Rapid Country Assessment Report of Social Health Protection for Women in High Migration Contexts in Honduras

Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

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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 strengthen local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Acronyms

BID	Banco Interamericano de Desarrollo/ Inter-American Development Bank
CAMI	Centro de Atención al Migrante Irregular / Center for the Care of Irregular Migrants
CAMR	Centro de Atención al Migrante Retornado / Center for the Care of Returned Migrants
CENISS	Centro Nacional de Información del Sector Social/ National Social Sector Information Center
CIS	Centro Integral en Salud / Integrated Health Center
GDP	Gross Domestic Product
INM	Instituto Nacional de Migración / National Migration Institute
LHSS	Local Health System Sustainability Project
MIISM	Mesa Interinstitucional Interagencial de Salud y Migración / Interinstitutional and Interagency Board of Health and Migration
NGO	Non-Governmental Organization
OIM	Organización Internacional para las Migraciones / International Organization for Migration
OSI	Oficina Sanitaria Internacional / International Health Offices
SESAL	Secretaria de Salud / Ministry of Health
SHP	Social Health Protection
SRECI	Secretaría de Relaciones Exteriores y Cooperación Internacional / Ministry of Foreign Affairs and International Cooperation
UAPS	Unidad de Atención Primaria en Salud / Primary Health Attention Unit
UMAR	Unidad Municipal de Atención al Retornado **/** Municipal Unit for Attention to Returned Migrants
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development

Executive Summary

Introduction

In August 2022, the USAID Local Health System Sustainability Project (LHSS) conducted a rapid assessment of social health protection (SHP[1]) for women in high-migration contexts in Honduras. LHSS's objective in Honduras is to strengthen SHP for women and children in high-migration contexts by supporting the Government of Honduras and other key stakeholders in identifying approaches for closing gaps in access and coverage and sharing lessons learned in the region. The purpose of this assessment was to deepen knowledge of the current state of the migration and health response in Honduras and identify areas where local stakeholders could seek to address the observed challenges and strengthen SHP for these priority groups, and opportunities where LHSS could support those efforts.

Methodology

LHSS partner Save the Children Honduras conducted the assessment including a literature review, stakeholder mapping, guided interviews, focus group sessions, and field visits, including visits to five migrant response centers. The Interinstitutional and Interagency Health and Migration Board (Mesa Interinstitucional Interagencial de Salud y Migración, MIISM), a Honduran platform that coordinates the national migration and health response, provided the space to interact with and interview representatives of more than twenty-four governmental, international development, and civil society organizations (see Annex A for a full list of members and see Annex B for a full list of interviewees). After concluding the assessment research, in September 2022, LHSS facilitated a two-part *"Intersectoral workshop on strengthening social health protection for women in high migration contexts in Honduras*" with representatives of the Government of Honduras, international migration and health organizations, USAID, and other organizations. The purpose of the workshop was: (1) to share and validate the information from this report; (2) to discuss the needed changes and adaptations to improve SHP for women at risk of migration; and (3) to build consensus on feasible adaptations to improve SHP for women at risk of migration in the country that could provide content for a roadmap to strengthen SHP for these groups. As a result of the workshop, the participants agreed on the key areas of intervention that would improve the quality and access of primary care health services for women and children in high migration contexts. These ideas provided the content for a draft four-year roadmap to strengthening SHP platforms.

The Target Populations

A key finding of the assessment is that the Honduran migration and health response includes three target populations in "high migration contexts":

- *Individuals at risk of migrating:* Many Hondurans do not migrate voluntarily but are involuntarily displaced due to various structural and contextual factors beyond their control. Typical age ranges for those at risk of migration are 6-12 and 20-24 years old. These populations often have limited access to public health services due to high costs, geographical distance and limited transportation, facility overcrowding, and lack of trained health staff. Motivations and

[1] "Social health protection" is understood as the guarantee that society grants, through the public authorities, that an individual or a group of individuals can satisfy their health needs and demands by obtaining adequate access to the services of the system or any of the health subsystems existing in the country, without the ability to pay being a restrictive factor (OPS 2022). Social health protection therefore requires both that good quality health services are available and that barriers to access, including financial barriers, are minimized.

push factors to migrate include family reunification, violence, food insecurity, economic and political instability, corruption, climate change, and COVID-19. The USAID Mission in Honduras' Migration Geo-Targeting Model has identified five clusters of municipalities where the largest populations at risk of migration reside - Sula Valley, North Coast, Central Corridor, Western Honduras, and Eastern Hub (USAID n.d.).

- *Migrants in transit:* In 2022, nearly 189,000 migrants (INM 2022a) passed through Honduras, mostly from Cuba, Venezuela, Ecuador, and Haiti. This population faces challenges accessing health care and social services due to lack of formal records or health documents. They also face high levels of stigma and limited economic means that may prevent them from seeking care. When they do seek care, near-constant displacement impairs needed follow-up. The National Migration Institute (Instituto Nacional de Migración, INM) operates three Centers for the Care of Irregular Migrants (*Centros de Atención al Migrante Irregular*, CAMIs) to provide primary health care and temporary accommodation services to migrants in transit with funding from international donors.

- *Returned migrants:* A total of 94,339 Honduran migrants returned to the country in 2022 (17 percent women; 57 percent men), a substantial increase of 28 percent from 2021 levels (INE 2022). Just over one quarter of returned migrants were children (of overall returnees, 16 percent were young boys; 10 percent young girls). The departments to which the most female migrants returned in 2022 are Cortés, Francisco Morazán, Yoro, Olancho, and Comayagua. Stakeholders consulted for the assessment assert that most returned migrants seem to return to their place of origin in the country. Theoretically, given their demographics, these returned migrants eventually reenter the group at risk of migration.

Social Health Protection for the Target Populations

Financial protection for health: Public sector resources for health in Honduras are limited. Government health spending represented only 3 percent of gross domestic product (GDP) in 2019 (approximately US$752.7 million). The COVID-19 pandemic further strained fiscal space for health. Most recent reports indicate that out-of-pocket payments made up 53 percent of total current health expenditures (WHO 2022). While there is little data on the financing and use of health services specifically for women at risk of migration or migrants, women at risk of migration and migrants, tending to be in lower income groups, likely face financial barriers to access health services, and have a high-risk of catastrophic health expenditures. The consensus among key informants is that facilities for the general population face significant resource constraints that limit the availability of key services in the public sector. As one consequence, many women in areas of high out-migration, such as the municipalities of Tegucigalpa and San Pedro Sula, seek care in the private sector, where they incur out-of-pocket costs, including medical fees. State agencies do not fully finance primary health care and emergency services for migrants, and funds from development partners for services have a fixed period of performance, inhibiting the long-term development and stability of these services.

Health service provision: Health care needs for returned and in-transit migrant women include treating and monitoring of pre-existing conditions such as non-communicable diseases, and medical conditions acquired along the migration route such as infectious diseases, mental health issues, and sexual and reproductive health needs. Several factors hamper the delivery of these services to the women who need them, including constant displacement that prevents follow-up of patients, absence of medical records or health documents, fear of extortion, pressure from traffickers to avoid seeking care and/or report sexual violence, fears about confidentiality, stigma, and lack of economic means.

A combination of international and Honduran government agencies coordinates to provide primary care and emergency services for returned and in transit migrants through a network of migrant first response care centers that operate outside of the core health system. These centers are central to the migrant health response in Honduras but are not connected to primary care services in the local system and do not disaggregate data on the services they provide by sex. There are three Centers for the Care of Returned Migrants (*Centros de Atención al Migrante Retornado*, CAMRs) in San Pedro Sula, Omoa, and the Ramon Villeda Morales Airport in Lima that offer medical and psychological services to help returned migrants reintegrate into local society. Fifteen Municipal Units for Care of Returned Migrants (*Unidades Municipales de Atención al Retornado,* UMARs) previously provided additional support to returned migrants; however, all but one (Central District) closed in 2021. CAMR and UMAR services are temporary; once returned migrants have reintegrated into local society, they access health and social services through regular public facilities. The Ministry of Health's (Secretaria de Salud, SESAL)'*s Guide to Health Care for the Migrant Population* (SESAL 2020a) applies to all providers of public and private health services at the national level. Migrant first response care centers are challenged to meet the needs of their target populations with human resource shortages and insufficient infrastructure, supplies, and equipment. In addition to financial barriers to access, MIISM and other interviewed stakeholders attest that returned migrants, in-transit migrants, and those at risk of migrating may not be aware of the services that are available to them, further limiting their access to care.

Health information systems: Data on access to and use of health services by the migrant population are weak and dispersed. At the time of this report, SESAL did not have official statistics that provide a clear and comprehensive picture of health care needs and gaps specifically for women in a high-migration context. Migrant first response centers do not follow the standard procedures to report to the SESAL's Health Surveillance Unit. Instead, data from development partners and government offices are compiled in processes that are not compatible with the established national information system. This lack of interoperability means that the information systems are unable to exchange information. Thus, SESAL cannot use the information collected at the migrant first response centers to understand health service needs of in-transit migrants and returned migrants, or to identify gaps in the provision of care for those groups.

Governance, donor coordination, and advocacy: According to national legislation and policy, migrants and non-migrants alike can access the public health system – with maternal and child health services specifically protected. The MIISM was created in 2018 under the stewardship of SESAL, with the objective of strengthening SESAL's support of migrant health through the management, promotion, coordination, and strengthening of public and private mechanisms to guarantee the rights, needs, and dignity of migrants, specifically as they relate to health. Given its membership and status, the MIISM could be a strong platform to further the cause of strengthening SHP for women in high-migration contexts. After the recent change in government, the MIISM remains active and a valid representative body of key stakeholders in health and migration. The current Minister of Health is a strong champion for the expansion of SHP for those impacted by migration.

Recommendations

Five of the following recommendations focus on cross-cutting strategic areas to strengthen the migration and health response in Honduras and to further the goal of strengthening SHP for women and children in all three target populations. An additional sixth recommendation for health information systems supports migrants in transit and returned migrants.

Co-develop a roadmap for phased implementation of adaptations to improve SHP for women in high migration contexts: Co-develop a detailed roadmap to systematize the

response and align activities from other actors to create SHP mechanisms that can improve access to high-quality services and financial protection for women and children in high-migration contexts.

Ensure the availability of sustainable and adequate resources for improving SHP for women and children in high-migration contexts: Support SESAL in identifying funding needs, including identifying gaps and sustainable sources of funding for priority services for women children in high-migration contexts. These data can be used to strengthen SHP for these priority groups, such as informing policy, allocating resources, developing partner priorities, and doing advocacy. The assessment will seek to identify financing sources, funding gaps, composition and distribution of expenditures, and total investment in migrant health in Honduras. The resulting recommendations will be discussed with the Government of Honduras and others to help to inform any future efforts to close identified gaps by either mobilizing additional resources or improving efficiencies for financing SHP for women and children in high-migration contexts.

Standardize data collection and integrate health and migration information systems to support decision-making: Strengthen health information systems to increase the transfer and sharing of information between the migrant first response centers and the core SESAL system to enhance the understanding of health needs and services for women and child migrants. LHSS recommends conducting an assessment with MIISM, and other relevant stakeholders of existing health information systems, policies, and platforms to identify opportunities to strengthen the health information system with a view to improve understanding and address health services gaps for populations in high migration context populations. The assessment will propose recommendations to strengthen migrant health information collection, use of data, and reporting. Results of the assessment will increase understanding of interoperability[2] gaps and barriers of migrant care registries and include recommendations to improve the interoperability of the various subsystems.

Improve coordination, operation, and function of first level of care service delivery for women and children in high-migration contexts: Support local governments, the INM, and the Ministry of Foreign Affairs and International Cooperation (Secretaría de Relaciones Exteriores y Cooperación Internacional, SRECI) General Directorate for the Protection of Honduran Migrants in improving the response capacity, operations, communications, coordination, and data management of the migrant first response care centers that provide services in regions with the highest flow of women and children in high-migration contexts. This includes CAMRs, CAMIs, UMARs, International Health Offices (Oficinas Sanitaria Internacional, OSIs), and temporary centers that emerge to respond to humanitarian emergencies, with a specific focus on women and children. This support includes developing standard operating procedures for migrant health needs, including bi-directional referral processes to other levels of health care in the public health system, documentation of health information.

Raise MIISM's profile as a coordination and advocacy mechanism for improved SHP for populations in high-migration contexts: Strengthen the technical capacity and visibility of the MIISM's coordination role in the health and migration response in Honduras to raise public awareness, maintain the issue of health and migration in the public debate, coordinate and coalesce donor support, and strengthen advocacy.

[2] The term "interoperability" describes the ability of two or more information systems or components to exchange information based on standards, and to use the information that is exchanged.

Strengthen and standardize risk communication and health promotion communication campaigns in high-migration contexts: The campaign will address the risks that women and children face if they decide to migrate and inform them of their rights to receive support along their migration journey. It will also include information on the type of centers, services provided, and requirements to access these services. The campaign will be shared with SESAL, SRECI, and INM to identify funding sources for future implementation at the local and regional levels.

Next Steps

As a next step to conducting this assessment, LHSS facilitated a two-part workshop with local stakeholders to validate the findings and agree on recommendations for collaborative support to strengthen SHP for these target populations. In September 2022, workshop participants validated the assessment findings. With their input, LHSS refined and augmented the findings and generated agreement on recommendations that would be included in a four-year roadmap to strengthen SHP for women and children in high migration contexts in Honduras.

Using the findings and recommendations of this country assessment and workshop inputs, LHSS drafted the roadmap. In early 2023, the draft roadmap will be finalized with the MIISM members and the SESAL, including agreeing on roles and responsibilities of actors/contributors, as a next step toward SHP strengthening for women and children in high-migration contexts. MIISM will lead the monitoring of Roadmap implementation within the framework of the platform's Strategic Plan. Through the MIISM platform, members will be asked to commit to roles and responsibilities to achieve the roadmap objectives. LHSS will support a subset of interventions to support roadmap implementation to foster improved access and coverage of comprehensive, high-quality primary health services for women and children living in high migration contexts in Honduras.

Introduction

The USAID Local Health System Sustainability Project (LHSS) supports countries in Latin America and the Caribbean, and globally, in transitioning to sustainable, self-funded health systems to promote universal health coverage. In the Latin America and Caribbean region, LHSS supports the strengthening of social health protection (SHP) for populations in high-migration contexts.[3]

This report documents a rapid assessment of the Honduran context to expand SHP for women and children in high-migration contexts, including women and children at risk of migration, returned migrants from the United States, and migrants in-transit through Honduran territories on their migration journey (these exceed returned migrants in absolute numbers). LHSS defines "women at risk of migration" as those women and girls who face migratory pressures and protection issues, including a variety of situations where safety and well-being are compromised (such as threats to physical safety and circumstances of extreme hardship and/or lack/exclusion from support and protection systems). Migrants face barriers to health, such as precarious legal status; discrimination; social, cultural, linguistic, administrative, and financial barriers; lack of information on rights to health care; low health literacy; and fear of detention and deportation. The assessment maps out the complexity of the migration and health response in Honduras and describes how returned migrants, in-transit migrants, and women and children at risk of migrating access health care through services funded and provided by international organizations and government, state, and multilateral agencies.

The findings and recommendations of the assessment are intended to provide an expanded understanding of the local health system landscape for migrants and those at risk of migration in Honduras—given the dynamic nature of migrant health in Central America, especially since the outbreak of COVID-19. As migration and health policy continue to evolve in Honduras, this assessment seeks to inform the efforts of stakeholders from the Government of Honduras, SESAL, and the Interinstitutional Interagency Board on Health and Migration (*Mesa Interinstitucional e Interagencial de Salud y Migración*, MIISM) in strengthening SHP for women and children in high-migration contexts in Honduras. Additionally, given the paucity of information on the subject within the literature, this report aims to contribute to global and regional knowledge of the migrant health situation in Honduras.

Methodology

The assessment methodology comprised a literature review, stakeholder mapping, guided interviews, group sessions, and field visits as described below. This assessment builds upon the information from the LHSS *Expanding Social Health Protection for Women at Risk of Migration in Honduras report: Regional Stakeholder Engagement Report Desk Review*, (Trichilo, Kulesza, and Gonzalez Ruiz 2022).

[3] "Social health protection" is understood as the guarantee that society grants, through the public authorities, that an individual or a group of individuals can satisfy their health needs and demands by obtaining adequate access to the services of the system or any of the health subsystems existing in the country, without the ability to pay being a restrictive factor (OPS 2022). Social health protection therefore requires both that good quality health services are available and that barriers to access, including financial barriers, are minimized.

Literature Review: To analyze opportunities to expand SHP of women at risk of migration, LHSS, through Save the Children Honduras, conducted an exploration of local documents and information (e.g., from government sources). The assessment team reviewed access to health services, coordination and governance structures, information systems, and the financing of services for migrants and those at risk of migration. By drawing on locally available documents and those shared by stakeholders through the data collection process, the assessment team was able to gather additional information and context to complement the *Regional Stakeholder Engagement Report Desk Review* (Trichilo, Kulesza, and Gonzalez Ruiz 2022).

Stakeholder Mapping: Save the Children Honduras completed a mapping of key actors (see Annex B: Institutions Visited Key Actors Interviewed) and identified national actors and other key stakeholders to be interviewed. LHSS participated in recurrent meetings with the MIISM Board of Directors and ordinary sessions and general assemblies with the MIISM members (see Annex C: Meetings with the Interinstitutional Interagency Board on Health and Migration in Honduras).

Key Informant Interviews: The assessment team developed an interview protocol (see Table 1 and Annex D: Interview Guide for Key Informants) and conducted guided interviews with select Honduras-based stakeholders. The questions facilitated exploration of health care and services currently offered for the migrant population, their health needs, and status of SHP.

Assessment limitations: In addition to data limitations, the recent (January 2022) transition to a new government caused changes in the leadership of government agencies, resulting in delays in assessment implementation related to interviews of key government actors. The team also had time constraints given the mandate of conducting a rapid assessment.

Table 1: List of Government Entities Represented in Key Informant Interviews

Organization	Suborganization
CAMR	CAMR-Belén
	CAMR-Lima/Villeda Morales
	CAMR-Omoa
CAMI	CAMI-Toncontín (Comayagua)
	CAMI-Los Almendros (Tegucigalpa)
UMAR	UMAR Distrito Central/ Tegucigalpa
Government of Honduras	SESAL
	Secretaria de Relaciones Exteriores y Cooperación Internacional (SRECI)
	Instituto Nacional de Migración (INM)
	Mesa Interinstitucional e Interagencial de Salud y Migración (MIISM)

Note: CAMR=Centro de Atención al Migrante Retornado / Center for the Care of Returned Migrants; CAMI=Centro de Atención al Migrante Irregular / Center for the Care of Irregular Migrants; Unidad Municipal de Atención al Retornado / Municipal Unit for Attention to Returned Migrants

Collaboration with the MIISM was fundamental to conducting this assessment. The MIISM Migration Response Plan and Management Report of the Board of Directors (*Plan de Respuesta Migraciones and Informe Gestión de Junta Directiva),* outlines the MIISM response to health and migration in Honduras in alignment with SESAL's strategic plan (MIISM 2022; MIISM and Vision Mundial, 2021). The assessment team participated in ordinary sessions, general assemblies, and working group sessions under the programmatic axes of the MIISM (see Annex C). During these meetings, the assessment team collected data and information on the activities of each of the

twenty-three diverse member organizations that make up the MIISM (see Annex A). The general working sessions informed the list of key informants to be interviewed.

Save the Children Honduras visited three CAMIs and two CAMRs, as well as key organizations such as the Ministry of Foreign Affairs and International Cooperation (*Secretaría de Relaciones Exteriores y Cooperación Internacional*, SRECI) and the INM. The assessment team also visited the El Paraíso Departmental Health Region in Danlí (located in the east of the country and bordering Nicaragua), which is currently the most critical entry point for irregular migration from neighboring countries (OIM 2022). This visit validated concepts related to SESAL's health service delivery system, verifying strengths, weaknesses, and opportunities for improvement.

The Honduran Migration Context

The Honduran National Institute of Statistics (Instituto Nacional de Estadística) projects a total population of approximately 9.6 million Hondurans in 2022. It is a relatively young country, with adults (ages 25 to 54 years) comprising 38 percent of the population, and older adults (over 55) constituting 11 percent. Thirty percent of the population are children (age 14 or younger), and 21 percent are young adults (between ages 15 and 24). Of the total population, 47 percent are men and 53 percent are women. There tends to be more migrants who are men, regardless of whether they are in transit or returning, with 63 percent men to date in 2022 (INE 2022).

There are three groups of individuals in high-migration settings, each with distinct characteristics:

1. Individuals at risk of migration
2. Migrants in transit (Honduran and irregular) [4]
3. Returned migrants

Women at Risk of Migrating

LHSS defines "women at risk of migration" as women and girls who face migratory pressures and protection issues, including a variety of situations where safety and well-being are compromised (such as threats to physical safety and circumstances of extreme hardship and/or lack/exclusion from support and protection systems). This definition captures the factors that may lead a woman to choose to migrate or see that as her best or only option. However, it does not align easily with existing, available quantitative data for a comprehensive picture of this group. Strengthening of SHP platforms for women living in high-migration contexts could contribute to preventing migration among this population by providing them access to affordable and quality health care services. However, the identification of this group is complex, since there are numerous variables to consider, including the context of their communities, age, marital status, and educational attainment.

Demographics

According to an LHSS study, women represent 52 percent of people prone to regular migration and 44 percent of those prone to irregular migration in Honduras. One of several methods to understand characteristics of those women at risk of migration is to identify the characteristics of those who have recently migrated. The USAID Mission in Honduras' Migration Geo-Targeting Model has identified five clusters of municipalities where the largest populations at risk of

[4] Citizens of Honduras who have left their place of origin and have joined the migration journey are considered migrants in transit even if they have not yet left the country.

migration reside - Cortés, Francisco Morazán, Yoro, Olancho, and Comayagua (USAID n.d.). Female migrants apprehended at the land border of the Southwestern United States are more likely to come from urban, rather than rural, backgrounds, and most tend to be girls between 6 and 12 years, followed by women between 20 and 24 years (Trichilo, Kulesza, and Gonzalez Ruiz 2022).

Between 2016 and 2017, there was a 72 percent increase in the migration of unaccompanied girls (considered under INM data to be 20 years of age or younger), highlighting the need to consider gender and age when examining drivers of migration among Hondurans.

Based on independently collected data by international organizations such as the IOM and the United Nations High Commissioner for Refugees (UNHCR), and research by the Inter-American Development Bank (*Banco Interamericano de Desarrollo*, BID), there is consensus on the three main contributors to migration in Honduras, in order of prevalence: (1) the search for better economic conditions (75 percent), (2) escape from violence (43 percent), and (3) family reunification (31 percent) (BID 2018). The search for better economic conditions is precipitated by both unemployment and underemployment.[5] In a 2017 Center for Latin American Monetary Studies study, 50 percent of Honduran migrants interviewed reported having a job when they decided to leave (CEMLA 2017). In 2022, the Honduran Council of Private Enterprise reported an unemployment level of 8.6 percent (approximately 3.3 million Hondurans) among adults between the ages of 30 and 65 (COHEP 2022). Pervasive unemployment in the working-age population is a driver of migration for better economic opportunity.

Women face unique and compounded challenges under each reported push factor. As institutions directly impacting the lives of women at risk of migration are often guided by local gender roles, discriminatory social practices and attitudes emerge and touch all aspects of daily life— from education levels, economic opportunities, access to health services, and community dynamics in locations of origin (IMUM 2016). Gender-driven wage gaps contribute to inequality in the labor market (Méndez et. al 2020). Gender-based violence and sexual assault are common, yet underreported, concerns for women in contexts of high migration. In Honduras, the Washington Office for Latin America's Central America Monitor reported at least 2,146 reports of rape and other sexual violence in 2020 (WOLA 2022). According to the National Autonomous University of Honduras' Violence Observatory, a woman is killed every 23 hours on average. Intimate partner violence is also a notable issue and the Violence Observatory note that 60 percent of perpetrators were domestic partners (Human Rights Watch 2020). Quantitative national data is weak, but there is wide recognition among key stakeholders interviewed and elsewhere that violence and gender-based violence is a major driver of migration and a risk along the migratory route (UNHCR, 2021).

Younger people with a lower level of education and lower incomes are more prone to irregular migration, compared to those regularly migrating. Additionally, children and adolescents will often choose to migrate rather than remain in Honduras so that they may reunite with parents and other family members who have departed for Mexico and the United States (Musalo et. al 2015). While extended family and or others within the community or origin will offer informal care for youth left behind, they are not legally responsible for their wellbeing— leaving many minors vulnerable to precarious situations such as caregiver abuse/neglect or even gang violence (Musalo et. al 2015).

[5] *Underemployment* is an inadequate job in which the company does not use the skills of the worker and is characterized by working fewer hours and receiving remuneration below the minimum wage. *Unemployment* is the situation of an individual who lacks employment, that is, a job and therefore a salary.

Migrants in Transit

In 2022, there has been a significant uptick in the number of irregular migrants, contributing to the ongoing humanitarian crisis. Different offices of the INM have reported nearly 315,000 migrants entering Honduras from 2014 through2022, most through the southeastern border (INM 2022). In the first half of 2022 alone, 66,170 immigrants have entered the country, representing a third of the total reported over the past 8 years (Figure 2). This implies a threefold increase in the first 6 months of the year, compared to all of 2019. This migration is facilitated by the fragile border control of Honduras, which allows entry through blind spots that favor land transit.

Demographics

In 2022, among irregular migrants transiting through Honduras, 64 percent were men and 36 percent were women. Disaggregating further by age, the irregular migrants in transit were 55 percent men, 29 percent women, 9 percent boys, and 7 percent girls (INM 2022). As shown in Table 2, through July 2022, some 47 percent of irregular migrants in transit were adults ages 31-60, 36 percent were adults ages 21-30, 9 percent were adolescents ages 11-20, and 7 percent were children aged 10 or younger.

Table 2: Irregular Migrant Population Age Range (through January-December 2022)

Group	Infancy	Adolescence	Young Adult	Adult	Old Age	Total
Age range	0-10 years	11-20 years	21-30 years	31-60 years	60 years or older	
Total number	17,524	19,945	67,035	82,259	2,095	188,858
Percentage (%)	9.3	10.6	35.5	43.6	1.0	100

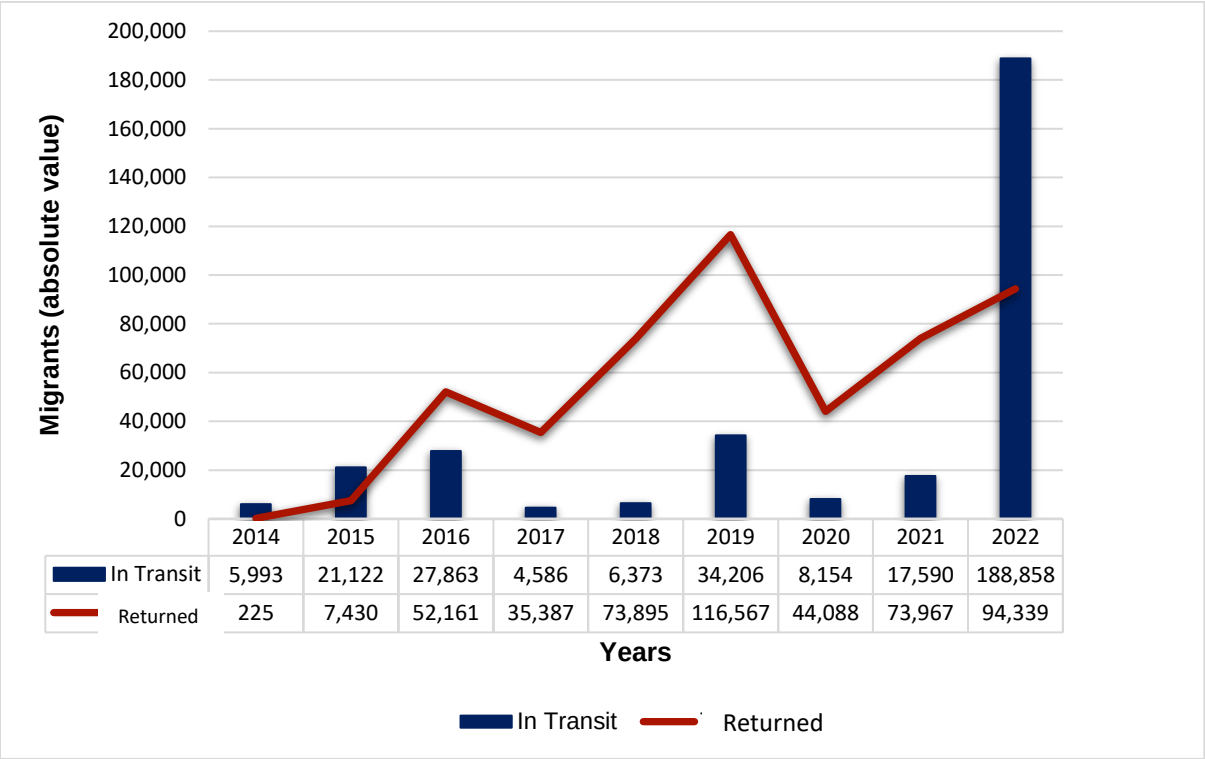
Source: INM, 2022

There was a marked increase of migrants in transit in 2022, following the 2020-2021 trend. Figure 2 combines data on the population of returned migrants and irregular migrants in transit through the country. The number of migrants in transit in 2022 was 188,858, substantially higher than the number of returned migrants (94,339), with migrants in transit doubling the number of returned migrants. The Government of Honduras recently started exempting migrants in transit from paying a mandatory $246 administrative immigrant fee to enter the country, making the trip north slightly more affordable (INM 2022b). This measure could be a contributing factor that explains the increased number of migrants in transit.

The assessment found that migrants in transit seem to have greater health needs than returned migrants, due to the consequences of travelling long distances in their migratory journeys and unhygienic conditions while in transit. United Nations agencies in Honduras/Central America report this situation as a humanitarian crisis, for which Honduras must bear some of the costs of the response, including health care and social services (OIM 2022).

The assessment team didn't find information on the causes of the increase in 2022 over 2021, although it is expected that there will be a resulting increase on demand for health and other services. Most of these migrants come from Venezuela, followed by Cuba, Ecuador, and Haiti, in roughly equal proportions. The land border of eastern Honduras is the primary site of influx.

Figure 1: Migrants in Transit and Returned Migrants by Year

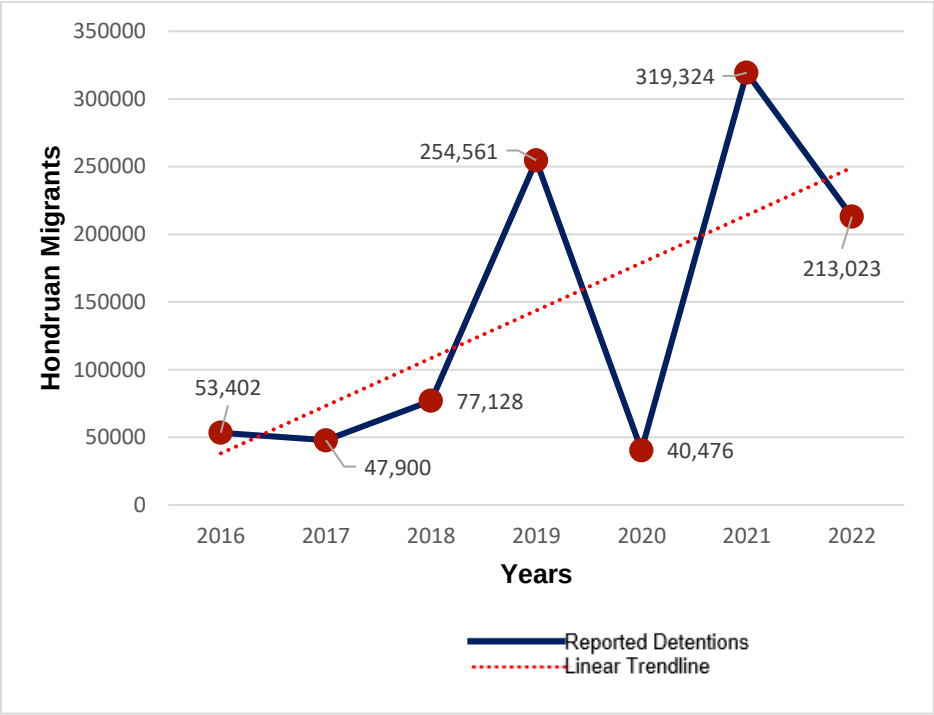


	2014	2015	2016	2017	2018	2019	2020	2021	2022
In Transit	5,993	21,122	27,863	4,586	6,373	34,206	8,154	17,590	188,858
Returned	225	7,430	52,161	35,387	73,895	116,567	44,088	73,967	94,339

Source: INM, 2022

The INM records only the number of non-Honduran irregular migrants who pass through the country and the number of regular migrants who are Honduran. Hondurans who leave Honduras through irregular means are not captured in INM records. This makes it difficult to determine the exact number of migrants leaving Honduras and the main factors driving migration, despite consensus on the main contributors to migration in Honduras. The U.S. Central Intelligence Agency projects that Honduras will generate 1.3 emigrants per 1,000 inhabitants in 2022 (CIA 2022). It is also possible to analyze migration trends (Figure 2) based on U.S. Customs and Border Protection reports, which show that from a 2016 figure of 53,402 Honduran migrants detained by 2021, this figure had increased to 319,324 Honduran migrants detained by its agents, with an average growth of 177 percent per year between 2016 and 2021 (CBP 2021). See Figure 3. U.S. Customs and Border Protection reports 213 percent increase, in 2022 (CBP 2022).

Figure 2: Honduran Migrants Detained in the United States

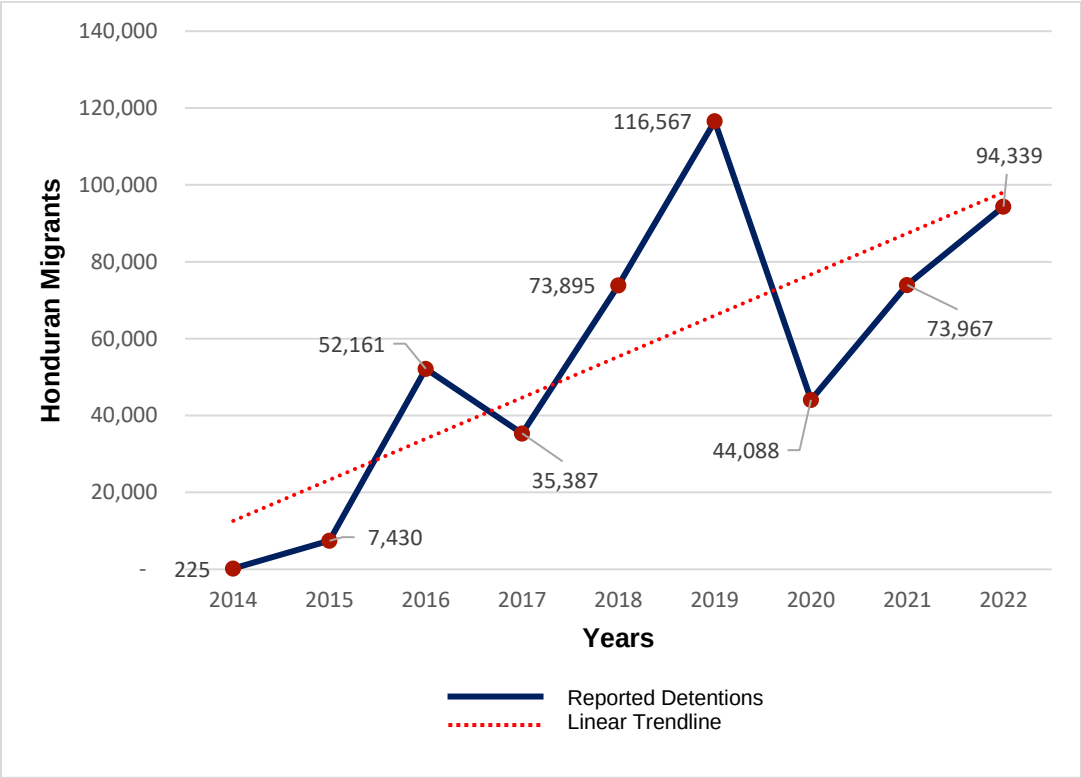


Source: U.S Customs and Border Protection, 2022

Returned Migrants

In 2022, the INM together with the SRECI reported having received a total of 94,339 returned migrants in the CAMRs, representing a 28 per cent increase of the total returned migrants reported in 2021(INM 2022a). The number of returned migrants in 2022 was the second highest peak of returned migrants, second only to 2019 level, which was the highest peak experienced in the past 8 years (Figure 4), constituting a humanitarian and health emergency at the national level, as recognized by SESAL and United Nations agencies.

Figure 3: Hondurans Returning by Year



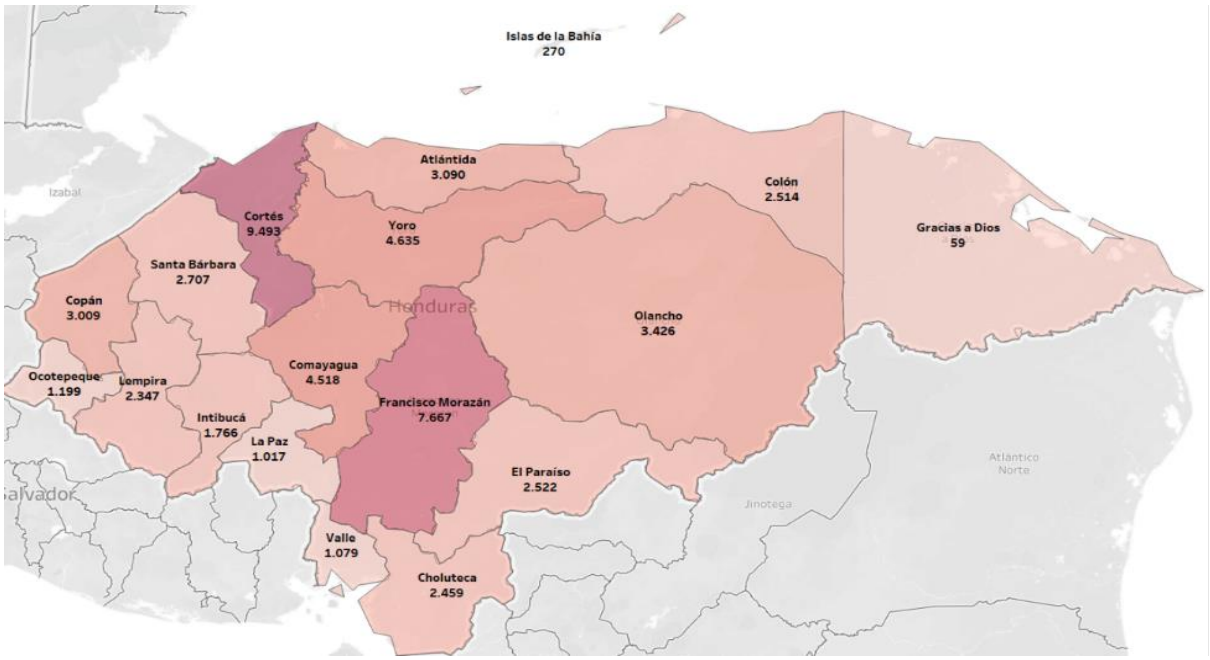
Source: INM,2022a

CAMR administrators reported that, since April 2022, the number of Honduran migrants returning to the country has increased 4 percent per month on average. They expect similar totals of returned migrants in 2022 as they did during the peak year of 2019.

Demographics

Map 1 shows that the departments to which the most migrants returned in 2022 are (in descending order of magnitude) Cortés, Francisco Morazán, Yoro, Comayagua, Olancho, Atlantis, Copán, Santa Bárbara, and El Paraíso.

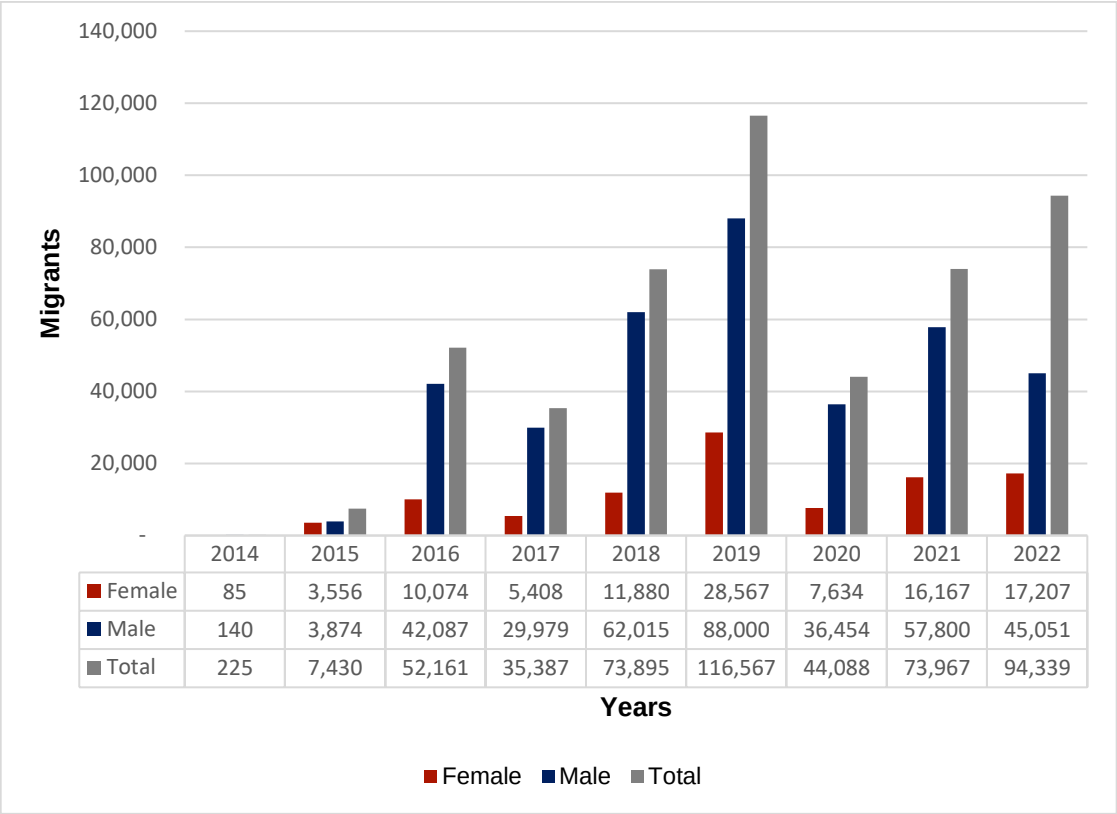
Map 1: Heat Map with Returned Migrants by Department, 2022



Source: LHSS, 2022

The overall trend from 2014 through 2022, shows on average 58.8 percent of returned migrants are men, a larger percentage compared to other categories of migrants. Figure 5 shows the year (2015) where this trend changed to almost equal proportions of male and female returned migrants, while in subsequent years males exceeded 80 percent. In 2015, there were only slightly more men (52.1 percent) than women (47.9 percent). In four subsequent years, the percentage of men has been over 80 percent.

Figure 4: Returned Migrants by Year (2014-2022)



	2014	2015	2016	2017	2018	2019	2020	2021	2022
Female	85	3,556	10,074	5,408	11,880	28,567	7,634	16,167	17,207
Male	140	3,874	42,087	29,979	62,015	88,000	36,454	57,800	45,051
Total	225	7,430	52,161	35,387	73,895	116,567	44,088	73,967	94,339

Source: INM,2022

In 2022, 24,391 Honduran child migrants have returned, 25 percent of the total number of returned migrants in that period. Of those, 62 percent were boys and 38 percent were girls; 49 percent were in early childhood, 20 percent were older children, and the rest were adolescents. At least 29 percent of the child population were unaccompanied children (INM, 2022).

Migrant Returnee Data as a Proxy for Migrants At-risk of Migration

Given the dearth of data on migrants as they are exiting the country, this assessment identified two ways to approximate the locations from which most women migrate, and thus may be most at risk of migration. First, the study team identified the departments of the country to which many migrants return (see Figure 5 of the rate of return by department and gender). Extrapolating from this information with the hypothesis – suggested by stakeholders interviewed - that the place of origin and the return is highly correlated, these areas could be prioritized for strengthening health services with a social protection approach, based on the criteria of greatest impact. As indicated in Figure 5, the departments to which the most female migrants returned in the first half of 2022 were Cortés, Francisco Morazán, Yoro, Olancho, and Atlántida. These departments have larger and denser populations than others. When migrants return to Honduras, they are received at one of three migrant first response centers, which connect migrants to their communities of origin. Based on this information, it is reasonable to conclude that there are larger concentrations of women at risk of migration in these departments because more women leave and return from these departments.

Figure 5: Migrant Returnees by Department and Gender, January- December 2022

Department	# Female	# Male	Department Total	% Female
CORTÉS	5605	11532	17137	33%
FRANCISCO MORAZÁN	3111	9968	13079	24%
YORO	2218	6023	8241	27%
OLANCHO	1988	4549	6537	30%
ATLÁNTIDA	1767	3705	5472	32%
COMAYAGUA	1705	5832	7537	23%
COLÓN	1464	3079	4543	32%
COPÁN	1371	3754	5125	27%
SANTA BÁRBARA	1197	3595	4792	25%
CHOLUTECA	1088	3178	4266	26%
EL PARAÍSO	856	3632	4488	19%
LEMPIRA	756	3047	3803	20%
INTIBUCÁ	694	2316	3010	23%
VALLE	573	1332	1905	30%
OCOTEPEQUE	495	1487	1982	25%
LA PAZ	325	1352	1677	19%
ISLAS DE LA BAHÍA	149	332	481	31%
GRACIAS A DIOS	25	102	127	20%
TOTAL	**25387**	68815	**94202**	

Source: INM, 2022

In addition, the USAID Mission in Honduras' Migration Geo-Targeting Model identified the following areas from which the highest numbers of Honduran migrants originate: Sula Valley, North Coast, Central Corridor, Western Honduras, and Eastern Hub. Looking at these two data sets, the assessment team concludes that there are likely larger concentrations of women at risk of migration near San Pedro Sula, Omoa, Tegucigalpa D.C, Yoro, and Catacamas, and La Ceiba than in other parts of the country.

The Health and Migration Response

The health system in Honduras is fragmented, constrained in its responsiveness to the many needs of the population, and fragile (ASJ 2022). At the same time, it is in a state of transition. In the past year's political transition of the new administration, the Honduran government has prioritized the promotion of universal health coverage (OPS 2022b). Recently, the Constitutional Chamber of the Supreme Court of Justice has declared the unconstitutionality of Decree 56-2015 - the Framework Law of the Social Protection System. Without this law, there is no legal definition for the national health care model nor related regulatory mechanisms (CSJ 2019). In the wake of this current legal vacuum, the SESAL's governing role as a national authority has been weakened due to fragmentation of its functions (OPS 2022b). In the meantime, a draft proposal for the new

National Health System Law is in development, which includes a mechanism for bolstering the provision of public health services in terms of the number of facilities as well as the quality and safety of health services (OPS 2022b). WHO's most recent figures for healthcare resources in Honduras show the country severely lags behind others in the region—for every 1,000 people there were 0.3 physicians (as of 2015, while the LAC average was 10 times that at 3.0) and there were 0.7 hospital beds for every 1,000 people (as of 2017, LAC average was 1.9) (World Bank Data Catalog n.d.).

Against this backdrop, high migration, which has surged in 2022, adds additional challenges. The migratory phenomenon and its multiple causes and effects strain access to health services, especially the most immediate care services (primary care and emergency), which are provided in coordination with institutions other than SESAL. Irregular migrants' inadequate access to health care services represents a humanitarian and public health challenge in the country.

The Honduras government has declared that:

1. Migrants legally have access to public health services on an equal basis with Hondurans.
2. Irregular migrants legally have access to first- and second-level health care services.
3. Migrants legally have access to mental health services provided by SESAL.

Even though migrants legally have access to health services, there are limited capacities to make this access effective. These principles are operationalized by the SESAL General Directorate of Standardization through Resolution No. 13 DGN-2020 of June 1, 2020. This resolution approved the *G20: 2018 Guide to Health Care for the Migrant Population.* This Guide is a normative instrument that regulates the procedures for the care of the migrant population (SESAL 2020a) including data collection, use of a systematized medical history, coordination between the actors involved in migrant care, compliance with bi-directional referral systems to improve access to health services, and improvement of the epidemiological surveillance and reporting system. This guide applies to all providers of public and private health services at the national level that participate in the orientation, evaluation, treatment, monitoring, and referral of the returned migrant population and/or those in transit at the migrant first response care centers. It is not possible to specify if this guide can be used with people at risk of migration, since they would access services without being identified as migrants.

As the public institution that governs the Honduran health system, SESAL has established the following interventions to help meet the needs of the migrant population:

1. Epidemiological surveillance, based on local regulations and SESAL's formats and protocols
2. Prevention, detection, and care of communicable diseases
3. Attention to violence, including gender-based and sexual violence
4. Access to information and care for sexual and reproductive health, maternal and child health, and family planning
5. Bi-directional referral services, functional and quality response (timely, providing follow-ups)
6. Consent and mandatory reporting of identified diseases without creating stigma
7. Health facility emergency preparedness plans at UMARs, CAMRs, and CAMIs

Preliminary analysis indicates that health care for returned migrants is better, in terms of access and utilization, than for migrants in transit. Key stakeholders attested that many women at risk of migrating seek care outside of SESAL. Because data on health services delivered outside the public health system is not available to the Honduran government, the government's data on the health needs of and services provided to women at risk of migrating is limited. Furthermore, women at risk of migrating in rural areas are more likely to face worse health outcomes than those

in urbanized parts of the country, due to increased travel distance to facilities and poor health system coordination in these regions.

Governance: The Interinstitutional Interagency Migration and Health Board

In the organizational structure of SESAL, there is the Health Emergency Committee (*Comité de Emergencia Sanitaria*), which activates and responds to emergency situations, including the phenomenon of migrant caravans. In response to migrant caravans in 2018 the Interinstitutional and Interagency Migration and Health Board (MIISM) was established by the Government of Honduras to make a space for the confluence of public and non-public actors involved in the care of the migrant population.

Led by SESAL, MIISM is the coordinating body for Government of Honduras public and private agencies engaged in the migrant response. It includes representatives from the Honduran ministries of health, education, security, and foreign affairs; PAHO; IOM; USAID; Doctors without Borders, International Committee of the Red Cross; and other international non-governmental organizations (NGOs) (See Annex A for full list of members). MIISM aims to strengthen the interventions that SESAL carries out for the benefit of the migrant population, and people affected by migration. The MIISM serves as a technical body that represents those who engage in migration issues, and therefore one of its implicit functions is the promotion, advocacy, and contribution of sustainable evidence to decision-makers seeking feasibility and political viability for technical recommendations.

The MIISM is a remarkable platform in the Honduran landscape for migration and health. The organization arose from the need to promote and guarantee orderly migration and with the purpose of ensuring and addressing migrants' rights, needs, and dignity. The MIISM serves as the steering committee that co-designs and validates the roadmap to strengthen SHP platforms in Honduras. It could play a key role in moving forward initiatives to strengthen SHP for women and children in high-migration contexts because it is official and integrates strategic partners, which promotes follow-up on plans for the future. MIISM has identified the following as the primary areas of health concern for migrants:

1. Mental health; sexual violence, interpersonal violence
2. Dermatological, respiratory, gastrointestinal diseases
3. Physical disability secondary to mutilation
4. Chronic degenerative noncommunicable diseases
5. Other communicable diseases

Most of these services are provided by the migrant first-response centers, with the exception of mental health services. Recently, MIISM leadership expressed an intent to incorporate an added focus on maternal and child health in the future. The current MIISM Strategic Plan lists six objectives (Figure 6) to address the needs of the migrant population.

Figure 6: Objectives of the MIISM Strategic Plan, 2018

To operationalize the objectives, the MIISM defined the following strategic axes (Figure 7) that form the basis of working committees:

Figure 7: The MIISM Strategic Axes

Source: LHSS, 2022

Challenges

- The new government is committed to expanding health to priority groups, but no clear plan/strategy is in place.
- The Consular and Migratory Observatory of Honduras (CONMIHGHO)[6] exists, but no health indicators/data are included.
- MIISM is an essential asset that could be built on to catalyze and further an agenda to expand SHP, but MIISM members act on behalf of their own organizations in policy and advocacy efforts and MIISM as an entity is not highly visible politically.
- Migrant response in health care is managed by three different government entities with disparate oversight at the subnational and national levels.

Financing Health Service Delivery

The SESAL interventions listed above are considered relevant and effective; however, there are gaps in their implementation. This is largely because of the considerable deficit of resources and inadequate physical infrastructure. In addition, SESAL services are not focused on identifying or meeting the specific health needs of migrants or those in conditions that put them at risk of migration, but rather for the general population. When considering the needs of migrants, SESAL seeks to prioritize attention to the care of children, especially those separated from their families or traveling alone.

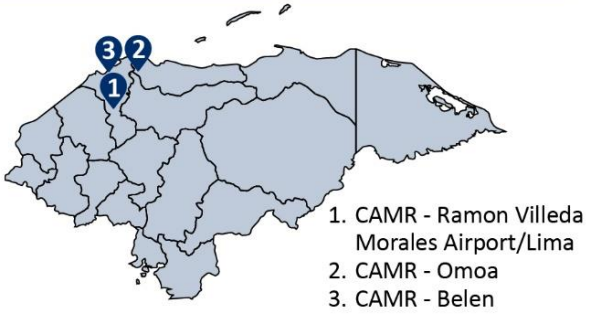
Health services for migrants and returning migrants in Honduras are currently provided by migrant first response care centers and financed according to specific mechanisms as summarized in Table 3 below and mapped out in Figure 8. There are specialized migrant first response care centers that offer a variety of services for in-transit/irregular and returned migrants. Multiple state and non-state actors under the direction of immigration entities in the country provide care in these centers. Migrant first response care centers include:

- CAMIS under the responsibility of the INM
- CAMRS under the responsibility of the SRECI's General Directorate for the Protection of Honduran Migrants
- UMARs under the responsibility of the SRECI's General Directorate for the Protection of Honduran Migrants
- International Health Offices (*Oficinas Sanitarias Internacionales*, OSIs)

[6] The Consular and Migratory Observatory of Honduras (CONMIGHO) is under the coordination of the SRECI Undersecretariat of Consular and Migratory Affairs. Its mission is to generate statistical reports on consular and migration issues, based on reliable and verifiable information. International organizations such as USAID, IOM, and U.S. Immigration and Customs Enforcement use information garnered by CONMIGHO to generate reports or other documents on Honduran migration.

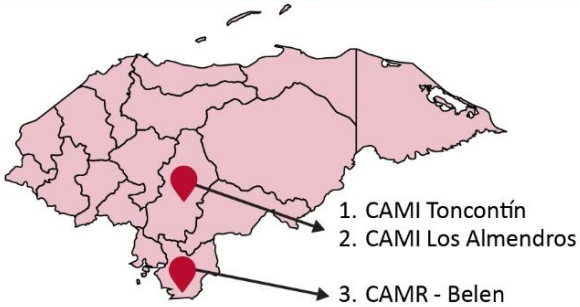
Figure 8: Migrant First Response Centers

Center for the Care of Returned Migrants (CAMR)



Funding: The General Directorate for the Protection of Honduran Migrants, the Ministry of Foreign Affairs and International Cooperation, United Nations High Commissioner, International Committee of the Red Cross, Norwegian Refugee Council, International Organization for Migration, among others.

Center for the Care of Irregular Migrants (CAMI)



Funding: National Migration Institute (75%) of funding and external cooperation agencies (25%).

Municipal Unit for Attention to Returned Migrants (UMAR)

Financing: Municipal governments. This initiative was supported by the migration working group of the local USAID Mission. Fourteen UMARs closed in 2021; currently only one UMAR operates in the Central District.

International Health Offices (OSI)

Funding: Secretary of Health (SESAL)

Source: LHSS, 2022

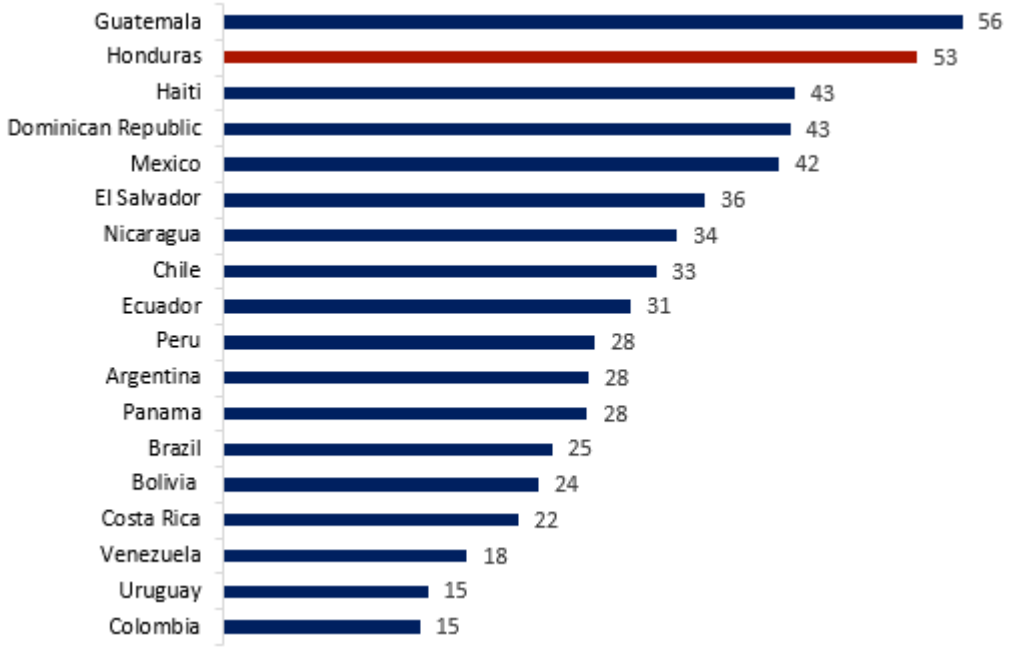
In addition to the established CAMIs, CAMRs, UMARs, and OSIs, there are other temporary centers that provide intermittent surge support for humanitarian response; however, their services are usually uncoordinated with the migrant first response care centers and do not follow SESAL guidelines.

Funds to finance services in CAMRs and CAMIs come from the national budget to SRECI and INM. Current funding is insufficient to sustain the services needed. SRECI and the INM have requested that the National Congress include funding to strengthen human resources in the 2023 budget. This funding for human resources is fundamental to providing care for migrants. No additional national funds will be available for the remainder of 2022 and 2023 funding from the national budget remains uncertain.

Challenges

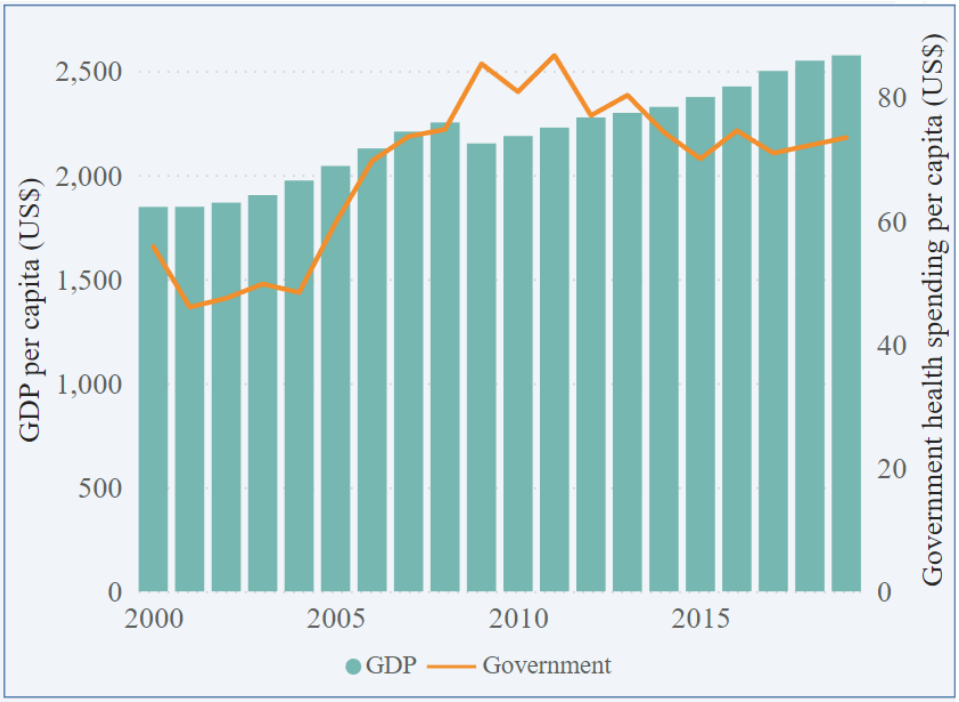
- In 2019, government health expenditure was equivalent to 3 percent of GDP in, and out-of-pocket payments accounted for 53 percent of health expenditure, the second-highest rate in Latin America (see Figure 8 and Figure 9) (WHO 2022). In 2020, as a result of the global health crisis, the national GDP contracted by 9 percent as private consumption, along with public investment decreased significantly. Ultimately, public spending on measures to address the pandemic amounted to 1.8 percent of GDP (approximately US$428.9 million) (ECLAC 2021).
- As a result of the global COVID-19 pandemic in 2020, national GDP contracted by 9 percent as economic activity decreased significantly. At the same time, public spending on measures to address the pandemic amounted to 1.8 percent of GDP (approximately US$428.9 million) and the COVID-19 pandemic further strained fiscal space for health.
- There is a lack of data related to the financial requirements and investments linked to the provision of health services for women and children in high migration contexts.
- Operation of migrant first response care centers is partially financed by state agencies and the rest, for limited periods of time, by multiple development organizations and NGOs, among others, making financing unreliable and insufficient. Funds from external cooperation are always of limited duration and can result in dependence and lack of sustainability. Even efficient and effective solutions aligned with SESAL regulations will not be available permanently if reliant on external funding.
- Both the CAMRs and the UMAR are underfunded. The SRECI quantified the human and material resources needed to operate the CAMRs, to request their inclusion in the 2023 government budget but that inclusion is not certain (CONMIGHO 2022).

Figure 9: Out of Pocket Expenditures by Country, as a Percentage of Total Health Expenditure, 2019



Source: WHO, 2022

Figure 10: GDP and Government Health Spending per Capita (Constant US$ 2019)



Source: WHO, 2022

Health Information Systems

Currently, there are no baseline statistics from SESAL on services for migrants, due to difficulties with the operation of its information system (INM, 2022). Information systems and/or subsystems in Honduras do not disaggregate important data such as ethnicity, religion, migration status, and disability, which limits the identification of the real health needs of migrants and particularly women and child migrants. The information is compiled in systems/subsystems from organizations and institutions that provide health care to migrant populations and that are not currently compatible with the established government information system.

Another challenge to addressing migrant health needs is the lack of availability of consistent data. The Honduras Migrant and Consular Observatory (CONMIGHO), under the management of the Sub-Secretariat for Consular and Migratory Affairs, collects, analyzes, and disseminates information to improve consular services and protection for Honduran migrant citizens, however, there are no health indicators to identify migrants' health needs. CAMRs and CAMIs are health establishments, but they do not follow standard SESAL reporting procedures. Instead, data is collected and reported into alternative incompatible systems than the current SESAL electronic surveillance platform, limiting the government's ability to make evidence-informed decisions on migrant SHP programs.

Challenges

- The assessment found that currently, it is not possible to characterize in detail the access to and financing of services among this specific group of women and children, as there is no existing disaggregated data on the subject. This absence of data also affects stakeholders'

ability to define and address challenges to accessing care. Rather, this would require further identification of the women and children at risk (i.e., an operational definition for the purposes of data collection and analysis) at the local level, which considers the local context, inequities, and asymmetries that exist within each department. This department level information is a major gap in the current understanding of the needs and available services related to the migration in Honduras.

- Migrant first response care centers are health facilities, but do not follow the standard notification procedures of the SESAL. Instead, data is collected and reported through systems incompatible with SESAL's current electronic surveillance platform. The lack of interoperability[7] of the information systems at migrant first response centers and the central health information platform limits the government's ability to make evidence-based decisions about SHP programs for migrants.

- The information system presents weaknesses in data collection, data analysis, and reporting. These discrepancies result in uncertainty about the conditions migrants report to have and in the number of migrants who seek care for these conditions.

Service Delivery

This assessment found that health care and other service facilities are under-resourced and under-staffed, standards of care are not clear or uniformly applied, and different migrant groups have different health needs, which indicates a need for differentiated care. The health care needs of migrant women, as well as women at-risk of migrating differ from those of the general population. Many of these women have vulnerable conditions such as pregnancy, disability, old age, etc. This group is also commonly affected by precarious situations such as gang violence; crime; violence based on gender, ethnic/indigenous, or LGBTQI+ identity; sexual slavery; and forced prostitution. All these factors can negatively affect physical and mental health, highlighting the importance of identifying and addressing issues related to their care and/or protection as distinct from other population groups (IOM 2020). Common diagnoses for migrants in transit include infectious diseases (gastroenteritis and common colds) and dermatologic conditions (dermatitis due to insect bites), and noncommunicable diseases. Legislatively, the provision of medical services for maternal and child health is specifically highlighted as a protected mandate under Honduras' Decree No. 73-96, Title 1, Articles 13-14, 16-17, and 22-23.

The assessment identified mental health care as health service need among migrants. It is important to recognize the well-being and mental state of the migrant facing the stresses of mobility, especially when considering the lack of a support network while exposed to traumatic situations. There is a lack of mental health support for both patients and providers. Differences in culture and fragile mental states can lead to misunderstanding and altercations between migrants and health service providers.

Several factors hinder the provision of health care and/or protection among migrants:

1. Constant displacement that prevents or inhibits the follow-up of patients' physical and/or mental health conditions.
2. Absent or limited medical records or health documents, limiting knowledge of physical and mental health issues.

[7] The term "interoperability" describes the ability of two or more information systems or components to exchange information based on standards, and to use the information that is exchanged.

3. Reluctance to seek access to medical care, due to fear of extortion, pressure from traffickers to avoid seeking health care and/or reporting sexual violence, fear of loss of confidentiality, stigma, and lack of economic means.
4. Other obstacles to timely access, including language and/or cultural barriers, lack of information on rights to access care, which are exacerbated by the tendency of migrants to seek assistance only in an emergency and/or when the severity of their health problems increases.

Table 3: Centers and Services provided based on Migrant Population Group

Migrant population	Type of center	Main Funding Sources	Services Provided
Returned migrants	CAMRs	SRECI's General Directorate for the Protection of Honduran Migrants, UNHCR, International Committee of the Red Cross, and Norwegian Refugee Council coordinate with SRECI to provide these services, among others	Migrant first response centers: provide basic need support and primary health care services
	UMARs	The SRECI's General Directorate for the Protection of Honduran Migrants, municipal governments, USAID Mission in Honduras	Migrant first response centers provide primary health care services
Migrants in transit and irregular migrants	CAMIs	INM (75%), and other international development partners (25%)	Migrant first response centers provide basic need support and primary health care services
	OSIs	SESAL	Detection of suspected COVID-19 cases at the point of entry and exit of Honduras border posts
People at risk of migration	SESAL local health facilities such as Primary Health Attention Unit (UAPS) and CIS (Integrated Health Centers)	Government	Primary care health services

The services provided in the CAMIs and CAMRs are specialized and different from the services provided in health facilities such as the Primary Health Attention Unit (*Unidad de Atención Primaria en Salud* – UAPS) and the Integrated Health Center (*Centro Integral en Salud*- CIS). A detailed description of these services is provided in Annex E. It is not possible to establish which services are most used by migrant women and women at risk of migration given a number of factors. The centers for the care of irregular and returned migrants operationalize the Guide established by SESAL and are directly providing services to irregular migrants in Honduras.

However, to date, there has not been standardization of services and operations across the centers. They operate independently of one another, fragmenting the health response to the needs of migrants. The centers are focused on primary care services and cannot address the more complex, yet common, health needs of migrants (e.g., pregnancy complications, physical trauma). Migrants with more complex or urgent health concerns may seek hospital level care directly. Because hospitals do not collect data on migration status, it is impossible to determine which services migrants need most often through service statistics. Similarly, migrants who are Honduran citizens may access services from primary care and higher-level facilities, where disaggregation of data by migratory status is currently unavailable. Migrant first response care centers do not provide daily regular medical consultations to migrants. Except for back-up hospitals, no services are available 24 hours a day and 7 days a week. Annex E: Migrant First Response Centers describes the centers, the services they provide to migrants, and illustrates the complexity and fragmentation of the current response. Table 4 summarizes the services provided by the different types of centers included in Annex E and Annex F: Primary Health Care Units and Integral Health Centers, that address the needs for people at risk of migrating.

Table 4. Comparison of Services offered to Migrants and People at Risk of Migrating in Honduras

Services Offered	Type of Care Centers				
	CAMI	CAMR	UMAR	OSI	UAPS/ CIS Primary Health Care Unit Comprehensive Care Center
Meals	Y	Y	Y	N	N
Clothing	Y	Y	N	N	N
Accommodations	Y	Y	N	N	N
Information on governmental social services*	N	Y	Y	N	N
Transportation to place of origin in the country	N	Y	N	N	N
Preventative medical services	Y	Y	Y	Y	Y
Sexual and reproductive care (maternal, child health, family planning)	N	Y	N	N	Y
Psychological and mental health care	N	Y	Y	N	Y
Nutrition	N	N	N	N	Y
Prevention and detection of non-communicable chronic diseases	Y	Y	N	N	Y
Prevention, detection, and care of non-transmissible diseases	Y	Y	N	N	Y
Vaccines (Including COVID-19)	N	Y	N	N	Y
Treatment of Disabilities	N	N	N	N	N
Referrals to provide immediate medical services follow-up	Y	Y	Y	Y	Y
Other: contacting family members	N	Y	N	N	N
Migratory identification and evaluation (biometric system)	N	N	N	Y	N

Source: LHSS, 2022
**Supporting livelihoods, target population 18-30 years old, those over 30 are generally excluded.*

Key: Y= services offered; N= services not offered.

Challenges

- The government has not developed clear standard operating procedures to guide the implementation of the SESAL's Migrant Health Care Guide.
- Migrant first response care centers face a shortage of human resources, infrastructure, and supplies and are not clearly connected to the health system.
- Health care services are not customized for migrant women, for example to address needs related to pre-existing or conditions acquired on the migration route and concerns relevant to their sexual and reproductive health.

Recommendations

The LHSS assessment identified three strategic areas of opportunities to strengthen SHP for the three categories of women and children in high-migration context (numbers 2, 3 and 4, below) and one strategic areas of opportunity for migrants in transit and returned migrants (number 6 below). The MIISM Strategic axes align with the key areas of work and LHSS recommendation to strengthen SHP for women and children in high migration contexts, as shown in Figure 11. During the September 2022 two-part stakeholder workshop stakeholders identified another strategic area (bullet point 6 below) and agreed that a first step would be to develop a mutually agreed roadmap to strengthen SHP (bullet point 1 below). For further details, see "Addendum - Stakeholder Workshop – Inputs and Results," These are medium-term recommendations for practical and sustainable steps for health system actors, including development partners, to consider:

1. **Co-develop a roadmap for phased implementation of adaptations to improve SHP for women and children in high migration contexts.**

LHSS will work with the SESAL, MIISM, and other local partners to co-develop a roadmap to systematize the response and align activities from other actors to create SHP mechanisms that can improve access to high-quality services and financial protection for women and children in high-migration contexts. The roadmap development was initiated in Year 2 through consultative workshops and a high-level meeting with the SESAL. The roadmap will focus on the five validated strategic areas and involving the activities and phases, including those that LHSS may support.

This roadmap will be validated in the coming months, including roles and responsibilities of actors/contributors, as a next step towards SHP strengthening for women and children in high-migration contexts.

MIISM will monitor the implementation of a roadmap for strengthening SHP for women and children in high-migration contexts.

2. **Improve coordination, operation, and function of first level of care service delivery for women and children in high-migration contexts.**

There is a need to improve the capacity of the migrant care centers. As a first step, conduct training needs assessment and provide training to the multidisciplinary teams in the migrant first response care centers. Stakeholders should seek to strengthening migrant health centers' capacity for surveillance and the management of communicable diseases; the arrival of migrants from multiple origins increases the risks of introduction of prevalent diseases, endemic to their

countries of origin or acquired on the migratory route, specifically linkages with and capacities of non-OSI facilities. Another opportunity would be to develop standard operating procedures based on the Guide for Health Care for the Migrant Population (SESAL 2020) to strengthen the primary health services provided in the migrant first response care centers (CAMIs, CAMRs, and UMARs) including bi-directional referral systems for women and children.

Migrant first response centers can adopt proactive protection and management strategies for altercations between migrants and care personnel, based on the type of population served and the conflicts generated by the emotional fragility of migrants and cultural barriers.

There is a need to strengthen capacities of the public health system to provide quality primary health services to migrant women and children, including training for health staff. Improve referral systems between primary, secondary care, and tertiary care, in high-migration regions could address concerns of lack of access and continuity of care.

This assessment also found the opportunity to develop management capacities in multi-sectoral environments to guarantee supplies of basic resources, differentiated by the type of service to the population, including reorienting the location and increase allocation of trained human resources and basic inputs to meet the basic and differentiated needs of the migrant population.

3. **Raise MIISM's profile as a coordination and advocacy mechanism for improved SHP for populations in high-migration contexts.**

LHSS recommends that MIISM strengthen their technical capacity to coordinate the health and migration response in Honduras. By increasing the visibility of their leadership role, MIISM will be able to foster increased public awareness and keep the issue of migration in the public debate.

With support, the MIISM can oversee the development of standard operating procedures based on SESAL's *Guide to Health Care for the Migrant Population* to strengthen the operation of CAMRs, CAMIs, and UMARs and to provide guidance for the development of a partner service delivery center. Developing standardized operating procedures would improve the provision of quality primary health services to migrants, including strengthening referral systems in regions with the highest migratory flow.

4. **Ensure the availability of sustainable and adequate resources for improving SHP for women and children in high-migration contexts.**

It is important to increase understanding of funding needs for SHP for women and children in high-migration contexts. A first step is to generate evidence on health funding gaps, with a specific focus on health services provided to migrant groups in Honduras, specifically for women and children living in areas with high-risk of migration. Through a financing gap study, identify financing sources, funding gaps, composition and distribution of expenditures, and total investment in migrant health in Honduras. This analysis can inform recommendations that can help to close identified gaps by either mobilizing additional resources or improving efficiencies. The resulting recommendations can help to close identified gaps by either mobilizing additional resources or improving efficiencies for financing SHP for women and children in high migration contexts and will be shared with GOH to inform planning to generate sustainable funding for these programs.

5. **Strengthen and standardize risk communication and health promotion communication campaigns in high-migration contexts.**

Migrants will benefit from an increase in information on the type of centers, services provided, and requirements to access these services including migrant first response care centers along the migration route in Honduras. The communication campaigns can address the risks that women and children face if they decide to migrate and inform them of their rights to receive support along their migration journey, with efforts focused on the highest migration departments. The campaign will address the first two bullets and messaging and materials will be shared with SESAL, SRECI, and INM to identify funding sources for future implementation at the local and regional levels.

Based on these recommendations, and stakeholder feedback and inputs gathered through a series of in-person workshops, and a meeting with the Honduras Minister of Health (addendum), LHSS will co-develop with MIISM members a detailed four-year roadmap that proposes steps to explore alternatives to strengthen SHP mechanisms that can improve access to high-quality services and financial protection for women and children in high-migration contexts. Stakeholders will have the opportunity to validate priorities and targets set out by the roadmap upon its development and dissemination, laying out the approach for collaboration towards improving SHP for migrant women and children in Honduras for the next few years.

6. Standardize data collection and integrate health and migration information systems to support decision-making.

Strengthened data on health needs of women and child migrants could provide evidence for decision making to expand access to quality services for these groups. LHSS recommends the first step, to conduct an assessment of existing health information systems, policies, and platforms to identify opportunities to strengthen the migrant health information system with a view to improving understanding and addressing health services gaps for populations in high migration contexts. This assessment will increase understanding of interoperability gaps and barriers of migrant care registries, and the core SESAL health system and propose recommendations to help the different subsystems achieve interoperability.

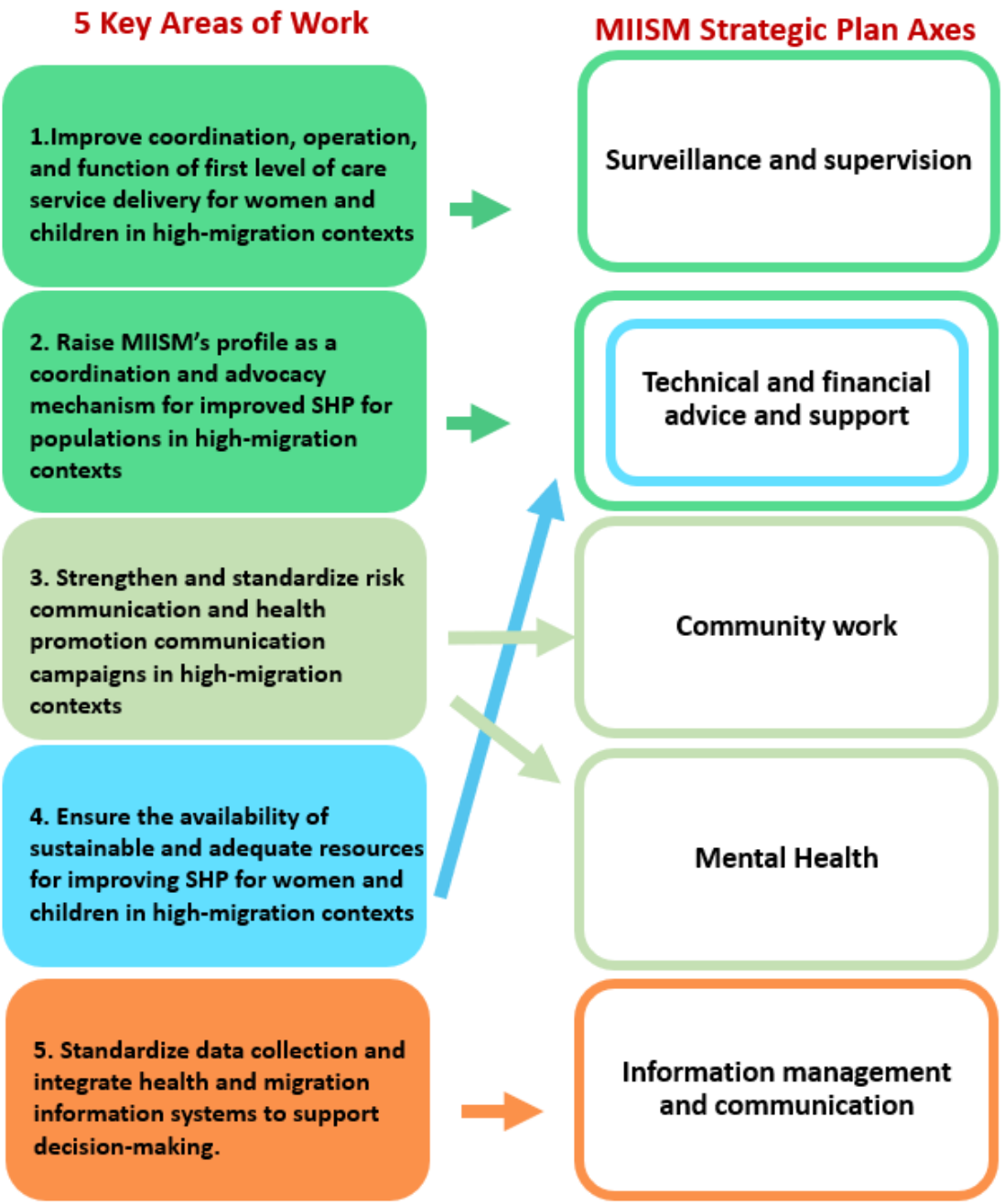
Based on the joint assessment findings, SESAL, MIISM and the Sub-Secretariat for Consular and Migratory Affairs, which manages CONMIGHO, can co-create a proposal with recommendations to strengthen and standardize migrant health information systems data collection, analysis, reporting, and use to improve interoperability of migrant health information systems with the existing SESAL core system.

The recommendations can include:

- Definitions and proposals for new health indicators and/or stratifications, if needed, that support the collection of sex-disaggregated and gender sensitive data at migrant first response centers and better identify migrants' health needs and primary health services provided to the three target migrant populations for incorporation into its monitoring and evaluation subsystem. A potential “home” for such data is the Consular and Migratory Observatory of Honduras (*Observatorio Consular y Migratorio de Honduras*, CONMIGHO). This would improve the quality and diversity of statistical information and explain the evolution and trends of the migratory phenomenon for better decision-making at national level.
- Data exchange mechanisms between stakeholders to ensure continuum of care for migrant populations to strengthen the Migrant Care Registry (at points of care, including CAMRs, CAMIs, and UMARs. The recommendations will focus on working towards data exchange, so that quality migration data can inform decision making at a national level.

While this recommendation of addressing a lack of data on migrant health needs will benefit women and child migrants in transit and returning to Honduras, it is also recognized that in the longer term, strengthening the availability of disaggregated data on women's health needs in high outward migration areas would also contribute to strengthening SHP for women and children at-risk of migration.

Figure 11: Five Key Areas of Work Aligning with the MIISM Strategic Plan



Source: LHSS, 2023

Addendum

Two-Part Stakeholder Workshop Summary

Table 5: Participating Organizations in Workshop

Pre-Workshop September 9, 2022	Workshop September 13, 2022
1. USAID/Honduras 2. Ministry of Health 3. Doctors of the World (Médicos del Mundo) 4. Ministry of Foreign Affairs and International Cooperation 5. National Institute of Migration 6. Ministry of Education 7. MIISM Board of Directors 8. Save the Children Honduras 9. Abt Associates	1.MIISM Board of Directors 2. USAID/Honduras 3. Ministry of Health 4. Ministry of Education 5. National Commission on Human Rights 6. International Organization for Migration 7. Honduran Red Cross Organization 8. Doctors without Borders 9. Doctors of the World 10. National Institute of Migration 11. Ministry of Foreign Affairs and International Cooperation 12. Directorate of Childhood, Adolescence, and Family 13. Network Federation for the Disabled 14.Health Region Paraíso #7 15. Pan-American Health Organization/World Health Organization 16. Save the Children Honduras 17. Abt Associates

Pre-Workshop September 8, 2022

Summary

On September 8, LHSS and Save the Children Honduras led the pre- “Intersectoral Workshop on Strengthening Social Health Protection for Women in High Migration Contexts in Honduras”, to bring a key group of local stakeholders (see Table 6), MIISM board members, together and garner their perspectives and contributions towards expanding SHP for migrant women in Honduras. Inputs from the pre-workshop laid the foundation for the direction of the following week’s workshop. Session participants brainstormed and validated preliminary recommendations of content for a roadmap to strengthen SHP for women at risk of migration. For small group discussions attendees were divided into three groups based on target population (women at risk of migration, migrants in-transit, and returned migrants.

The meeting participants were divided into focus areas according to the special needs of three groups of women in high migration contexts and were tasked with considering solutions to the specific challenges in accessing SHP:

1. Group 1: Women at Risk of Migration

2. Group 2: Migrants- in-Transit
3. Group 3: Returned Migrants

The small groups' recommendations were presented to the broader group for discussion.

Report-outs from the Groups:

Group 1: Women at risk of migration

This group recognized a myriad of challenges to accessing SHP for women at risk of migration including insufficient infrastructure, HRH (Human Resources for Health), and financing. The group considered strengthening information systems as a key priority. Specific recommendations included:

1. To address the issue of equity, conduct a stratified assessment to identify priority networks (those with the worst service provision) since not every area can be bolstered at once.
2. Implement an integrated health system. For example, women at risk of migration often seek care at health networks outside of SESAL, especially for maternal and childcare. Thus, there is a need to connect them to the health system more effectively to increase their access to more complete services and close the gaps.
3. Socialize data protocols to accumulate the correct data of the population at risk of migrating.
4. Accelerate the process for strengthening the data collection capabilities of the SESAL's information platform, with a focus on the population at risk of migrating.
5. Fortify coordination, operation, and communication between NGOs and regional health authorities for the development of an action plan to improve care for the population at risk of migrating.
6. Develop a coordinated risk communication plan and align collaborators such as SESAL's communications branch, Red Cross, IOM, MSF, etc. Consider using social media to bridge the gap with the target population and curate content for different language groups among the migrant population (Portuguese, Creole, 'bajo venezolano').
7. Establish, monitor, and evaluate the implementation of the vaccination day plan in accordance with the MOH's epidemiological strategy.

Group 2: Migrants-in-Transit

This group presented the following ideas to address the challenges that migrants in transit face in accessing health care:

1. Train health personnel in current SESAL regulations.
2. Update the new regulations for health personnel.
3. Coordinate with all the institutions involved.
4. Have an integrated and strengthened information system.
5. Increase awareness of security protocols among the population in transit, to ease their concerns about safety when accessing health centers. If migrants in transit perceive health centers as safe zones, they may be more likely to access services.
6. Promote access to facilities that are within the health system for adequate medical attention.

Group 3: Returned Migrants

This group presented the following ideas to address the challenges that returned migrants face:

1. Strengthen first and second level health services close to the migrants' point of entry, for diagnosis, treatment, and referral response.
2. Strengthen social integration and reintegration programs.
3. Develop communications campaigns with mass media for key messages to disseminate among affected populations to augment awareness on accessing health services and the right to access quality care.
4. To address the very deep gaps in access to health services in rural areas, improve the referral system for where patients can be sent for problems that cannot be resolved in their closest establishment, given not all health centers have sufficient staff.
5. Advocate for greater inclusion of LGBTQI+ community in migration statistics, related to health and other relevant data areas.

Pre-workshop conclusions:

One of the main conclusions of the discussion was that it is necessary to include the definition of women[8], girls, and adolescents in a consistent way to unify the language of women at risk of migrating. The key validated areas of opportunity included: 1) strengthening information systems, 2) coordination and operation of services, 3) identify alternative sources of financing, and 4) provide technical support to MIISM to improve its organizational infrastructure. Additionally, participants identified a fifth area: risk communications and health promotion.

Workshop: September 13, 2022

Summary

On September 13, LHSS and Save the Children Honduras facilitated the "Intersectoral Workshops on Strengthening Social Health Protection for Women in High Migration Contexts in Honduras" with the objective to:

1. to share and validate the information from the LHSS Rapid Country Assessment Report to understand the context for expanding social health protection to women in high migration contexts.
2. to discuss and agree on the changes and adaptations that are needed to improve social health protection for women at risk of migration; and,
3. to build consensus on feasible adaptations to improve social health protection for women at risk of migration in the country.

LHSS presented the results of the previous workshop, kicking off an active dialogue among participants (see Table 6) where some of the following insights were gathered, among others:

[8] Per the Gender Unit of Honduras' Judicial Branch, LHSS recognizes the following groups under definition of "women": 1) cisgender women –refers to those whose gender identity corresponds with the sex registered for them at birth, and 2) transgender women – refers to those whose gender identity does not correspond with sex registered for them at birth

1. Training personnel who work at the borders to offer mental health care for health service providers, along with migrants, should not be overlooked.

   Information system management should unify both criteria and collaborators at the interagency, interinstitutional level in the notification and transmission of data. Guidelines and all categories of care protocols should be digitally available for the training of healthcare personnel.

   With the new president and administration, the MIISM has more visibility, credibility, and support for the joint work with other member organizations that work daily with the migrant population.

   Medical professionals directly treating migrants should provide differentiated care according to the profile and needs of each migrant for better quality service.

   The 14 UMARs in Honduras are considered by the SESAL to be a key player among the types of health facilities (while they were supported) working with the migrant population. However, these facilities lack adequate financial support and were not effectively enmeshed within the local health system, so currently work is underway to find a better approach.

   As health systems became more overburdened and complex in the pandemic, and even for serious cases, patients were not able to access the appropriate level of care for months.

Conclusions

At the end of the workshop, the participants validated and agreed that there are five key areas with cross-cutting strategies that will improve the quality and access of primary care health services for women in high migration contexts, including populations at high-risk of migration, in transit, and returned migrants.

The final validated strategic areas are:

1. Strengthening health information systems
2. Improving risk communication practices to improve outreach to key demographics
3. Provision of adequate stock of essential medical supplies and technical support for mental health services for both migrants as well as health service providers
4. Fortification of interagency coordination among MIISM members through management of written conventions/agreements as well as improved infrastructure for member meetings
5. Generation of evidence and identification of resources to support financing for SHP in Honduras

LHSS Meeting with the Minister of Health: September 16, 2022

Summary

On September 16, LHSS met with the Minister of Health, the USAID Mission, and Save the Children Honduras to discuss the results of the agreed with advancing efforts in these areas. pre-workshop and workshop. The Minister agreed with the information presented by LHSS and expressed that SESAL is supportive of these proposed efforts. The Minister of Health communicated his support of the five strategic areas and agreed with advancing efforts in these areas.

Annex A: Interinstitutional and Interagency Board on Health and Migration Members

Interinstitutional and Interagency Board on Health and Migration Members
1. Secretaría de Salud / Ministry of Health (SESAL) 2. Comisión Nacional de Derechos Humanos / National Human Rights Commission (CONADEH) 3. Secretaría de Relaciones Exteriores y Cooperación Internacional / Ministry of Foreign Affairs and International Cooperation (SRECI) 4. Fondo de las Naciones Unidas para la Infancia /United Nations Children's Fund (UNICEF) 5. The USAID Honduras Creando Mi Futuro Aquí (Creating My Future Here) Activity (DAI-USAID) 6. Instituto Nacional de Migración / National Migration Institute (INM) 7. Centro de Atención al Migrante Irregular / Center for the Care of Irregular Migrants - Los Almendros 8. Organización Internacional para las Migraciones / International Organization for Migration (OIM) 9. Federación Red Pro-Personas con Discapacidades / Federation Network for People with Disabilities (FEREPRODIS) 10. Médicos del Mundo / Doctors of the World (MdM) 11. Comité Internacional de la Cruz Roja / International Committee of the Red Cross (CICR) 12. Región Sanitaria El Paraíso N.7 / Sanitary Region El Paraíso N.7 13. Cruz Roja Hondureña / Honduran Red Cross 14. Dirección de Niñez Adolescencia y Familia / Directorate of Children, Adolescents and Family (DINAF) 15. Secretaria de Desarrollo Social Género y Justica Social / Secretariat of Development and Social Inclusion (SEDESOL) 16. Fondo de Población de Naciones Unidas / United Nations Population Fund (UNFPA) 17. Medicos sin Fronteras / Doctors without Borders (MSF) 18. Visión Mundial / World Vision 19. Organización Panamericana de Salud / Pan American Health Organization (OPS) 20. Cristosal 21. Pastoral de Movilidad Humana 22. Federación Luterana Mundial / Lutheran World Federation 23. Save the Children Honduras

Annex B: Institutions Visited and Key Actors Interviewed

Representatives of the following institutions and organizations were interviewed in the course of this assessment.

Government of Honduras	Development Partner	Migrant first response care centers
Secretary of Health (SESAL) National Institute of Migration (INM) Secretary of Foreign Relations and International Cooperation (SRECI)	USAID Mission Honduras International Organization for Migration (OIM) UNHCR Pan American Health Organization (PAHO) Honduran Red Cross International Committee of the Red Cross Doctors of the World Doctors without Borders (Médecins sans Frontières) World Vision	Return Migrant Attention Center: CAMR–Belen CAMR–La Lima CAMR–Omoa Centers for Attention to Irregular Migrants: CAMI–Toncontín Airport CAMI–Los Almendros Municipal Units for Attention to Returned Migrants: UMAR Central District Danlí El Paraíso: Delegation of Attention to Migrants El Paraíso Health Region #7

Annex C: Meetings with the Interinstitutional Interagency Board of Health and Migration in Honduras

Date	Activity
May 17, 2022	Introduction to the MIISM at the fourth regular meeting.
June 10, 2022	Meeting with the Community Axis with the aim of joining forces with other institutions that make up the community axis.
June 14, 2022	Meeting with the MIISM in the Ministry of Health (SESAL).
June 17, 2020	Meeting of the Community Work Committee with the aim of providing contributions and building the mapping of activities to be carried out.
June 22, 2022	Meeting of the Board of Directors and Strategic Committee with the aims of following up on the diagnosis of the response capacity of the establishments at the first level (UAPS, CIS, Polyclinics, CAMI, CAMR, and UMAR) and second level (regional and national hospitals) near an entry point to provide health care to the migrant population and learn about the proposal for the diagnostic study on the health conditions of migrants in Honduras and the region (PASMO).
June 23, 2022	Virtual meeting to follow up on the development of activities of the community axis.
June 24, 2022	Meeting with the Community Work team in the facilities of the SESAL UVS Environmental Risks Room. We worked on the MIISM strategic plan for the attention of the migrant population and those affected by migration at the regional, national, and local levels in the context of the COVID-19 pandemic.
June 28, 2022	Meeting with the community committee, monitoring, and design of activities.
July 19, 2022	The fifth regular meeting of the MIISM was held at the Excelsior hotel. The LHSS team provided the space for the meeting.

Annex D: Interview Guide for Key Informants

1. Can you 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., geographical location and socioeconomic profile?
4. What are the main drivers of migration for these women?
5. What do you see as the main challenges for women regarding access to health and access to social health protection (SHP)?
6. Who are the main stakeholders working on these issues and what are their roles?
7. Are you aware of any cross-border, bilateral, or multinational approach to expanding SHP for women who migrate?
8. What is the role of regional and subregional governance bodies and platforms in addressing the SHP needs of migrants in Honduras?
9. What are the most relevant efforts of CBOs or non-governmental organizations (NGOs) focused on migrant women?
10. Who are your main partners in this work?
11. How is the private sector involved in supporting SHP or women's access to health?
12. What are the main multi-institutional networks, coordinating bodies, and knowledge-sharing networks working on migration issues in Honduras?
13. What are the main gender constraints and social inclusion issues related to strengthening the capacity of the health system to respond to current and future crises, including the COVID-19 pandemic?
14. How many CAMIs, CAMRs, and UMARs are in operation in Honduras and of them, which are the ones that register the greatest movement of people?
15. Do you handle statistical data on Honduran migrant women in transit?
16. Are there data that demonstrate the quality of care in migrant first response care centers, i.e., ratio of service applicants vs. existing staff in the centers / opening hours and time spent per migrant?
17. Do you consider that the physical spaces of the care centers for (female) migrants meet the appropriate conditions to provide a timely, efficient, and effective care?

Annex E: Migrant First Response Centers

Centers for the Care of Irregular Migrants

The INM oversees three CAMIs in:

1. Toncontín Airport
2. Los Almendros, Boulevard Morazán
3. Choluteca

The three CAMIs each have a general physician. SESAL is responsible for the administrative costs of the attending doctor at the CAMI–Los Almendros, Boulevard Morazán. OIM is responsible for the physician at CAMI–Choluteca, and the INM covers the entire budget of medicines and in CAMI–Toncontín Airport. The INM finances 75 percent of the operation of a CAMI (human resources, medicines, and infrastructure, among others); the remaining 25 percent is absorbed by international cooperation agencies.

A CAMI provides the following services during the migrants' stay in the center (from a few hours to five days depending on their immigration status and/or their health problems):

- reception and initial shelter for migrants in transit
- immigration identification and evaluation
- primary care medical services and in some cases referrals according to specific needs or demands
- temporary accommodation for some migrants (whether they must remain in the center for protection reasons or because they are in immigration custody)
- food
- showers and washing services only for the migrant population housed in the center
- re-establishment of family contact

Patients walking from the border make extensive use of this medical service; however, due to the rush to continue their migratory trajectory, even if they need it, not all people use health services.

Centers for the Care of Returned Migrants

The SRECI's General Directorate for the Protection of Honduran Migrants is responsible for implementing policy and programs for the protection of Honduran migrants abroad, as well as for the return of Honduran migrants. Among its specific programs, it manages the CAMRs and UMARs.

The CAMRs are units of the General Directorate for the Protection of Honduran Migrants that provide services and attention to migrants during the transition period (on average of two to four hours):

- government social services (food, telephone call, money for the purchase of tickets to return to their place of origin or destination)
- registration of the migrant
- medical and psychological care

- communication with relatives within or outside the country
- clothing
- accommodation (not all CAMRs have this service)
- legal protection for people displaced by violence

There are three nationally authorized CAMRs in the northern part of Honduras, in the municipalities of San Pedro Sula and Omoa, and near the Ramón Villeda Morales Airport in Lima. Although all the CAMRs are in the same department, they coexist by offering different services to match the dynamic needs of the returned migrant population, as described below. The UNHCR, International Committee of the Red Cross, and Norwegian Refugee Council coordinate with SRECI to provide these services.

CAMR	Target Populations	Services	Other Orgs	Common medical issues
Belen (San Pedro Sula)	• Adolescents • Victims of abuse • Unaccompanied children • All migrants under 18	• Voluntary psychological services • Medical services (including COVID antigen testing) • legal and humanitarian care • food • transport • lodging • a hygiene kit with toilet paper, masks, alcohol, sanitary pads for women, disposable diapers for children, toothpaste, toothbrush, soap, and shampoo	• Directorate of Children, Adolescents, and Family	Information not available
Omoa • operates on Wednesdays, Thursdays, and Fridays • Saturdays and Sundays only when migrants leave from there in caravans	• Only migrants older than 18 • 220 to 300 people daily (92 percent men)	• two doctors and nurses • same services as the other CAMRs • temporary accommodation spaces, if necessary	• SESAL • UNHCR • Honduran Red Cross • International Red Cross • OIM • National Institute of Vocational Training • Interpol	• common cold • COVID-19 • Heatstroke • insect bites • gastroenteritis and gastritis • urinary tract infections • vaginal infections
Lima/Villeda Morales	• only migrants older than 18 • migrants returned from Mexico and Guatemala (by land) and Belize (by water) • approximately 2,000 and 2,500 weekly, with a higher percentage of men	• immigration processes • access to voluntary medical and psychological care • special attention to people displaced by violence	• Association of Escalabrinianas Sisters	Information not available

At CAMR-Belen, the INM staff provide a general explanation of the immigration process, then migrants are directed to a processing room where they fill out required registration forms. Subsequently, migrants receive a transport ticket (departure voucher) to bring them as close as possible to their residences. There is also a fact-checking unit that connects to the national registry and verifies the documents of migrants to ensure that minors have some kinship or blood link with the adults accompanying them; otherwise, corresponding investigations are conducted to ensure that the minors are safe with the persons who return them to their homes.

Municipal Units for the Care of Returned Migrants

The UMARs were in the fifteen municipalities considered to be the largest sources of migrants to the United States and the most transited municipalities in the Northern Triangle countries. Fourteen UMARs ceased operations in 2021, with the UMAR of the Central District (UMAR–D.C.) remaining the only one in operation, but there is an effort underway to reopen those that have closed. Map 4 provides the specific locations. The SRECI provided the funds for UMARs through a trust under the previous administration that no longer exists. Although the SRECI is now redirecting funds to operate the centers under a new mechanism called the Solidarity Fund for Honduran Migrants (*Fondo de Solidaridad con el Migrante Hondureño*), this has been slowed since the government transition in early 2022.

UMAR–D.C. can provide care to approximately fifteen people a day, 40 percent of whom are women seeking medical care for weight loss, stress, first-degree malnutrition, and psychological well-being.

Article No. 24 of the Law on the Protection of Honduran Migrants and Their Families by Decree 106-2013 created the General Directorate for the Protection of Honduran Migrants, which among others is responsible for the CAMRs and the remaining UMAR[9] (Undersecretariat of Consular and Migratory Affairs of Honduras 2022). At the UMAR–D.C. returned migrants have already been treated in a CAMR. The request for health care services at a UMAR is for those who have not received sufficient medical attention at CAMRs, have already been redirected to health care facilities, or are unaware of the health care services upon their return to the country. UMAR–D.C. also provides crisis intervention and psychological first aid onsite. NGOs and international cooperation organizations offer links to training opportunities, specifically for the population between the ages of 18 and 30. The UMAR refers people without housing to UNHCR, which conducts a consultation process. If the person meets the requirements, they can enter the "Temporary Room" program.

Currently, SRECI is restructuring the closed UMARs in order to focus on care, starting with an institutional mapping and identification of resources to support the municipalities where the UMARs are located. The SRECI will be the governing body to manage all the actors involved and manage the proposal for the reformulation of the UMAR with a multidisciplinary team composed of a project officer, a monitoring and evaluation specialist, social workers, and psychologists, among others. The efforts aim to create sustainable conditions with the help of international cooperation agencies, local cooperation agencies, and municipalities, among others.

[9] CONMIGHO Platform – General Directorate for the Protection of Honduran Migrants; www.conmigho.hn

International Health Offices

An OSI is a multipurpose triage center, with the scope and purpose to prevent, protect, avoid, and control the international spread of diseases and deliver a public health response focused on prevention of health risks. The OSI does not provide direct services to migrants or other individuals. The OSI has a more administrative scope and covers any medical ailment or condition, whatever its origin, which could cause significant damage to humans. An OSI's main objective is currently the detection of suspected COVID-19 cases at the point of entry and exit of Honduras border posts.

OSIs are financed and supported by SESAL, responding to the international agreement "International Health Regulations of WHO." There are 22 OSIs and a surveillance point, at Soto Cano Air Base (U.S. Army Base/Southern Command in Palmerola Comayagua, Honduras). Map 5 shows the total number of OSIs; however, not all are functional. An OSI's scope of work is to:

- Provide access to appropriate medical services, personnel, equipment, and facilities, including diagnostics that allow for immediate assessment and care of sick travelers
- Provide access to equipment and personnel for the transportation of sick travelers to an appropriate medical unit
- Provide trained personnel for the inspection of means of transport
- Provide a healthy environment for travelers who use entry point facilities and services
- Develop a program, and train personnel, for the control of epidemiological vectors and reservoirs at the points of entry and their vicinity

Annex F: Primary Health Care Units and Integral Health Centers

The Primary Health Care Units (UAPSs), Integral Health Centers (CISs), are primary health care centers and, along with hospitals, are part of SESAL's primary service network. UAPSs and CISs are, as such, part of the migration and health response for people at risk of migrating, and those returning to their places of origin. While being mainly funded by SESAL, non-governmental organizations frequently provide materials, supplies, and human resources specifically to serve the migrant population. The UAPSs and CISs often provide care under the modality of mobile care brigades. The primary and secondary levels of SESAL's Service Network offer sexual and reproductive health services for women including those in contexts that put them at risk of migrating. These services are often a priority in these centers. In 2020, (*SESAL 2020b)* SESAL provided over 3,245,00 instances of comprehensive care for pregnant women (including both Level I and II). Also, SESAL provided another 2.17 million instances of family planning care, including modern methods as a strategy for reducing maternal morbidity and mortality. Table 4 summarizes the type of health services provided to the general population, including people at risk of migrating, at I Level - local health facility, and II Level - polyclinics/hospitals.[10]

Table 6: Provision of Health Services to the General Population by SESAL

Provision of Health Services, 2020		
Health Secretariat of Honduras (SESAL)		
Final Product	No. of Care Attended at I Level	No. of Care Attended II Level
Comprehensive care for pregnant women	2,996,563	249,899
Comprehensive care for children under five years of age	2,461,822	111,329
Comprehensive care for the population and the environment for prioritized vector diseases (Dengue, Chicungunya and Zika)	1,497,380	9,713
Comprehensive care for the population and the environment due to Malaria	37,008	38
Comprehensive care for the population and the environment due to Chagas disease	10,764	214
Comprehensive care for the population and the environment due to Leishmaniasis disease	7,882	56
Comprehensive care for HIV – AIDS	188,845	44,802
Comprehensive care for Tuberculosis	106,451	1,229
Comprehensive care for Arterial Hypertension	686,646	153,633
Comprehensive care for Diabetes Mellitus	250,888	123,236
Comprehensive care for Oncological Diseases	129,962	15,674
Comprehensive care for Chronic Kidney Disease	5,898	28,562
Comprehensive care throughout Lifetime	6,442,709	1,580,105
General Average of Care Carried Out	**14,822,818**	**2,318,490**

Source: Data from SESAL (2020b)

[10] Report No. 087-2021-dfep-sesal, period evaluated from January 1 to December 31, 2020

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