fall back into poverty and even consider emigration themselves (Salvador 2017). For successful cases where the emigrant finds a stable economic opportunity in this study, more than half of remittances to Honduras are used to buy food for the household, followed by investments in education and healthcare (Salvador 2017). Additionally, women and youth are disproportionately affected by this phenomenon in that if the male partner or father has emigrated, then the woman and children are responsible for taking on the household workload activities, often including agricultural duties (Salvador 2017).

## Family Reunification

Reunification with family is an important migration pull factor for many Honduran women, children, and adolescents. Within the northern Central American region (inclusive of Guatemala, El Salvador, and Honduras (known as the Northern Triangle) and southern Mexico), 82 percent of migrants have family members in the United States, creating a diaspora network which helps to provide support through whether through legal sponsorship, information-sharing, and advocacy, etc. (ECLAC 2018). Thus, family reunification is also considered to be a conditioning factor since many family members who are already established in the destination country will fund the travel costs for other members of their families left behind. Twenty-two percent of unaccompanied minors registered at the U.S. border report family reunification as the main factor in their migration.

## Government Instability and Corruption

Government instability and corruption within the Honduran system is an issue with multifaceted challenges that have developed over decades. Honduras currently ranks among the most corrupt countries in the world on the Transparency International's Corruption Perceptions Index (Transparency International 2020). Corruption at a high level undermines a population's faith in the government and discourages domestic and foreign investment; while corruption within police forces and among lower-level public officials makes the daily life of Honduran residents challenging and contributes to the decisions that many make to migrate elsewhere. When citizens lose hope in the ability to live and move safely within their communities, this spurs out-migration to environments where they are less likely to fall victim to corrupt actors (National Security Council 2021). Between 2017 and 2019, 25.3 percent of Honduran citizens report having been a victim of systemic corruption in the country (Montalvo 2019).

. Recently, the U.S. administration and international aid efforts have committed to making greater efforts to build political will to stem corruption and build government reforms across several Latin American countries to decrease irregular migration from the region. For example, one new line of effort the U.S. Strategy for Addressing the Root Causes of Migration in Central America includes is the launch of an Anticorruption Task Force, which will bring U.S. prosecutors and other experts to investigate corruption cases as part of a regional initiative (National Security Council 2021). Previous efforts had been attempted under the U.S. Strategy for Engagement in Central America and the Plan of Alliance for Prosperity in Central America, which consisted of a five-year investment of $22 billion to create incentives for individuals to remain in their home country. However, efforts to evaluate this project were not successful and the recent withdrawal of international anti-corruption agencies from Honduras has not proved promising to these efforts (Testimony of Ariel G. Ruiz Soto 2021).

## Additional Drivers: COVID-19 and Climate Change

The COVID-19 pandemic and climate change recently introduced additional challenges for populations at risk of migration. The public health crisis of COVID-19 has disproportionately affected the world's most vulnerable groups and accelerated many migration push factors in Central America. In response to the pandemic, Honduras entered a national lockdown during which residents could only leave their homes once every 15 days and only large chain grocery stores were permitted to remain open. Informal vendors and locally owned businesses were closed for months, triggering significant economic losses for many. Since April 2020, the country's gross domestic product (GDP) dropped by 7 percent and new estimates suggest that the percentage of Hondurans living in extreme poverty has risen from 42 percent of the population to 64 percent (Corson and Hallock 2021). According to a survey completed by the World Food Program and the International Organization for Migration in August 2020, 68 percent of respondents expressed concern about having enough to eat during this time, and, by February 2021, almost one-third of the population faced extreme hunger. In comparison to male residents, women have suffered the largest of this economic burden and are reported to have been more likely to experience unemployment during this time (World Food Programme 2020). According to the World Bank, women face this disproportionate effect for three reasons: first, because women in Latin America tend to work in sectors more greatly affected by the pandemic (customer facing occupations, such as sales); second, a high proportion of women in this region are self-employed and/or work in the informal sector (in jobs that cannot be carried out remotely); and third, the pandemic has increased the time burden of household work that falls primarily to women as a result of local social norms (World Bank 2021).

In November 2020, Hurricanes Eta and Iota directly hit Honduras within two weeks of each other. The storms, which inflicted extensive damage, affected nearly half of Honduras' 9 million residents, displaced 368,000 individuals, and subsequently forced 200,000 into shelters. In combination with the effects of COVID-19, the storms are estimated to have accounted for nearly an 8 percent loss in the country's GDP, with 80 percent of this loss coming from the agricultural sector (Corson and Hallock 2021). In Honduras, which has a 58 percent rural population that relies on agriculture for their family livelihood and food, large-scale natural disasters such as hurricanes compound the economic hardships families face and exacerbate food scarcity among indigenous populations and women and children living in poverty (IOM 2018). The recent storms were reminiscent of 1998's Hurricane Mitch, in that the large-scale damage coincided with an economic crisis and stimulated emigration. Hurricane Mitch left roughly 10 percent of the Honduran population homeless, damaged health care networks, destroyed about 20 percent of schools, and forced many workers from the formal employment sector to the informal sector (Quijada and Sierra 2019). Especially in Olancho, the mostly agricultural central region of Honduras that accounts for a large number of migrants, Hurricane Mitch and the more recent storms are similar in that they damaged natural resources and disrupted the ecosystems that provide a livelihood to rural Hondurans, and they highlighted geographical and socioeconomic inequities in the most vulnerable populations, specifically women and the indigenous Garifuna communities living along the nearby northern coast (Griffith 2020).

Within the LAC region, Honduras especially experiences environmental fluctuations that lead to recurring periods of drought. When crops are threatened, household agricultural production and source of income is put at risk and families must purchase water at a higher price. Consequential water-rationing, compounded by COVID-19, has left women and children increasingly vulnerable to economic shocks that strain communities and drive Hondurans to migrate (FAO 2021).

# Access to Social Health Protection Platforms

## Barriers to Accessing SHP

According to the Pan American Health Organization (PAHO), 17 percent of the general population in Hondurans do not have access to health care (PAHO 2017a) and 40% do not have access to SHP (UNDP 2021) Physician population density is low, with 0.31 physicians per 1,000 population in 2017, compared to 1.57 in El Salvador, 0.91 in Nicaragua, and 0.36 in Guatemala (CIA 2017). Even with low coverage of physicians, there are many physicians who are unemployed in Honduras (46 percent in 2009), probably related to the limited investment on human resources hiring and migration of highly qualified health staff to more developed countries in the There is also a critical lack of nurses and technical personnel, specifically in the areas of X-rays, anesthesiology, and laboratories, as the government lacks the capacity to train human resources in these areas (Carmenate-Milián et al. 2017).

As explained earlier in this report, the health system of Honduras is divided into public and private subsectors with the public subsector covering 63 percent of the total population but serving only about 50 percent of those eligible for services. This leaves various gaps in access to health care services for diverse groups of the population, particularly those that experience low levels of autonomy such as women, as well as those with low education and low socioeconomic status. Additionally, there are gaps in rural areas where the public health system has no coordinated network and health centers are commonly closed due to lack of medical personnel and supplies (IDB 2014). Beginning in 2003, Honduras began implementing a

decentralized model, the Basic Health Package (PBS), which includes a health benefit plan (HBP). The goal of implementing this model was to increase coverage and improve the quality of services by decentralizing health care. As a result, coverage expanded from reaching 483,782 beneficiaries in 2008 to 891,938 in 2021. This change in population coverage corresponds to 10.7 percent of the total population, breaking down into 25.5 percent of the rural population and 16.8 percent of the population living in poverty (IDB 2014). Studies comparing the PBS model to the traditional model found higher levels of productivity within health centers, greater cost effectiveness, and greater reported satisfaction with services (IDB 2014).

However, this model presents several distinct challenges with regards to accessing health care, especially for women. First, an established process does not exist for coverage expansion of the model, nor does an entity exist to protect the rights of beneficiaries. Secondly, there is no information management system to monitor patient data compliance across the system and with regards to financing, there are significant delays in payments to providers, which can delay care (IDB 2014). As seen in many health systems, maternal and child health indicators speak to the robustness of a system as described in the section about health of women at risk of migration.

These indicators highlight not only the socioeconomic gaps within the population, but also emphasize the various barriers to access the system. Reports show that many factors limit the utilization of services, especially among women and children, such as insufficient medical personnel, lack of supplies and medicines, long distances to health centers, and women's general lack of autonomy in decision making within the household (IDB 2014).

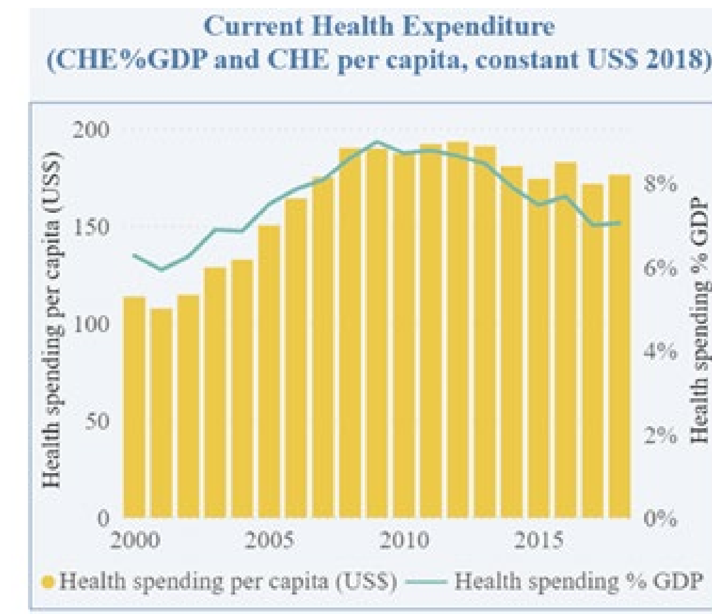
Since the current system has been in use, myriad studies have been done to measure access across populations and communities which found that attempts to increase access to care through decentralized service delivery have been broadly unsuccessful. In one, Pearson et al. compared access to health care between three rural communities in Honduras. Data from all sites indicated considerable gaps in access to care related to the distance from a health provider and having limited access to transportation, diagnostic testing, and specialty services. Forty percent of respondents in the study reported no contact with a health provider in the last year. The study found that cost of care, time needed to access care, and health care facility overcrowding were major barriers to health services (Pearson et al. 2012).

# Financing of SHP

## Health Financing

According to the World Health Organization Global Health Expenditure Database, in Honduras, total health expenditure as a percentage of GDP was 7.05 percent in 2018. This is slightly lower than the average for the LAC region of 7.97 percent. Honduras reached its highest health expenditure as a percentage of GDP in the last 20 years in 2009, at 9 percent, but the percentage has steadily decreased since then (WHO 2021). As demonstrated in Figure 4, Honduras has the second lowest level of investment in health care per person in the LAC region at $176 per person in 2018. By comparison, the average investment in health care in LAC was $667 per person in 2018 (WHO 2021). Note that health expenditures are often disaggregated in studies according to health area, but not according to sex of health care recipient, thus spending on women as a percentage of total spending is unknown.

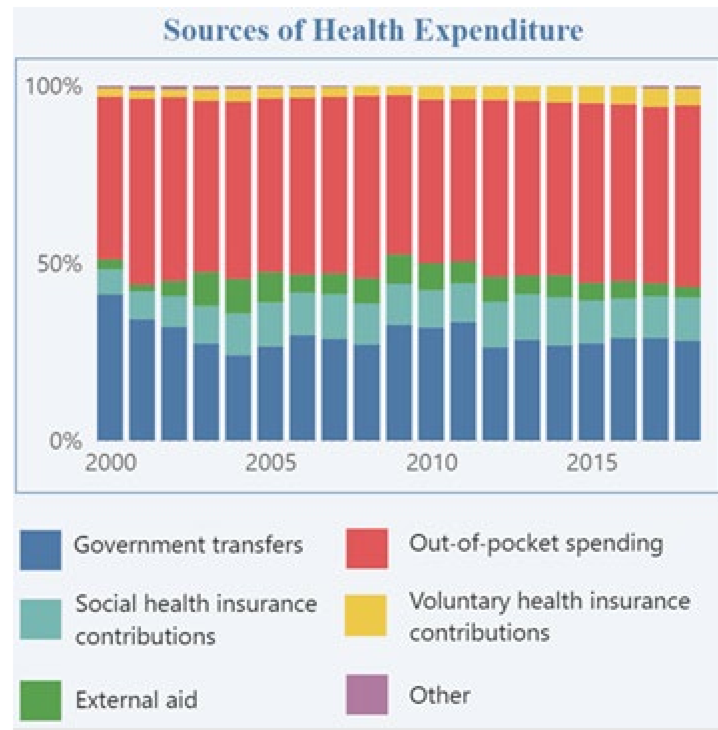
**FIGURE 5: HEALTH SPENDING PER CAPITA (US$) AND HEALTH SPENDING AS % OF GDP IN HONDURAS, 2000–2018**




*Source: WHO Global Health Expenditures Database 2021*

Out-of-pocket spending made up 51 percent of the total health expenditure in 2018, which was significantly greater than the LAC average of 30 percent and the same as the average of lower middle-income countries globally (51 percent). In the past 20 years, the percentage of out-of-pocket spending of the total health expenditure in Honduras has stayed between 45 percent and 53 percent, showing no real change. Figure 5 shows the sources of health expenditure in Honduras per category. Out-of-pocket spending is the largest source of expenditure, followed by government transfers, social health insurance contributions, voluntary health insurance contributions, and external aid (WHO Global Health Expenditures Database 2021). Significantly, when out of pocket expenditures are high, individuals and households may need to cut back on other necessities and are at greater risk of financial catastrophe (WHO 2005).

**FIGURE 6: SOURCES OF HEALTH EXPENDITURE IN HONDURAS, 2000–2018**




*Source: WHO Global Health Expenditures Database 2021*

The health sector accounted for 11.5 percent of total expenditure of the national budget in 2017, a reduction from the previous five years. According to the Secretary of Health budget, 76 percent of funds invested in health comes from the National Treasury, 11 percent from external loans, 9 percent from donations, and 4 percent from national debt relief (Carmenate-Milián et al. 2017).

## Health Care Expenses

The percentage of women who borrowed for health or medical purposes (% age 15+) was 21.8 in 2014 and 15.6 in 2017, evidence that many women do not have the resources to meet their or their family's medical needs in Honduras. More recent data on borrowing for health in Honduras was not found in this review. Remittances are an important source of household income, demonstrated by the high percentage of GDP from remittances in Honduras (21.5 percent in 2019), the second highest in LAC after El Salvador (World Bank 2020a). Almost one in every six Hondurans receive international remittances and 69 percent of these recipients are women. Departments with the largest number of remittance beneficiaries are Cortes, Francisco Morazan, Olancho and Atlantida. These four departments combined account for almost half of all beneficiaries. Remittances play a role as a health care safety net as nearly two in five remittance recipient households report using them to cover medical expenses (IDB 2016). Female-headed households receive monthly amounts of remittances that are 58% higher than those received by male-headed households and on average, remittances constitute 38% of the total monthly household income of remittance recipient households. This is greater among rural and female-led households including households led by young adults. Remittance recipients are more likely to be working as microentrepreneurs, which suggests a lack of access to paid work amongst this population and a correlation with the high proportion of women among the

population of recipients. A reported 38% of households report using remittances to pay for healthcare costs. The likelihood of spending remittances on healthcare was found to be higher among rural than urban recipient households and found to be higher among retirement age individuals rather than working age (IDB 2016).

# Initiatives to Improve Access to SHP for Women

## Social Protection Programs

Honduras set goals in its Country Vision 2010–2038 for greater equity and established solidarity and equity as criteria for intervention in the social sectors, including health. The goals include equal access to quality services in education, health, vocational training, social security, and basic services (PAHO 2017a). In 2012, the GoH adopted the Social Protection Policy, and, in May 2015, it approved the Social Protection System Framework Law (Ley Marco del Sistema de Protección Social) to benefit around 6 million Hondurans living in poverty and extend social protection to the entire population (ILO 2018).[4] The law consists of five schemes including: a social protection floor, contributory pension scheme, health insurance, workman's compensation, and unemployment insurance (World Bank 2019). The law envisioned a universal public health insurance system with coordinated benefits and services provided by the contributory and subsidized systems (PAHO 2017a). Implementation of the new model has been stalled and a significant proportion of the population is still not protected (World Bank 2019) as only 63 percent of the poorest quintile was covered by social safety nets in 2017 (World Bank 2020b).

One of the most significant achievements has been the establishment of the social registry managed by the National Center for Information on the Social Sector, consisting of the Unique Registry of Participants (Registro Único de Participantes, RUP) and the Registry of Institutional Services (Registro de Oferta Institucional, ROI). The RUP was developed in 2013 and serves as the targeting instrument for all social interventions by the GoH. In 2018, the RUP contained socioeconomic information of 4.2 million individuals, about 45 percent of the population. The RUP identifies extremely poor, moderately poor, and non-poor households throughout the country.

The Ley Marco del Sistema de Protección Social also established the Social Assistance Platform (Plataforma de Asistencia Social), which prioritizes the extreme poor and uses a conditional cash transfer (CCT) program called Bono Vida Mejor (PBVM) as the country's key social protection program. The PBVM is managed by the Sub-Secretariat of Social Integration, part of the Secretariat of Development and Social Inclusion, and was established in 2010 with the goal of allocating funds to address poverty in the country (World Bank 2019). The PBVM transfers up to 10,000 lempiras per year (about US$500) to families living in extreme poverty. These transfers are conditional on the families' commitments to education, health care, and nutrition (Franzoni 2013). As of 2015, the estimated average transfer received per household was about $225 per year. As of June 2018, the PBVM provided cash transfers to 234,000 households, and around 90 percent of all program grantees were women (World Bank 2020a). In a World Bank assessment, the PBVM was found to be well targeted, as over 80 percent of the program beneficiaries belonged to the lower five income deciles (World Bank 2019).

[4] Note that as of 2020, per the World Bank's definition / methodology, the amount of the population living in poverty is closer to 4.3 million.

Most recently, the Inter-American Development Bank (IDB) approved a $45 million project, to be disbursed over two years as part of the PBVM to ensure minimum levels of quality of life for people and families affected by the COVID-19 pandemic and hurricanes Eta and Iota. Additionally, the project will expand two other programs: the Cuidate Program, a program to promote sexual and reproductive health, and prevent domestic violence; and the Emprendiendo una Vida Mejor Program, a companion program to the PDMV to provide training in entrepreneurship and financial education to augment income generation among rural households. The project aims to target 72,000 rural households living in extreme poverty, specifically 2,000 families benefiting from the Cuidate Program and 1,000 households benefi ting from the Emprendiendo una Vida Mejor Program (IDB 2021).

In addition to these extensions of the PBVM, the Bono Unico was launched with support from the United Nations Development Programme (UNDP) in 2020 in response to the COVID-19 pandemic. This "single voucher" program consists of a one-time subsidy of 2,000 lempiras (US$82) that is delivered through an electronic voucher that can be used for food, medicine, and/or medical supplies. The social protection program aimed to protect those most vulnerable, both unemployed and not, from the effects of the pandemic and was dispersed to 260,000 individuals. In an effort for transparency and speed, UNDP partnered with one of the largest banks in the country and the mobile telephone companies to distribute electronic notifications to the mobile phones of beneficiaries or provided those without access to a phone with a cell phone SIM card to receive their transfer. The operation, thus far, has been praised as both innovative and easily scalable due to the development and use of a multidimensional selection process and SIM CARD provision to receive transfers (UNDP 2020).

With respect to employment generation, the GoH launched the National Program for Job Creation and Economic Growth, or "Plan 20/20." The plan aims to attract US$13 billion in investments, raise annual exports, and generate 600,000 jobs by 2020. Under it, the National Institute for Professional Skills Formation is reforming processes to provide better technical training for youth and workers to meet the needs of the labor market. However, a critique of these programs is that they do not meet the needs of youth coming from the lowest socioeconomic strata due to lacking capacity to incentivize secondary school enrollment for the extreme poor (World Bank 2019).

## Long Term Impact of Conditional Cash Transfer Programs

Honduras has a long history of CCT programs aimed at encouraging school attendance and health care utilization and addressing malnutrition. In 1990, Honduras launched the Family Allowance Program (Programa de Asignación Familiar, PRAF) to address food insecurity and malnutrition in the poorest communities and the Honduran Social Investment Fund (Fondo Hondureño de Inversión Social), a workfare program (Franzoni 2013). The PRAF program consisted of CCTs given to mothers through public health care facilities for the utilization of health services (PAHO 2007). The PRAF has gone through different stages that included different sources of funding. The first iteration, PRAF I, was funded with national resources and provided CCTs to families living in poverty with children aged 6 to 12 years and included an allowance for the elderly and a training program for women. PRAF II (1998–2006) was funded by the GoH and the IDB. This iteration included a CCT program, and a program aimed at developing teachers. The next round, PRAF III (2007–2009), also funded by the GoH and IDB, provided CCTs and health and education allowances to promote school attendance, nutrition, health care, skilled attendance at delivery, and the expansion of education and health services (Franzoni 2013). This third iteration of the PBVM is funded by the GoH, IDB, World Bank, and the Central American Bank for Economic Integration (ECLAC 2021). In 2017, the

PBVM covered over one-third of the 681,500 extremely poor households identified by the RUP (World Bank 2019).

In 2013, the GoH created the Solidarity and Social Protection Fund for Extreme Poverty Reduction (Fondo de Solidaridad y Protección Social Para La Reducción de la Pobreza Extrema, FSPSRP) to serve as a financing source for social assistance (World Bank 2019). The FSPSRP was established to finance the CCT Program; however, until 2017, the CCT program relied almost solely on external funds from the World Bank and the IDB. In 2018, as the external funding of the PBMV was decreasing, the GoH committed to financing one-third of the annual cost of the program, which had a total budget of approximately $23.3 million USD, through the FSPSRP. The total budget allotted for social assistance programs was $230 million USD for the country that year.

In a study of the long-term effects of the CCT program under PRAF II using census data collected 13 years after the program began, Millán et al. (2020) found that the program led to long-term, significant increases in schooling for both women and men. Men and women who had been enrolled in the program experienced a 50 percent higher probability of completing secondary school and continuing to study at the university level. Educational gains were more limited for indigenous men and women. Even with gains in educational attainment and poverty reduction, coverage of the CCT program remains a challenge.

Interestingly, men who had been enrolled in the CCT program were more likely to emigrate than those who had not been enrolled. This was not true for women or indigenous men. Non-indigenous men in the two oldest cohorts of the study had double the probability of international migration (from 3 to 7 percentage points) (Millán et al. 2020). The findings on international migration raise the question of whether CCTs encourage disproportionally more migration among the better educated. The authors suggest more research is needed on this topic but there is recent work that suggests migrants from Honduras are likely positively selected, meaning those who have higher education levels and a higher earnings distribution relative to individuals who do not migrate (Del Carmen and Sousa 2018). Better access to migration channels between the Northern Triangle and destination countries plays a notable role in this phenomenon; however, it is worth acknowledging that historical undercount of undocumented migrants also biases data towards higher educated/earning groups (Del Carmen and Sousa 2018).

When looking across the LAC region, studies on CCT programs show mixed outcomes on migration. In some cases, the transfers contribute to the decision to migrate, either by financing the costs of migration or because the cash transfer is insufficient to meet household needs. Mexico's social insurance system, which subsidizes medical care and daycare, has been shown to lower the propensity to migrate, and similar outcomes have been found for CCTs in Brazil. However, as in Honduras, findings were mixed for the Oportunidades program in Mexico and the Programa de Asignación Familiar Red de Protección Social in Nicaragua (Hagen-Zanker and Himmelstine 2012).

## Non-Governmental Organizations and Foreign Aid

In many countries, non-governmental organizations (NGOs) provide services to those in poverty to fill health system gaps and meet critical needs. These efforts are usually supported by donor agencies. In 2021, due to ongoing impacts of drought, Hurricanes Eta and Iota, and COVID-19, food insecurity has increased in Honduras. Plan International Honduras, the Adventist Development and Relief Agency, CARE International, and World Vision are among a few NGOs

that redirected funds from their existing projects to increase food assistance and other emergency relief in 2021. The USAID Bureau of Humanitarian Assistance responded to the recent disasters and food insecurity in Honduras with $52,807,320 of dedicated funding going to different implementing partners in 2021. For example, the World Food Programme received $15.5 million to provide emergency food assistance and cash transfers that will benefit 5,186 households (USAID 2021). The United Nations launched its Honduras Humanitarian Response Plan on August 9, 2021, which requested $222 million to reach approximately 1.8 million of the most vulnerable people in Honduras who are experiencing poverty, violence, climate vulnerabilities, lack of access to basic services, impacts from storms, and COVID-19.

In response to a lack of quality health care access in Honduras, the Millennium Challenge Corporation implemented a $15.6 million Threshold Program in Honduras that sought to improve government efficiency and transparency in health care. The project included social audits of health care clinics in rural areas. The results of the audits were delivered to health center managers who created new plans to fix the problems that were found. In response to the audits, clinics became more transparent about what they offer and improved doctor-patient relationships (MCC 2019).

## The Government’s Response to Violence Against Women

To address violence against women, Honduras criminalized femicide in 2013, created a special unit in the Office of the Prosecutor to investigate violent deaths of women and femicide and adopted the National Plan to Combat Violence against Women 2014–2022 (OHCHR 2016). Honduras created the National Institute of Women in 1998 under the Secretariat of Development and Social Inclusion, which oversees nearly 300 municipal offices for women across the country. These offices implement gender equality plans and offer services to women and children. Honduras also adopted the National Policy on Women and the Plan for Gender Equality 2010–2022. However, based on the findings of a visit by the Office of the High Commissioner for Human Rights (OHCHR) in 2018, these laws, interventions, and institutions lack sufficient funding. Although Honduras has strengthened the legal and institutional framework for women’s rights, reforms need to be followed up with budgetary commitments (OHCHR 2018a). Additionally, it is worth highlighting the looming issue of impunity— in January 2020, the GoH shut down the Mission to Support the Fight Against Corruption and Impunity in Honduras (MACCIH) (WOLA 2021). The MACCIH was established in 2016 with the Organization of American States (OAS) and had facilitated the prosecution of 133 people (including senior officials and congresspeople) which led to 14 criminal trials (HRW 2021). While progress has initiated towards the treatment of this issue in Honduras, sustained support of these reforms is vital to appropriately address violence against women in the future.

In 2016, the National Institute of Women, along with 14 other public agencies, launched its Ciudad Mujer initiative, which provides a network of services aimed at preventing violence as well as improving women’s economic autonomy, sexual and reproductive health, and educational attainment. The IDB provided two loans totaling $20 million to fund Ciudad Mujer, along with a grant for $460,000 (IDB 2016). There are six working Ciudad Mujer Centers across the country, in Choluteca, Choloma, Juticalpa, Tegucigalpa, La Ceiba, and San Pedro Sula, as well as a mobile Ciudad Mujer center (Ciudad Mujer n.d.). All services are free, and each center provides services and educational modules in the areas of economic autonomy, violence prevention and care, adolescent pregnancy prevention and care, sexual and reproductive health, and education (Ciudad Mujer n.d.).

# Recommendations

There are a multitude of factors that drive migration and that adversely impact quality of life for women in Honduras. Strengthening SHP as part of a multi-sectoral approach, could be an effective strategy to improve quality of life for women at risk of migration. Developing specific programming solutions for non-SHP-related recommended areas to address to combat migration is beyond the scope of this review, and thus these recommendations focus on areas that the Government of Honduras, development partners, and USAID and LHSS specifically, could explore to strengthen SHP and address some of the barriers to SHP faced by women in Honduras. The proposed recommendations to improve SHP aim to be gender-transformative, intersectional, and improve the overall quality of the lives of women at risk of migration considering specific women migration drivers and needs. An explicit goal of these recommendations would be to expand access to health care services targeting the specific needs by age-group of women at risk of migration considering that 96.6% of migrant women are between 18-65 years old. Since one of the main reasons for Hondurans to migrate is violence, it is imperative to include prevention of gender-based violence that addresses both men and women.

It would be important to assess the quality and accessibility of currently available health services for women including incorporating users' perspectives to determine the most needed services and most urgent gaps in access considering the quality and accessibility of maternal health services, reproductive health services, mental health services, and violence prevention and reduction programs.

The next step for the LHSS project is to engage country stakeholders to deepen understanding of opportunities to strengthen SHP, including developing a roadmap to strengthen SHP. Below is a list of recommended strategies that LHSS may explore to strengthen SHP for women in Honduras.

Women working outside the formal sector are not able to access public benefits including health services. Explore strategies to increase opportunities for women to participate in formal employment and strategies for expanding public benefits to informal workers, as was explored in Mexico's Seguro Popular program (Nikoloski and Mossialos, 2018).

Explore how the information in the Social Registry managed by the National Center for Information on the Social Sector, is utilized by the National Institute of Woman and the six Ciudad Mujer Centers to assess ways to use this information to strengthen the targeting of services and education on violence prevention and care, adolescent pregnancy prevention and care, sexual and reproductive health.

The authors recommend that the key findings of this report be shared with the National Institute of Women and other local partners as a learning opportunity. Explore areas where LHSS can collaborate to strengthen existing programs such as six Ciudad Mujer Centers to increase access to SHP for women at risk of migration.

Engage with the National Institute of Women and other local partners that work with women in Honduras to learn about the programs they offer in the six Ciudad Mujer Centers and learn about users' demographics, accessibility of these services to the women in high risk of migration, and to expand our understanding on how their services increase access to SHP.

Ideally, any plans to strengthen SHP would work with existing programs that target women in Honduras, such as six Ciudad Mujer Centers, to identify gaps in terms of services coverage and accessibility with the aim to propose a join plan to increase access to SHP. LHSS could explore developing a proposal for existing collaborating centers in Honduras to sustain their gains and expand services in other areas where women with high risk of migration live.

Improve financing for SHP and reform regulatory policies and procedures to expand coverage of the PBS for the general population with a gender equality and social inclusion lens to ensure benefits to women are realized. Specifically, we recommend the following:

- Improve future cost estimates for PBS service delivery through better regulation and measurement of temporary and permanent migratory flows, to ensure sufficient coverage is available where needed and sustainable into the future.
- Improve planning for pension schemes to cover those living in extreme poverty and to increase these schemes' long-term sustainability.
- Consider expanding decentralized models using results-based payment.
- Continue to evaluate and explore blended financing and other non-traditional mechanisms of funding for SHP.
- Ensure that monitoring and evaluation is standard practice for evaluating the effectiveness of SHP expansion and improvement efforts. Measure effectiveness more accurately among populations served, and long-term trends in at-risk communities.
- Increase opportunities to participate in national health plans either through formal employment or expansion of services for women.

# Conclusion

This desk review found the main drivers of migration for Honduran women include violence and lack of public safety, economic conditions such as unemployment, food insecurity, family reunification, government instability and corruption, as well as emerging drivers such as climate change and the COVID-19 pandemic. Violence in the forms of femicide, sexual assault, domestic violence, organized crime, and extortion affects women at risk of migration across socioeconomic strata, educational attainment levels, and geographic region. Climate change and the increased frequency of natural disasters highlight geographical and socioeconomic inequities, as vulnerable populations such as women and indigenous communities are disproportionately unable to absorb such shocks. This study found several gendered drivers of migration that may impact health status such as lacking opportunities for formal employment, decreased access to food security, among others covered in earlier sections of this report. Motivations to migrate are complex and multi-faceted, requiring a systems-thinking approach around solutions. Developing specific programming solutions for non-SHP-related recommended areas to address to combat migration is beyond the scope of this review, but it is worth mentioning that the review found the following efforts should be pursued to address interrelated factors leading to migration beyond SHP.

In order to holistically address the health and welfare of women at risk of migration, there are a number of strategies that could be considered, in addition to those that may be pursued under the LHSS project (See Annex D). For example, development partners should continue to support local organizations that have programs in the following areas that particularly impact women at risk of migration: community violence reduction efforts, prevention of gang violence,

workforce development programs, climate change advocacy, and disaster risk management. Pursuing greater gender equity in social sectors such as health services, education management, and vocational training could promote increased access and resources for women in rural communities, as well as the urban poor.

While access to services including health is a challenge for women in Honduras, the nature of many of the drivers of migration themselves translate into demand for social health protection. Financial barriers to access to care – as evidenced by out-of-pocket expenditures on health representing more than 50% of spending – impact equitable access to care[5] in addition to others that may exist. This review concludes that working to strengthen SHP by exploring the strategies recommended above, could significantly both address and mitigate factors that contribute to women's migration from Honduras.

[5] World Bank, 2019. (*see https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=HN accessed March 24, 2022)*

# Annex A: Regional Stakeholder Interviews

| Organization | Key Informant Name and Title |
|---|---|
| International Organization for Migration (IOM) | Aleksandar Arnikov, Regional Migration and Health Specialist, Latin America and Caribbean |
| United Nations High Commissioner for Refugees (UNHCR) | Johanna Reina, Tegucigalpa Associate Protection Officer<br><br>Vanessa Vaca, Associate Protection Officer, Global Strategy and Border Intervention and Ops |
| United Nation s Children’s Fund (UNICEF) | Jose Ramirez Arita, Early Childhood Officer, Health Program<br><br>Karina Cantizano, Health Specialist |

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# Annex C: Stakeholder Interview Question Script

## Script: Key Informant Interviews for LHSS Honduras Desk Review

**Agenda:**

- **Introductions**
- **Overview of LHSS LAC Bureau Activity**
    - The Local Health System Sustainability Project's goal is to help low- and middle-income countries achieve strong, sustainable health systems as a means to support access to universal health coverage.
    - The (LHSS) LAC Bureau Activity aims to strengthen the capacity of two focus countries in the LAC region (Honduras and the Dominican Republic) to adapt, finance, and implement appropriate social health protection (SHP) platforms that provide adequate and equitable coverage for women migrants and women at risk of migration.
    - One of our interventions is to strengthen the capacity of Honduras to adapt, implement, and sustainably finance SHP for women at risk of migration. As a first step we are conducting a desk review to identify the particular health needs of women at risk of migration, and gaps in SHP coverage for those women. We are also reaching out to international/regional organizations to better understand the local context.

**SPANISH**

- El objetivo del Proyecto de Sostenibilidad del Sistema de Salud Local es ayudar a los países de ingresos bajos y medianos a lograr sistemas de salud sólidos y sostenibles como un medio para apoyar el acceso a la cobertura universal de salud.
- La actividad de la Oficina de LAC (LHSS) tiene como objetivo fortalecer la capacidad de dos países de enfoque en la región de LAC (Honduras y República Dominicana) para adaptar, financiar e implementar plataformas adecuadas de protección social en salud (PSH) que brindar una cobertura adecuada y equitativa a las mujeres migrantes y en riesgo de migrar.
- Una de nuestras intervenciones es fortalecer la capacidad de Honduras para adaptar, implementar y financiar de manera sostenible las PCS para mujeres en riesgo de migración. Como primer paso, estamos llevando a cabo una revisión documental para identificar las necesidades de salud particulares de las mujeres en riesgo de migración y las brechas en la cobertura de PSH para esas mujeres. También nos estamos acercando a organizaciones internacionales / regionales para comprender mejor el contexto local.
- Preguntas

- **Questions**
    1. Can you please share the focus of your work with women/health/migration issues in Honduras?

2. Are there particular groups of women that you focus on in your work?
3. What are the characteristics of women at risk of migration in Honduras, e.g., geographic location, socio-economic profile?
4. What are the main drivers of migration for these women?
5. What do you see as the main challenges for women in respect to access to health and access to social protection?
6. Who are the main stakeholders working on these issues and what are their roles?
7. Do you know of any cross-border, bilateral or multi-country approaches to expand SHP for women who migrate?
8. What is the role of regional and sub-regional governance bodies and platforms in addressing migrant SHP needs in Honduras?
9. What are the most relevant CSO or NGO efforts focused on migrant women? Who are your main partners in this work?
10. How is the private sector involved in supporting SHP or health access for women?
11. What are the main multi-agency networks, coordination bodies or knowledge sharing networks that work on migration issues in Honduras?
12. What are the key gender-based constraints and social inclusion issues related to strengthening health system capacity to respond to current and future shocks, including the COVID-19 pandemic?

**SPANISH**

1. ¿Puede compartir el enfoque de su trabajo con temas de mujeres / salud / migración en Honduras?
2. ¿Hay grupos particulares de mujeres en los que se centra en su trabajo?
3. ¿Cuáles son las características de las mujeres en riesgo de migración en Honduras, p. Ej. Ubicación geográfica, perfil socioeconómico?
4. ¿Cuáles son los principales impulsores de la migración para estas mujeres?
5. ¿Cuáles considera que son los principales desafíos para las mujeres con respecto al acceso a la salud y el acceso a la protección social?
6. ¿Quiénes son los principales interesados que trabajan en estos temas y cuáles son sus funciones?
7. ¿Conoce algún enfoque transfronterizo, bilateral o multinacional para expandir la PSH para las mujeres que migran?
8. ¿Cuál es el papel de los órganos y plataformas de gobernanza regionales y subregionales para abordar las necesidades de PSH de los migrantes en Honduras?
9. ¿Cuáles son los esfuerzos de las OSC u ONG más relevantes centrados en las mujeres migrantes?

10. ¿Quiénes son sus principales socios en este trabajo?
11. ¿Cómo participa el sector privado en el apoyo a los PSH o al acceso a la salud de las mujeres?
12. ¿Cuáles son las principales redes multiinstitucionales, órganos de coordinación o redes de intercambio de conocimientos que trabajan en temas migratorios en Honduras?
13. ¿Cuáles son las principales limitaciones de género y los problemas de inclusión social relacionados con el fortalecimiento de la capacidad del sistema de salud para responder a las crisis actuales y futuras, incluida la pandemia de COVID-19?

**Potential questions from Key Informant Interviewees:**

- **What is social health protection?** SHP encompasses a broad range of contributory and noncontributory schemes designed to help vulnerable groups access appropriate medical care without incurring costs beyond their means.
  - Some examples of SHP platforms are social security, community health insurance, conditional transfer programs, and systems that reimburse private providers with public funds.
- To learn more about the project: visit the website: https://lhssproject.org/about/mission

# Annex D: Summary of recommendations to address non-health factors impacting women at risk of migration

The authors of this report found a number of strategies that are recommended in order to holistically address the health and welfare of women at risk of migration. While outside of the scope of social health protection, the authors consider it important to include these findings here. According to the findings of this literature review, the following strategies are worthy of exploration and/or building on current efforts where they exist.

1. Policy and community level efforts could be explored to prevent violence through changing social norms and tackling harmful masculinities, strengthening legal and policy level protections for women and youth, and improving systemic responses to violence against women.
2. Continue to evaluate the expansion of current SHP programs, both under traditional mechanisms as well as innovative financing approaches (such as development impact bond, remittance-funded health insurance products, among others mentioned in Y1 LAC Landscape Analysis[6]) to cover those living in extreme poverty and those not receiving social pensions. Incorporate a GESI lens while addressing general population level improvements.
3. Continue to work with and expand programs that create employment opportunities, especially for at-risk youth, rural youth, and youth living in extreme poverty.
4. Strengthen local organizations that have programs in the following areas that particularly impact women at risk of migration: community violence reduction efforts, prevention of gang violence, workforce development programs, climate change advocacy, and disaster risk management.
5. Establish long-term commitment with traditional and non-traditional stakeholders and partners to change in-country conditions and target social determinants (i.e., education, social support, exposure to violence, housing, etc.) of those most at risk of migrating.
6. Expand programs that provide women financial support or specific skills training and strengthen local opportunities to use the skills obtained.
7. Increase educational opportunities for young women, focusing especially on matriculation into secondary education.
8. Expand partnerships to include governmental, private sector, and non-traditional partners, not solely NGO or foreign aid organizations, to cultivate a sense of shared responsibility and accountability, while still ensuring there is a community-based focus

[6] Insanally, Sarah, Marty Makinen, Julia Watson, Yady Ibarra, Lisa Tarantino. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. June 2021. Social Health Protection for Women in High Migration Areas Landscape Analysis Report. Rockville, MD: Abt Associates.

and local decision making. Increase funding opportunities for small, local partners to keep efforts local.

9. New or expanded assistance programs should include community-based aspects and ensure that there is a focus on food security, violence prevention, and communities and populations most at risk of migration.
10. Reunification with family is an important migration pull factor for many Honduran women, children, and adolescents. As the numbers of unaccompanied minors, especially girls, continues to increase, the need for educational opportunities and financial support for children and youth with emigrated family members will increase. CCT approaches may help support SHP for these populations.
11. Food insecurity could be addressed through both programmatic efforts to assist families sustained through agricultural work, but also through climate change prevention efforts to promote land and resource protection.
12. Government entities and aid organizations should work with communities to improve infrastructure and recovery resources, as well as develop risk mitigation and emergency response plans to protect those most vulnerable, specifically women.