LATIN AMERICA AND THE CARIBBEAN BUREAU ACTIVITY

SOCIAL HEALTH PROTECTION FOR WOMEN IN HIGH MIGRATION AREAS

LANDSCAPE ANALYSIS REPORT

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, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journeys to achieve self-reliance and prosperity.

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ACRONYMS

ACA	Affordable Care Act
ANC	antenatal care
ASEAN	Association of Southeast Asian Nations
BLA	bilateral labor agreement
CARICOM	Caribbean Community
CAN	Andean Community of Nations
CCSS	Costa Rica Social Security Fund
CHIP	Children's Health Insurance Program
CSME	CARICOM Single Market and Economy
COVID-19	2019 novel coronavirus
DACA	Deferred Action for Childhood Arrivals
ECLAC	United Nations Economic Commission for Latin America and the Caribbean
GBV	gender-based violence
GDP	gross domestic product
HIV	human immunodeficiency virus
IDB	Inter-American Development Bank
IDIQ	Indefinite Delivery Indefinite Quantity
ILO	International Labor Organization
IOM	International Organization for Migration
LAC	Latin America and the Caribbean
LHSS	Local Health System Sustainability Project
Mercosur	Southern Common Market
MMR	Maternal mortality ratio
MoH	Ministry of Health
MoU	memorandum of understanding
MSF	Médecins Sans Frontières

NGO	non-governmental organization
NTCA	Northern Triangle of Central America (El Salvador, Guatemala, Honduras)
OAS	Organization of American States
OECD	Organization for Economic Co-operation and Development
OOP	out-of-pocket
ORAS	Andean Health Organization
PAHO	Pan American Health Organization
PLISA	Health Information Platform for the Americas
PROSUR	Forum for the Progress and Development of South America
PRM	Population, Refugees and Migration
PTP	Temporary Resident Permit (Peru)
RMRP	Regional Refugee and Migrant Response Plan
SACM	South American Conference on Migration
SDG	Sustainable Development Goal
SHP	Social health protection
SGSSS	General System of Social Security and Health (Colombia)
SRH	sexual and reproductive health
SUS	Unified Health System (Brazil)
TMF	Border mobility card (Tarjeta de Movilidad Fronteriza) (Colombia)
UHC	Universal health coverage
UN	United Nations
UNASUR	Union of South American Nations
UNICEF	United Nations Children's Fund
UN DESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
US	United States
VA	Veterans' Affairs

1. EXECUTIVE SUMMARY

USAID's Local Health System Sustainability Project (LHSS) Latin America and the Caribbean (LAC) Bureau Activity seeks to strengthen the capacity of countries in the LAC region to provide and sustain equitable access to affordable, acceptable, and quality health services for women who are migrants or at risk of migration. This landscape analysis report on Social Health Protection for Women in High-Migration Contexts will provide the LHSS LAC Bureau Activity, USAID, national governments, regional stakeholders, and other development partners with an inventory of country experiences and strategies for improving access to social health protection (SHP) for women migrants and women at risk of migration. SHP encompasses a broad range of contributory and noncontributory schemes designed to help vulnerable groups access appropriate medical care without incurring costs beyond their means; these include social security, community health insurance, conditional transfer programs, and systems that reimburse private providers with public funds.

The findings from this landscape analysis will generate evidence on existing social health protection platforms in the LAC region to help influence policy to expand SHP for women living in high migration contexts. In addition, this report will inform country-specific assessments, reports and technical assistance to be provided by LHSS for two countries in the LAC region: a destination country for large numbers of migrants (the Dominican Republic) and an origin country with significant outflows of migrants (Honduras). Country-level reports will assess these issues within the Dominican Republic and Honduras contexts. The objective of this body of work is to accelerate progress towards key program results, helping to determine the barriers and priority health needs of women, and feasibility and sustainability of proposed SHP amendments.

METHODOLOGY

The information presented in this report was collected through desk review of published and gray literature and key informant interviews. The desk review encompassed literature that (1) provided analysis of key challenges for migrants to accessing social health protection and (2) identified country experiences in expanding and financing social health protection. To the extent possible, the review sought to identify issues and experiences specific to women migrants and women at risk of migration.

Key informant interviews were used to gather primary data from actors involved in health and migration programming at the regional level in LAC to uncover any specific challenges and significant efforts to improve SHP for migrant women populations and women at risk of migration in the region. Country case studies were developed to explore in more depth the key issues related to migration and SHP for women in high-migration contexts (Annex 1.) Key informants were drawn mainly from United Nations (UN) agencies. Annexes 3 and 4 describe the methodology and key informant interviews.

FINDINGS

The report first presents an overview of data on women migrants, drivers of migration for women, and the health status of women in origin countries, during the migration journey, and in destination countries in the LAC region. Following this, we discuss the findings from international and LAC regional experience in the following key areas:

- Access to social health protection for women in high-migration contexts;
- Strategies to improve social health protection for women in high-migration settings; and
- Financing expansion of social health protection for women in high-migration contexts.

Overview of women and migration

Migration patterns and flows in the LAC region have grown in size and complexity within the past decade. An estimated 4.2 million Venezuelan migrants are present in the region, with the highest numbers hosted by Colombia, Peru, Chile, Ecuador, and Brazil. While global migration has become increasingly feminized, the percentage of migrants that are women in LAC has remained at around 50 percent over the past 30 years; nevertheless, in some destination countries, like Colombia, there is a growing share of women migrants.

Understanding why women migrate can guide improvement of social health protection programs to influence migration decisions and to meet the needs of migrant women. The analysis finds that women in the LAC region face a wide range of experiences and pressures that may influence migration decisions. These include several pull and push factors, or a mixture of both.

Pull factors for migration

Availability of health services. Migrants often come from communities where health outcomes are poor and access to health services is disrupted, as is the case for Venezuela and Haiti. Countries with broader access to health services tend to attract migrants.

Access to social protection: In the LAC region, social protection programs have mixed influence on migration. In some instances, conditional cash transfers may contribute to the decision to migrate by financing the costs of migration while in others, they were found to decrease the propensity for migration. Therefore, access to social health protection can be considered both a pull and push factor.

Economic opportunity. Poverty is an important driver of migration from Central America, and increasingly, women are migrating in search of decent work and sustainable livelihoods.

Financial access to health services. Financial barriers to accessing health services may influence women's decisions to migrate in search of improved access to health and to generate remittances to finance health access in origin countries.

Labor policies of receiving countries. Sub-regional governance initiatives (e.g., the Southern Common Market and the Andean Community) in LAC have led to increased mobility of people among member countries.

Push factors for migration

Conflict and violence. Violence is recognized as an endemic public health issue in the LAC region and large numbers of migrant women identify direct attacks or threats as the main reason for fleeing their countries.

Gender-based violence. Many women in the region experience extreme forms of sexual and gender-based violence such as domestic violence, rape, and battery, by gangs or in their homes.

Involuntary migration. Trafficking and forced migration of women and girls for prostitution and forced labor is a form of gender-based violence that is growing internationally; in the LAC region, women constitute 80 percent of detected trafficking victims.

Climate change and natural disasters. Persistent drought, fluctuating temperatures, unpredictable rainfall, and severe hurricanes have increased food insecurity and loss of livelihoods, which has had a significant impact on mobility in Central America and the Caribbean.

Status of migrant women

Understanding the vulnerabilities faced by migrant women is key to expanding social health protection to ensure access to appropriate, high-quality services. In particular, it is important to consider the following:

Health status of women migrants. Women experience higher levels of health risks at all stages of migration. In Venezuela, widespread malnutrition and declining living standards mean that women migrants are likely to leave the country with existing health conditions. The migration journey exposes women to infectious diseases and arduous conditions that are especially serious for pregnant mothers.

Intersection of health and migration vulnerabilities. Many of the social determinants of migration also affect health and, therefore, social health protection needs. Migrant women may experience negative physical and psychological consequences from over-work, undernutrition, injuries, violence, accidents, and exposure to infectious diseases. They may also be more vulnerable to adverse pregnancy outcomes and find it difficult to comply with the 2019 novel coronavirus (COVID-19) prevention measures and to access vaccines.

Access to health services. Women migrants face multiple health access issues related to migration status, poverty and informal work, language barriers, low levels of education, and lack of information.

Access to social health protection for women in high-migration contexts

Most LAC countries have made significant efforts to allow recent migrants to access public services, although policies and practice vary across and even within countries. Women typically experience lower coverage rates and lower benefit levels of social health protection systems, and migrant women face particular legal, cultural, and other barriers. The most frequently discussed barriers include:

Labor markets. Migrant women are overrepresented in low-productivity and low-wage informal sectors and, as a result, are generally excluded from employment-related contributory social health protection, pensions, and retirement health plans.

Restrictive migrant policies. Undocumented women migrants may not be eligible for social health protection. Gender bias embedded in migration policies and regulations often leads to fewer opportunities for legal migration, increasing the number of undocumented migrant women.

Discriminatory gender norms. Access for women is also curtailed by discriminatory social and cultural norms and practices in the provision of social health protection and health services, as well as laws that criminalize certain services, such as abortion.

Health system capacity. Most countries in the LAC region have weak and fragmented health systems that could not guarantee universal access even before the demand created by migrant inflows and the COVID-19 pandemic.

Information gaps. Migrants and health providers may not understand and share information on how health systems are structured and the benefits that migrants can access.

COVID-19 pandemic. While not specific to women, there is emerging evidence that COVID-19 is exacerbating pre-existing inequalities and affecting emergency social protection programs.

Strategies to improve social health protection for women in high-migration settings

The literature indicates that governments, both globally and within the LAC region, need to develop the capacity to provide innovative approaches to expanding and managing social health protection, and that continued policy support is required to increase coverage and scale up migrant-friendly services in LAC. While the evidence of effective strategies to expand social health protection for women migrants was limited, the examples we found in the literature fall into three major categories.

Modify social health protection platforms to improve access for migrant women. International experience suggests that the most important step governments can take to improve migrants' access to health services is to provide them with the same legal entitlements as other residents. One example of this approach, which holds promise, is Colombia's recent decision to make all migrants eligible for national social health protection. Other successful strategies include allowing undocumented migrants to purchase insurance and implementing publicly mandated, private health insurance that is defined by a legal framework and subsidized and monitored by the state. Bilateral agreements across countries can help to protect migrant workers by establishing minimum standards for wages and benefits and access to health care or health insurance.

Improve health service delivery and accessibility. Strategies to improve social health protection for women migrants are likely to be more broadly effective if women's vulnerabilities and health needs are taken into account when planning, designing, and implementing systems and services. Examples underway in the region include support to countries to respond to local and migrant needs by creating integrated service delivery networks centered on primary health care services.

Strengthen the capacity of women to access social health protection. Programs to raise awareness about safe labor migration can ensure that women labor migrants understand and access the social health protection available to them in destination countries. In addition, migrant networks can play an important role in supporting integration into their host countries, including access to health protection and health care.

Financing expansion of social health protection for women in high-migration contexts

Expansion of social health protection will require additional funding in both origin and destination countries. The potential financing mechanisms available to meet the additional costs for migrants and people at risk of migration include both traditional and innovative mechanisms. What is most appropriate will vary from country to country, and a combination of mechanisms may be required.

Traditional mechanisms. These involve increasing budgetary space for migrant health using one of the following methods: raising additional government revenue, elevating the priority of spending on social health protection for migrants, or reducing inefficiencies in government spending. General government tax revenues and mandatory contributions are likely to be the main mechanism for sustainably increasing

the funding for social health protection. In the LAC region, this may require improving tax administration and collection, increasing tax rates and/or expanding the tax base. Where there is a large formal sector, mandatory contributions to finance social health protection could be increased to cross-subsidize people in the informal sector.

Innovative financing approaches. Options depend on country context factors. However, a single innovative financing scheme would not likely be sufficient to meet gaps in funding for migrant health protection. Innovative mechanisms that could be used in LAC to raise public financing, private financing, or a combination of the two include both tested and untested strategies:

Tested innovations for social health protection

- Remittance-funded health insurance products, which offer the possibility for migrants to buy in to government or private programs, thereby providing more predictable financial protection.
- Earmarking government revenue, which may help generate a budget for social health protection for migrants but is generally accepted to not be a good public finance practice and it is unlikely to provide a sustainable source of additional funds.

Innovations that are untested for social health protection

- Development impact bonds which may contribute to financing SHP through improved or expanded service delivery and accessibility for people in high migration contexts. For example, a government or donor might enter into a performance-based contract with providers to cover migrants for specific services. Even though there are multiple examples of impact bonds in Latin America, including in Colombia and Peru, this has not been tested for SHP.
- Debt swaps and blended finance may have potential to contribute to improved SHP through funding improved service delivery and accessibility for migrants and people at risk of migration. However, there is little evidence on feasibility of applying such approaches to addressing SHP for migrant populations.

RECOMMENDATIONS

1. **Governments and other stakeholders, potentially with the support of development partners, should seek to address both migrants' immediate health access needs and long-term improvements in social health protection platforms.** Countries experiencing increased immigration are challenged to implement measures to meet the needs of migrants alongside those of local populations, including the increased demand for health services in both the short and the long term. International donors should support government efforts by strengthening existing government and multilateral networks working on social health protection, health, and migration issues to enhance knowledge sharing, cross-border coordination, and capacity building for governments to respond to increased health demands.

2. **Governments should seek to integrate migrants into national health systems and policies.** The long-term management of migrant health care is best assured when integrated into existing national policies, with provisions to facilitate the enrollment of migrants into the public health care system. Integration into national health systems can improve services and outcomes for both nationals and migrants, and minimize disruption associated with large-scale flows. The February 2021 policy announced in Colombia represents a new example of this idea.

3. **Governments and other stakeholders, including development partners, should further explore the potential for private sector, blended finance, or other mechanisms to address the financial challenges of expanding SHP for women migrants.** The landscape analysis has begun to identify approaches to expand health service coverage for migrant women that might be scaled up and sustained using innovative financing tools to augment and encourage increased public spending for health protection. As they begin to explore innovative financing approaches, USAID, other development partners, and development finance institutions have an opportunity to provide support in structuring and participating in instruments.

4. **Governments and other stakeholders, including development partners, should address information gaps.** While there is a large amount of information about migration, including with a focus on the health, there is less information in the literature specific to migrant women and women at risk of migration, or on efforts that countries may be implementing to specifically improve social health protection coverage (rather than health service coverage) for these groups. The systematic collection of data on these issues by governments would allow a better understanding of actual situations and needs; the formulation of more specific, tailored, and quantified responses; and understanding of the effectiveness and impact of country efforts.

2. INTRODUCTION

2.1 BACKGROUND AND METHODOLOGY

USAID's Local Health System Sustainability Project (LHSS) Latin America and the Caribbean (LAC) Bureau Activity will strengthen the capacity of countries in the LAC region to provide and sustain equitable access to affordable, acceptable, and quality health services for women who are migrants or at risk of migration. To inform this effort, LHSS has conducted a landscape analysis of social health protection (SHP) efforts, needs, and challenges, including those specific to women. SHP encompasses a broad range of contributory and noncontributory schemes designed to help vulnerable groups access appropriate medical care without incurring costs beyond their means; these include social security, community health insurance, conditional transfer programs, and systems that reimburse private providers with public funds [1].

The landscape analysis seeks to answer the following questions:

- Which strategies and financing mechanisms have countries implemented to improve SHP platforms for women migrants and women at risk of migration?
- How well do current SHP platforms in destination and origin countries meet the needs of migrant women and women at risk of migration?
- What lessons can be learned from country experiences to improve design, implementation, and sustainable financing of SHP for women migrants and women at risk of migration?

We also developed country case studies that examine pairs of origin and destination countries in the LAC region and extract key findings related to health, SHP, and financing. These are presented in Annex

1. An overview of international and regional frameworks for addressing SHP and women's migration is presented in Annex 2.

The findings will increase understanding by USAID and other development partners of the link between SHP and migration, and document evidence of successful strategies for improving and sustainably financing SHP platforms to better meet the needs of women migrants and women at risk of migration. The landscape analysis was conducted through a desk-based literature review and stakeholder interviews. A detailed description of the methodology is provided in Annex 3.

3. OVERVIEW OF WOMEN AND MIGRATION

The following section provides an overview of the data on migration and women migrants within the LAC region, drivers of migration for women, and the health status of women in origin countries, during the migration journey, and in destination countries.

3.1 MIGRATION AND THE LAC CONTEXT

The International Organization for Migration (IOM) defines a migrant as any person who is moving or has moved across an international border or within a state, away from their habitual place of residence, regardless of the person's legal status; whether the movement is voluntary or involuntary; the cause of the movement; or the length of the stay [2]. International migrants are persons who are either living in a country other than their country of birth or in a country other than their country of citizenship [3]. Regular migration is defined as "migration that occurs in compliance with the laws of the country of origin, transit and destination". Conversely, irregular migration refers to the "movement of persons that takes place outside the laws, regulations, or international agreements governing the entry into or exit from the State of origin, transit or destination" [4].

The LAC region has been facing an "unprecedented migration crisis," characterized by intra-regional and extra-regional migration patterns and flows that have grown in size and complexity [5, 6]. Between 2010 and 2019, the number of migrants in the region grew from 6.6 million to 11.7 million [160]. Migration northward continues to be the predominant trend in Central America, Mexico, and the Caribbean. In 2019, migration from LAC to North America was second only to Europe-Europe movement, with more than 26 million migrants from LAC residing in the United States and Canada [8].

Venezuelan migration is the largest human mobilization in the region's recent history. Political and economic turmoil and the resulting humanitarian crisis have displaced an estimated 5 million people, with the vast majority (4.2 million) staying within the region: Colombia hosts 1.8 million Venezuelan migrants; Peru hosts 861,000; Chile, 455,500; Ecuador, 366,600; and Brazil, 253,500 [9]. There have also been several periods of migration from Nicaragua to Costa Rica; as of 2018, migrants from Nicaragua constitute roughly 2 percent of the population of Costa Rica [7]. Haitian migrants in the United States number more than 680,000 and Haitians make up the largest migrant group in the Dominican Republic, with the most recent flows occurring in the wake of the 2010 earthquake and 2016 hurricane 10]. The IOM estimates that one million people of Haitian descent live in the Dominican Republic [11].

3.2 GENDER DATA IN MIGRATION

While global migration has become increasingly feminized [12], the percentage of migrants that are women in LAC has not changed considerably in the past 30 years, rising from 49.5 percent in 1990 to 50.1 percent in 2000 to 50.3 percent in 2010 [13]. The Inter-American Development Bank (IDB) points to heterogeneity of migration patterns across LAC countries resulting in differences in the breakdown by gender within their immigrant populations. Argentina, Costa Rica, Nicaragua, Panama, and Uruguay tend to have larger shares of female migrants than male migrants, while the opposite is true for Brazil, Paraguay, Peru, and the Dominican Republic [14]. In 2020, the countries in LAC with the highest percentage of female migrants were El Salvador (52.4 percent) and Guatemala (52.7 percent), while the Dominican Republic had the lowest percentage of women migrants in the region (36.6 percent). In some destination countries, there is a growing share of women migrants; for example, between 2015 and 2020, the number of migrants in Colombia increased by 49.6 percent overall, but the annual rate of change for women migrants was 51 percent [13]. Outside of the region, the highest proportion of migrant women from LAC was recorded in North America, at 51.8 percent in 2019 [3].

There is also substantial diversity across the countries in the age distribution of the migrants. In some countries the share of the migrant population of working age (between 15 and 64) is below 50 percent, while elsewhere it is larger than 80 percent, most notably in Costa Rica, Chile, the Dominican Republic, and Panama [14]. In 2017, there were 6.3 million migrants under the age of 18 in LAC. Notably, many of these are unaccompanied and have unique social and health needs [15].

3.3 DRIVERS OF WOMEN'S MIGRATION

Women at risk of migration in the LAC region face a wide range of influences and pressures. As recently as March 2021, investigative journalism has found increasingly desperate women migrants from the Northern Triangle of Central America (NTCA) countries citing a range of reasons—lawlessness, violence, lack of economic opportunity, and gender-based violence (GBV)—as the drivers for their migration [16]. Understanding why women migrate, including the role played by health and social protection, can guide policymakers to develop SHP programs to influence migration decisions and to meet the needs of migrant women in destination countries. In this section, we describe factors recognized in the literature as important in women's migration decisions and, where possible, discuss how these drivers are experienced in the LAC region.

Economic opportunity. A study of migrant women detained in Mexico City found that while most identified complex, multi-faceted reasons for migrating, almost 80 percent said they migrated primarily for economic purposes, also citing the need to avoid violence and insecurity [28]. The 2020 World Migration Report identifies poverty as an important driver of migration from Central America, including of intraregional migration of Nicaraguans, Panamanians, and other Central Americans to Costa Rica for temporary or permanent labor, and migrants from Honduras, Guatemala, and El Salvador to Belize because of instability and a lack of employment opportunities [8]. Increasingly, women are migrating in search of decent work and sustainable livelihoods [29]. For example, 73.4 percent of domestic service migrant workers globally are female and are more likely to be the lead migrant within their families [19].

Conflict and violence. Although localized to certain countries, violence is recognized as an endemic public health issue in the LAC region that is an important driver of migration. With only 10 percent of the world's total population, the region generates 25 to 30 percent of the world's homicides. The

regional homicide rate is about four times the global average, and in the NTCA countries of Guatemala, Honduras, and El Salvador, as much as five to seven times higher. An estimated 500,000 people from the NTCA enter Mexico every year fleeing violence and poverty, according to the United Nations High Commissioner for Refugees (UNHCR) [32].

The 2020 World Migration Report notes a significant increase in the number of asylum claims from Central America and Mexico, accounting for 54 percent of all asylum claims in the United States in 2017. Migrants from El Salvador made up the majority of applicants (over 33,000), followed by those from Guatemala (around 33,000) and then Venezuela (27,500) [8]. A 2016 Médecins Sans Frontières (MSF) study found that almost 40 percent of migrants from NTCA countries identified direct attacks or threats as the main reason for fleeing their countries [32]. The UNHCR interviewed Central American women seeking asylum in the United States and 64 percent cited risk of rape, assault, extortion, and other threats as their main reason for migrating [28].

Gender-based violence. High levels of physical, sexual, economic, verbal, and psychological violence against women are pervasive in the LAC region [7]. Many women in the region experience extreme forms of sexual and GBV, such as domestic violence, rape, and battery, by gangs or in their homes [28]. El Salvador has the highest rate of femicide globally, and Guatemala and Honduras feature at third and seventh place, respectively, in the global femicide index [33].

Access to social protection. Inadequate social protection systems in the place of origin may be a contributing factor in the decision to migrate in search of better living conditions [17]. A review of evidence on how access to social protection programs, in general, influences decisions to migrate found that the potential impact depends on the mechanism as well as the contextual factors driving migration. For example, having access to social protection programs could be perceived as a factor to stay in order to continue to access financial benefits or as a way to finance the migration journey, depending on the context and priorities of prospective migrants [18]. The United Nations Children's Fund's (UNICEF's) 2016 Health Equity report also cites studies that point to mixed experiences of the influence of broad social protection programs on migration decisions. The report points to "a near balance of positive and negative impacts on migration", with ten studies finding that access to social protection in origin countries increased migration; ten studies finding that it did not; and a further five studies finding no impact on migration [12].

A study of conditional cash transfer programs in the LAC region found that such social protection efforts have had mixed results in their influence on migration. In some instances, the transfers contribute to the decision to migrate, either by financing the costs of migration or because the cash transfer is insufficient to meet household needs [18]. Mexico's social insurance system, which subsidizes medical care and daycare, has been shown to lower the propensity to migrate, and similar outcomes have been found for conditional cash transfers in Brazil. Specifically, the Procampo conditional cash transfer and social insurance (including health benefits) in Mexico, as well as Bolsa Familia in Brazil were found to decrease the propensity for migration, while findings were mixed for the Oportunidades program in Mexico and the Programa de Asignación Familiar Red de Protección Social in Honduras and Nicaragua [18].

Financial access to health services. In both origin and destination countries, women face financial barriers to accessing health services [19]. Women consistently experience higher out-of-pocket (OOP)

and catastrophic costs for health care services than men who have similar levels of insurance coverage, in part due to limits on coverage for sexual and reproductive health (SRH) services. Insurance co-pays and other user charges, no matter how small, pose a significant barrier for women who lack autonomy, decision-making power, and information about service access [20].

Data for several LAC countries, including Brazil, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Jamaica, and Mexico show that women across all income groups report challenges in accessing health care because of financial barriers. Across countries, between 37 percent and 90 percent of women in the lowest income groups have reported such problems [21]. Throughout the region, remittances have been shown to be important for meeting the costs of health services in origin countries [22]. In Nicaragua, for example, a survey of 200 families of migrants and repatriated migrants showed that about 48 percent of remittances are used to pay for health services; and in Ecuador, remittances are used for both preventive and emergency situations [23].

Availability of health services. World Health Organization (WHO) examinations of migration patterns have found that migrants often come from communities where health outcomes are poor and health services are disrupted as a result of war, conflict, economic crisis, or climate shocks [24]. In the LAC region, for example, Venezuela's health system has collapsed to the point where basic infrastructure and services are unavailable; as a result, by January 2019, 10 percent of all Venezuelans diagnosed with human immunodeficiency virus (HIV) had left the country [25, 26]. "Pendular" migrants from Venezuela cross the border to Colombia to access health care services and return to Venezuela after doing so [27]. Hundreds of pregnant women are among those crossing to access necessary health care. Conditions are similar for other groups of women throughout the LAC region who are forced to seek health care in other countries. For example, women pendular migrants from Haiti in the Dominican Republic predominantly seek pre- and post-natal care, as well as treatment for chronic conditions.

Labor policies of receiving countries. Sub-regional governance initiatives in LAC impact labor migration. For example, the economic integration agreements of the Andean Community (CAN) and the Southern Common Market (Mercosur) have led to increased mobility of people among member countries [30]. Both bodies have adopted agendas, agreements, and measures to jointly manage labor markets by adopting standards that provide for the free movement and residence in the host country, and the right to work ensuring the respect for the principles of equal treatment and opportunities, especially in terms of wages, working conditions, and social security. CAN has adopted the Andean Labor Migration Instrument, the Andean Instrument on Social Security, and the Andean Instrument on Occupational Safety and Health at Work. Member countries have signed and adopted the Mercosur Agreement on Residence and the Multilateral Agreement on Social Security. In the Caribbean Community (CARICOM), agreements cover the free movement of 11 categories of migrant workers among Member States [31].

Involuntary migration. Trafficking and forced migration of women and girls for prostitution and forced labor is a form of GBV that is growing internationally; in the LAC region, women constitute 80 percent of detected trafficking victims. Flows mainly move from south to north, from the relatively poorer towards relatively richer countries [34]. Human trafficking has been on the rise among Venezuela's migrant population, from 2.3 percent in 2015 to 6.2 percent in 2018 [35]. Root causes of trafficking, such as poverty and a lack of legal avenues for migration, overlap with the drivers of irregular migration [36].

Climate change and natural disasters. The 2020 World Migration Report highlights the impact of climate change on mobility in Central America and the Caribbean [8]. Persistent drought, fluctuating temperatures, and unpredictable rainfall have reduced crop yields throughout the NTCA, increasing the risk of food insecurity and loss of livelihoods. In 2020, hurricanes and the COVID-19 pandemic have contributed to a huge rise in the levels of food insecurity. A recent survey found 15 percent of people in these countries are now planning to migrate, almost twice the proportion of 8 percent from 2018 [37].

Haiti is still recovering from the earthquake of 2010 and Hurricane Matthew in 2016, and infrastructure and water and sanitation systems have still not recovered [35]. While 60 percent of female-headed households had been living in extreme poverty before the earthquake, working in the informal sector, and earning less than half of men's wages, reconstruction and recovery efforts have been gender blind, further exacerbating gender inequality [38]. This has contributed to the migration of Haitian women to the Dominican Republic, United States, Turks and Caicos, and Bahamas and more recently, to Brazil, Argentina, and Chile [39].

3.4 PROFILE OF WOMEN MIGRANTS

Women migrants face similar and multiple vulnerabilities linked to the complex intersection of gender and social issues, such as class or caste, nationality, ethnicity, age, disability, race, sexual orientation, and gender identity. These dynamics impact how women migrants experience discrimination, exclusion or inclusion, and power relations across various geographies and at different points of the migration journey [40]. Understanding these dynamics is key to expanding SHP in destination countries to ensure access to appropriate, high-quality health services.

3.4.1 HEALTH STATUS OF MIGRANT WOMEN

Women experience higher levels of risk at all stages of migration than do men, including a greater probability of undocumented migration. Women are more likely than men to experience emotional and physical abuse and financial exploitation and face a range of barriers to accessing SRH services; this should inform the design of SHP programs [41, 42]. On average, migrants will use a different mix of services and national SHP schemes should ensure these are included in the benefit package. Given the adverse security and health risks women migrants face, national SHP schemes should cover comprehensive SRH services.

In Venezuela, widespread malnutrition and declining living standards have resulted in the rapid deterioration of the population's health status, including women at risk of migration [27]. SRH indicators are worsening, including increases in maternal mortality, adolescent pregnancy, and HIV infection. From 2015 to 2016, the last years with official information available, maternal mortality rose by more than 65 percent, while infant mortality increased by more than 30 percent [35]. The country has also been facing the resurgence of vaccine-preventable and vector-borne infections that pose health risks to the population at the borders, particularly women, infants, and children [43].

During the migration journey, women are exposed to arduous conditions that may worsen their already poor health status. Diseases such as malaria, gestational syphilis, and HIV, as well as gender-based and sexual violence, have increased dramatically in this population, according to data reported in Colombia, the main country of destination. Health conditions are especially serious for pregnant mothers, who

arrive without having accessed prenatal care [44]. A study of Venezuelan migrant women in Brazil found that the main health issues reported were unmet family planning needs and healthcare during pregnancy and following childbirth [43].

Intersection of health and migration vulnerabilities. The literature shows that there is a large overlap between the factors influencing the health of migrant women and drivers of migration, suggesting that many of the social determinants of migration are also social determinants of health and, therefore, affect SHP needs. Immigrants and particularly those from ethnic minority groups generally experience a lower socio-economic status than nationals, resulting in health inequalities. [12].

Specifically for women care workers, the literature documents negative physical health consequences related to over-work, undernutrition, injuries, violence, accidents, and exposure to infectious diseases. Many migrant women care workers experience poor reproductive and sexual health. There is also evidence that they are subject to physical violence, including sexual harassment, assault, and regular beatings.

A recent *Lancet* article on the mental health of Venezuelan migrants in Colombia found that they experience psychological stressors that include existing, untreated mental health disorders; loss and separation from home and family; dangerous migration journeys; migration status; COVID-19 risk and prevention measures; increasing xenophobia. A study that assessed depression, generalized anxiety, and post-traumatic stress disorder in Colombian women who were internally displaced from conflict-affected areas to Bogotá also found that 63 percent reported symptoms of at least one of these conditions [45].

In some countries, migrant women face discrimination based on pregnancy or their maternity status and may be subjected to mandatory pregnancy tests upon arrival [40]. A systematic review of perinatal outcomes among refugee and asylum-seeking women found adverse pregnancy outcomes complicated by poor access to health care and identified the need to overcome access barriers and tackle inequalities in this vulnerable population [46]. In 2013, another study from Colombia found that forcibly displaced persons live in situations of poverty in their new cities and often face discrimination due to their informal employment and need for public assistance. In Argentina, Guaraní-speaking Paraguayans often face language and cultural barriers in their new cities, and Bolivian migrant women encounter social exclusion and ethnic and gender inequalities in work settings [12].

COVID-19 has exacerbated vulnerabilities for migration and health (see Exhibit 1). Among the effects are reduced mobility within and across borders, interrupting migrants' movement and leaving thousands stranded across the region. Others were forced to return to the same danger, social

Exhibit 1. Impact of COVID-19 pandemic on migrant women.

Stakeholder interviews point to the following ways in which the COVID-19 pandemic has affected migrant women:

- Increased poverty and decreased access to services
- Increased xenophobia
- Increased frequency of human rights violations, including deportation and trafficking
- Gender-blind responses to address different vulnerabilities
- Lack of access to SRH and other essential services
- Disproportionate socio-economic impact
- Exclusion from social protection measures and vaccination
- Closed borders limit economic and health-seeking options

exclusion, inadequate health care, and poverty they had fled. Migrant women who were trapped in transit, or who were living with undocumented or irregular status, became even more vulnerable to family separation, trafficking, or exploitation [47]. COVID-19 prevention measures are challenging for, and may exclude, migrant populations as a result of poor public health communication, reduced access to public health approaches such as handwashing, and living or working in conditions where it is difficult to isolate [47].

Recently, the UN Network on Migration expressed concern that migrants may be left behind in national COVID-19 vaccine campaigns [48]. In Colombia, the government's early assertion that irregular Venezuelan migrants would not be eligible for the government-provided COVID-19 vaccine was followed, in February 2021, by a dramatic announcement that all migrants from Venezuela would be regularized for 10 years. Colombia received its first COVAX vaccines on March 10, 2021, but much uncertainty lingers for migrants who are not yet regularized and have no clear path to access the vaccines [49]. In February 2021, the Dominican Republic announced a vaccination plan that offers free vaccines to citizens and legally resident foreigners but does not include those who are irregular immigrants. Among the people affected by this decision are the children who were born in the Dominican Republic but have not yet obtained their papers [50].

Access to health services. In addition to unique health challenges, there are unique health access issues for women migrants in destination countries (see Exhibit 2). For example, Haitian women migrants, who are among the most vulnerable to HIV in the Dominican Republic, face barriers related to anti-Haitian stigma, language differences, and limited social resources even though they experience better economic opportunities and access to healthcare than in Haiti. In general, Haitian women are often limited to low-paying non-technical jobs, and low levels of education and lack of information about services affected undocumented women, in particular. For all individuals of Haitian descent, regardless of immigration status, language and the cost of medicines were also barriers to seeking healthcare services [51].

Exhibit 2. Barriers to health service access for migrant women.

Stakeholder interviews point to the following ways barriers to health services:

- Lack of awareness about access to health services in destination countries
- Disruptions to continuity of care across borders
- Inadequate information sharing, e.g., health cards for immunization, pregnant women, HIV
- Varying national protocols for ARV and other treatment regimens
- Inadequate data on the health needs of migrant women for planning
- Insufficient financing to support expanded service provision

4. ACCESS TO SHP FOR WOMEN IN HIGH-MIGRATION CONTEXTS

WHO defines SHP broadly as "affordable health insurance or government-funded health services" [52]. The Pan-American Health Organization (PAHO)/WHO further elaborates that SHP can be understood as "the guarantee that all individuals and communities can satisfy their health needs and demands, without their ability to pay being a limiting factor, approaching health as a fundamental right and a requirement for human and social development". In practice, SHP encompasses a range of contributory and noncontributory schemes, such as social security, micro-insurance (community health insurance), targeted plans, and conditional cash transfer programs [1]. SHP may also include private insurance, such

as private employers that offer their employees private insurance options (not just payroll contributions to the public scheme). Furthermore, a system that channels public funding directly to service providers without an intermediary also provides SHP.

4.1 ACCESS TO SHP IN LAC COUNTRIES

To support universal health coverage (UHC) and improve population health outcomes, LAC countries have expanded social protection coverage (both health and pensions), increased social spending, and increased efficiency in social assistance. Countries in the region have implemented diverse coverage models; most countries, including Argentina, Chile, Colombia, Mexico, Peru, and Uruguay, have contributory schemes with separate pooling arrangements that subsidize enrollment of the poor, and differing degrees of integration of these two systems [53].

The region has also made progress in establishing a menu of SHP systems aimed at guaranteeing access to health care to mothers and children, but these have achieved varying degrees of success [54]. Between 1990 and 2015, the regional maternal mortality ratio (MMR) fell by 52 percent, but this reflected progress primarily among populations with higher socio-economic status; today, maternal deaths continue to be disproportionately concentrated among more disadvantaged women and ethnic minorities [12]. Inequalities persist across and within countries in reproductive, maternal, neonatal, child and adolescent health, as well as in areas such as non-communicable diseases; these especially affect women in low-income settings and from ethnic minority populations [55, 12].

Maintaining achievements in expanding SHP is increasingly difficult in the face of complex migration flows that are altering the demographics of countries throughout the LAC region. Most LAC countries have made significant efforts to allow recent immigrants to access public services, although policies and access in practice vary across and even within countries (see Exhibit 3 for details). A 2020 IOM survey of Venezuelan migrants shows significant levels of access to health care in their destination countries: Brazil (87 percent), Chile (80 percent), Paraguay (61 percent), Costa Rica (59 percent) and Trinidad and Tobago (57 percent). In contrast, 62 percent in Guyana reported having no access [56].

As recently as June 2020, the IDB has found that "[i]n terms of strict affiliation (full access) to health care systems (whether public or private), the gap between the affiliation rates of immigrants and of natives varies across hosting countries in the region". The gap is particularly large for irregular migrants in Colombia (68 percentage points) and in the Dominican Republic (57 percentage points), followed by Mexico (28 percentage points), Peru (25 percentage points), and Panama (21 percentage points) [57]. Several countries, such as Brazil, Chile, Costa Rica, Ecuador, Mexico, and Panama, do not restrict access to the health system based on nationality [58]. Other countries, including Colombia and Peru, do not have universal systems but do have public insurance options, with some limited access for migrants. Colombia's health system is among the most generous of the three countries, providing urgent treatment for more than 24,000 Venezuelans in 2017, according to Colombia's Ministry of Health (MoH) [59]. In Peru, access is more limited; according to a 2018 survey, 92 percent of Venezuelans in the country lacked health insurance [7]. Political will to change the regulations to allow expanded enrollment for migrants may be limited because the system had begun to collapse even prior to the Venezuelan crisis and challenges have worsened in the context of the COVID-19 crisis [60].

Exhibit 3. Migrant access to health services and SHP in LAC countries

Country	Access to health care
Argentina	Migrants are predominantly attended to through the public network of primary-care centers in communities throughout the country and can access all types of public health care using an identity document from their country of origin. In practice, staff at health care centers require an Argentinian identity document [7].
Brazil	Legal residents are entitled to access the country's health care system and eligible for the national health card but report encountering language barriers and discrimination. Migrants who do not have legal status are limited in the services they can access. [61].
Chile	Regular migrant status is required for health care access. Policy implementation at the level of clinics and hospitals is inconsistent, hinging on training of staff at health centers and the prevalence of discriminatory practices [62].
Colombia	Public healthcare is available without cost to everyone in the country regardless of immigration status. Venezuelan immigrants with Special Permanency Permit can access both the contributory and subsidized versions of the public insurance system, depending on their income levels. International organizations have filled in some of the gaps for irregular migrants. The definition of emergency care is also expansive, and all migrants are entitled to this, although resource limitations prevent its full implementation [63]. In February 2021, the government announced that temporary protective status would be offered to displaced Venezuelans, which will guarantee access to the national healthcare system as well as the Covid-19 vaccine [64].
Costa Rica	The public and private insurance system is meant to provide universal coverage. Migrants with regular status can access the social security system, which provides health insurance through formal employment, but irregular migrants (who do not have work authorization) cannot. Private ("voluntary") insurance is available to anyone, but it is expensive. Costa Rica's social security agency signed an agreement with UNHCR in December 2019 to insure 6,000 refugees and asylum seekers using UNHCR funding for one year, beginning January 2020. This agreement is an important step forward in covering the most vulnerable migrants, though thousands more will remain uninsured [7].
Dominican Republic	All immigrants can access public health services and social security, regardless of their legal status. However, a 2020 PAHO/WHO study found that service coverage for Haitian migrants, at 69 percent, was significantly lower than coverage for native Dominicans, at almost 80 percent. Furthermore, access to services is limited by the capacity of migrants to pay, as only citizens can register for subsidized national insurance [65].
Ecuador	Healthcare providers, by law, may not turn someone away due to their immigration status, but this has been reported to happen, even in emergency situations. The Daily Automated Registry of Outpatient Consultations and Care (RDACAA) for monitoring migrants' access to health services has been implemented in all institutions of the National Health System [55].
Guyana	Although Guyana's health system aims to guarantee universal coverage, it does not have the resources to do so. Unlike in many other receiving countries, Venezuelan migrants in Guyana are mainly moving to rural areas near the border with Venezuela—areas where residents have long struggled to access adequate care [7].

Country	Access to health care
Mexico	The "Juntos por la Salud" Initiative was created as an extension of the "Ventanillas de Salud" program to reach migrants living in remote inaccessible communities. The initiative operates through mobile units offering free services such as mental health support, vaccination, screening, referrals, legal advice, and general advice on health care.
Panama	Panama, like most other Central American countries, has a dual healthcare system, with both private and public options. Anyone may use either system, but the public system aims to provide medical services to citizens and residents who are enrolled in the Caja de Seguro Social (social security program). Health services are not free, although they are accessible. Migrants must pay the same costs as Panamanians for such services, without discrimination. If the person cannot pay, the hospitals' social work department will conduct an evaluation and allow payment in installments. There are health centers in each district, where refugees and applicants for refugee status can go [66].
Peru	Only migrants with identity documents (carnets de extranjería) can access the Comprehensive Health System (Sistema Integral de Salud, or SIS)—Peru's public health insurance, which has both contributory and subsidized plans. In addition to irregular migrants, those with Temporary Residence Permits (PTP) cannot access SIS as they do not receive carnets de extranjería [7].

4.2 BARRIERS TO ACCESSING SHP FOR WOMEN IN HIGH-MIGRATION CONTEXTS

Women typically experience lower coverage rates and lower benefit levels of SHP systems, and migrants face legal, cultural, and other barriers that impede their internationally recognized right to health [67, 68]. Of the international migrants who are working in other countries, only some 22 percent are estimated to be covered by social protection and, while sex-disaggregated data are limited, evidence suggests that migrant women struggle to access SHP that responds to their needs [69]. In this section, we present the most frequently discussed barriers in the literature reviewed.

Labor markets. As previously discussed, migrant women are overrepresented in low-productivity and low-wage informal sectors and as a result, are generally excluded from employment-related contributory SHP, pensions, and retirement health plans. For example, in the United States, in 2016, 34 percent of the 6.4 million non-citizen immigrant women of reproductive age were uninsured, compared to 9 percent of United States-born women [70].

Migrant women who are involved in sex work face a lack of access to health and social protection services on account of their mobility, increased insecurity, and legal restrictions related to sex work. Even in countries where sex work is regulated, for example, in Canada, New Zealand, Finland, the Netherlands, and Singapore, migrant sex workers are excluded from SHP mechanisms. Throughout LAC, migrant sex workers cannot benefit from state agreements such as those set by Mercosur countries and so, lack labor rights and protections [71].

Restrictive migrant policies. Access to SHP for women migrants is shaped by legal frameworks governing the regulation of migration status, and gender bias embedded in migration policies and

regulations often leads to fewer opportunities for legal migration, increasing the number of undocumented migrant women [19].

Undocumented women migrants may not be eligible to access the SHP that is available to documented migrants, particularly in countries with more privatized health care systems, and are less likely to apply for benefits or seek care, fearing that they will jeopardize employment opportunities and citizenship applications [19, 72]. In addition, women who are the spouses and family members of migrant workers and do not have independent migration status are unable to seek employment or access social security benefits [69].

One example of how legal barriers can impede access for women migrants even where SHP is not linked to formal employment is the Dominican Republic, where a 2013 law stripped tens of thousands of people of Haitian descent of Dominican citizenship. In addition to depriving them of their right to nationality, this law has served to exclude people of Haitian descent from accessing any form of state assistance, including SHP. For women within this population, this has meant that SRH care is unavailable. Women of Haitian descent also face problems in registering their Dominican-born children for SHP because they do not have birth certificates [73].

In the United States, although most documented immigrants are eligible to purchase private coverage through the Affordable Care Act's (ACA's) health insurance marketplaces using premium tax credits and cost-sharing subsidies, undocumented immigrants are barred from marketplace coverage [19]. Many more migrants, and their United States-born children, are uninsured than are citizens and even with insurance they have less access to care [74].

Discriminatory gender norms and inadequate coverage of women's health issues. In the LAC region, in both origin and destination countries, PAHO/WHO has assessed micro-insurance policies and community health insurance as typically unable to provide the full range of health services that women need, as these schemes tend to exclude SRH services. Other SHP mechanisms reinforce gender norms and societal prejudices about women's reproductive and caregiving roles, by prioritizing maternal and child health services while ignoring women's comprehensive health needs; and conditional transfer programs target women in their roles as mothers and caregivers [1]. Access for women is also curtailed by discriminatory social and cultural norms and practices in the provision of health services, as well as laws that criminalize certain services, such as abortion. These norms and practices include third party authorization requirements, such as parental or spousal consent; lack of information, education, and decision-making power; and health care workers' prejudices [40].

Pension-related schemes also discriminate, including by establishing lower retirement ages for women and lower maternity and survivor benefits. Lower retirement ages translate to fewer working years to build up a pension entitlement in a contributory scheme and so, women end up with lower pensions. Lower pensions translate into a decreased ability to pay for (and access) health services in old age. Over 85 percent of the countries in which there is no gender gap in effective pension coverage have noncontributory pensions; this is usually universal or means tested [67]. PAHO/WHO reports that in 10 LAC countries where data is available, the percentage of women 65 years or older who receive some kind of pension in urban areas is 51.5 percent; for men, it is 63.5 percent. Also striking are inequalities between countries in access to pensions, with women's access rate ranging from 11 percent to 92 percent; in the case of men, from 16 percent to 95 percent (considering contributory and non-contributory retirement and pensions) [1]. To mitigate this discrepancy, International Labor

Organization (ILO) Recommendation 202 on social protection floors sets out that states should provide universal and gender-neutral access to essential health care and basic income security in every stage of life [67].

Health system capacity is an important limitation to provision of SHP that meets the needs of women migrants and women at risk of migration. For example, although policies in Argentina, Ecuador, Guyana, and Trinidad and Tobago guarantee care to anyone who needs it, this does not translate to universal access in practice, as health systems that are already under-resourced can quickly become overwhelmed by additional demand for services, resulting in poor quality and constrained access for migrants [7]. The United Nations Population Fund (UNFPA) reports that most countries in the LAC region have weak and fragmented health systems that cannot guarantee universal access even before the additional demand created by migrant inflows and the COVID-19 pandemic [75].

Even where national policies and legally guaranteed access to care exist, migrants report discrimination and barriers such as a lack of confidentiality, high costs, and language and cultural barriers [75]. These can prevent many migrant women from accessing SHP, especially if registration processes are unfamiliar, complex, burdensome, and disrupt continuity of care, resulting in acute and chronic health conditions being inadequately addressed [68, 22].

Information gaps. While many destination countries offer migrants access to emergency health care, the types and extent of other available services vary, particularly for women. Often, it is unclear exactly which services are available to migrants, and access to health care is limited because both migrants and health providers do not understand and share information on how health systems are structured and the benefits that migrants can access. This especially disadvantages newly arrived and undocumented migrants [68].

COVID-19 pandemic. As mentioned in Exhibit 1, migrants have been adversely impacted by the proliferation of COVID-19 cases due to increased xenophobia, increased poverty, and exclusion from social health protection measures and vaccination. While not specific to women, there is emerging evidence that COVID-19 is exacerbating pre-existing inequalities and vulnerabilities, including among migrant groups, and affecting emergency social protection programs [76]. For example, the proportion of the Colombian population finding integration of Venezuelan migrants unfavorable has increased from 67 percent in February 2020 to 81 percent in April 2020 [77].

5. STRATEGIES TO IMPROVE SHP FOR WOMEN IN HIGH-MIGRATION SETTINGS

In this section, we present strategies discussed in the literature for expanding SHP for women at risk of migration in origin countries and women migrants in destination countries. While implementation challenges to ensure genuine inclusion of migrants persist, lessons point to the need for government capacity to innovate and manage expanded SHP, and for continued policy support to increase recruitment to the SHP scheme and to scale-up migrant-friendly services. Importantly, external political pressure can push governments to take action in support of better healthcare for migrant populations [78]. We identified three main types of strategies to expand SHP for women that are implemented in

both origin and destination countries: modifying existing SHP platforms; improving health service delivery and accessibility; and supporting women's capacity to access SHP.

5.1 MODIFY EXISTING SHP PLATFORMS

The Lancet Commission on Migration and Health conducted a systematic review of the countries that have improved SHP coverage. The review found that these countries have largely focused on labor and documented migration; within that focus area, they have improved health coverage for migrants by adopting the following strategies: 1) adjusting eligibility criteria; 2) improving awareness; 3) reducing insurance costs to improve affordability; 4) improving enrollment processes; 5) strengthening delivery of health care; and 6) improving the organizational delivery of insurance schemes [79]. LHSS research identified the strategies below as the most effective at reducing barriers for women migrants regardless of their participation in the formal economy or their documentation status. Exhibit 4 shows examples of international partner efforts to improve SHP for migrants in LAC countries.

Exhibit 4. Examples of international partner efforts to improve SHP for migrants in LAC countries.

Stakeholder interviews identified the following efforts to improve SHP:

PAHO/WHO works with MoHs to promote multisectoral approaches to SHP and integration of women migrant health needs into national policy to achieve UHC.

CARE is piloting cash transfer programs for migrant women in Ecuador, including transgender women.

UNAIDS works with RedLacTrans to provide social protection for transgender women migrants, including a focus on HIV.

UNAIDS is working through the Quito process to advocate with Colombia, Peru, Chile, Dominican Republic to increase SHP, with a particular focus on migrants living with HIV.

UNHCR provides cash transfers and pays for migrants to access services that are not provided free of charge.

In Brazil, UNFPA, IOM and UNHCR are advocating for inclusion of groups of migrants, such as pregnant women, to access the Unified Health System (SUS) card that is needed for non-emergency services.

Modify eligibility policies to support inclusion of migrants. Changing eligibility policies would benefit both migrants and host communities, including by expanding access to important public health interventions like immunization, SRH, and management of chronic disease. Mexico's Seguro Popular was successful in expanding eligibility for migrants, with a strong gender focus and prioritization of social determinants and health disorders that especially affect women. Special efforts were made to include female heads of households, and evidence shows that they enrolled women migrants at an accelerated pace [80]. In many destination countries, there are programs that could provide health protection for immigrants, but for which the migrants are ineligible until their status is "regularized." International experience suggests that the most important step that governments can take to improve migrants' access to health services is to regularize immigration status and provide migrants with the same legal entitlements as other residents [81]. One example of this approach is Colombia's recent decision to make all migrants eligible for SHP.

Successful strategies to expand SHP may create more than one pathway to reach segments of the population. A review found five Association of Southeast Asian Nations (ASEAN) receiving and sending countries (Indonesia, Malaysia, Philippines, Singapore, and Thailand) have multiple schemes that cover migrants to varying extents. For example, in Thailand, the growing cost of subsidizing migrant workers'

health care, through exemption of user fees on a humanitarian basis, prompted the government to initiate a health insurance scheme for migrant workers [82].

Countries such as Mongolia, Rwanda, and the Philippines have shown that sustained political and financial commitment makes it possible to extend SHP to all, even in low-income settings with high levels of informal employment. They have achieved results using different financing modalities, including publicly mandated, private health insurance that is defined by a legal framework and subsidized and monitored by the state [83].

Strengthen the implementation of existing policies. Experience also shows the importance of monitoring and strengthening the practical application of enabling policies. For example, European countries sometimes make accommodations for migrants in principle, but in practice make the mechanisms difficult for migrants to use. Undocumented migrants can purchase statutory private health insurance in some countries, such as Switzerland, but the process to receive subsidies is burdensome and premiums are expensive. In Germany, the requirement to apply for medical care in welfare offices can deter migrants along with high out-of-pocket costs [81].

Bilateral labor agreements (BLAs) for portability of SHP across two or more countries. Some origin countries have entered into BLAs with destination countries to protect migrant workers and ensure that their rights are recognized, including through minimum standards for wages and benefits and access to health care or health insurance for workers overseas. For example, BLAs are being negotiated by the Philippines authorities to ensure that all countries recruiting Filipino migrants comply with the Migrant Workers and Overseas Filipinos Act (1995), which requires overseas employers to provide the same health insurance benefits to Filipino migrant workers as are provided for their locally hired employees [84]. In the LAC region, BLAs exist for the Canada-Mexico and Spain-Ecuador corridors [19].

In LAC, Mercosur countries provide migrants with universal social protection and have established bilateral agreements for portable pensions for people who already have SHP in the origin country and would retain the right to it in the destination country. The Mexican government has extended its national health insurance to cover its migrants abroad: family members still living in Mexico get comprehensive coverage, while people living outside the country can access primary care and have catastrophic coverage in Mexico [19].

A recent ILO report examines migrants' access to social protection under several BLAs in 120 countries and reviews legislation granting equality of treatment between nationals and non-nationals. The report found that only 30 percent of the BLAs analyzed included provisions for social security including health benefits (mainly in Europe and the Americas—Canada, Mexico, and Ecuador). Effectiveness of these schemes depends on the basic benefits package, the duration of coverage, and the extent of costs covered. Migrant workers may be left vulnerable if employment rights and health entitlements are not honored by employers in receiving countries [19].

5.2 IMPROVE HEALTH SERVICE DELIVERY AND ACCESSIBILITY

Make integrated, comprehensive services widely accessible. In the LAC region, PAHO/WHO is supporting countries to respond to local and migrant needs by reorganizing and improving health care services in general, creating integrated health services delivery networks that are centered on primary health care services. Countries are increasing the capacity of their first line of care to address the needs of the community, and reforming hospital organizational structures to improve sustainability [85]. For example, Ciudad Mujer (Women's City) in El Salvador provides "one-stop" centers where a range of psychosocial, legal, and health services are accessible to women. Since the inception of the program, approximately 750,000 women have benefitted from the services provided. Ciudad Mujer is a flagship social program of the Salvadoran government, implemented via the Secretariat of Social Inclusion [86]. Exhibit 5 shows several efforts that have been taken to support improved services for migrant women in LAC.

Exhibit 5. Efforts to support improved services for migrant women in LAC.

Stakeholder interviews identified the following efforts to improve services for migrants:

- **Direct service provision:** mobile health teams, community health workers, services in shelters, remote areas assistance, immunization, provision of health products to providers and migrants; border health
- **Increasing service uptake:** community mobilization; improved referral pathways, community-based surveillance; health and risk communication; transportation and cash to access services
- **Strengthening health systems:** improving infrastructure; provision of supplies and equipment; training in supply chain; logistics; medications; contraceptives; UHC policies; evidence-informed guidelines
- **Advocacy:** improved migration policy; UHC roll-out
- **Migrant protection programs:** legal, financial, cultural, and linguistic barriers

Engage communities. In many countries, CSOs and non-governmental organizations (NGOs) are providing services directly to migrant populations to fill health system gaps and meet critical needs. These efforts are usually supported by donor agencies. Recently, in the DR, three PEPFAR-funded NGOs joined the provider network of the national health insurance agency, SENASA, under its subsidized scheme to cover people living with HIV, including Haitian migrants and people of Haitian descent. While NGOs funded by PEPFAR have long provided HIV prevention and treatment services to vulnerable populations in the country, this was a step towards their integration as primary care providers within the Dominican health system [93]. Examples of private voluntary initiatives in Guatemala and the Dominican Republic can be found on Exhibit 6.

Strategies to improve SHP for women migrants are likely to be more broadly effective if their vulnerabilities and health needs are taken into account when planning, designing, and implementing systems and services. Colombia's Response Plan for Venezuelan migrants includes community-based strategies that allow for the political and civic participation of migrants and their communities to advocate for their rights [63].

Exhibit 6. Examples of private voluntary initiatives Serving populations at risk of migration in Guatemala:

- Organization for the Development of the Indigenous Maya works to provide health care, supplementation, and support groups for 250 women and children [87].
- Health for Humanity is a Canadian charitable organization that partners with local NGOs for surgical missions and for public health and educational initiatives for marginalized populations in rural and remote regions [88].
- Health and Help built (with local volunteers) and staffs a clinic in Guatemala's underserved Chuinajtajuyub, Totonicapan region [89].

Examples of private voluntary providers in bateyes in DR:

- The Fundación Enciende Una Luz provides health education in bateyes, focusing on child health, primary care, and hypertension—not specifically on women's health [90].
- The Batey Relief Alliance works with the Association of Haitian Physicians Abroad to organize medical missions [91].
- Timmy Global Health (associated with the Montana State University School of Nursing) provides prevention and primary care services, invests in health systems; sends medical teams to treat chronic conditions. Covers but is not specifically focused on women's health [92].

5.3 STRENGTHEN THE CAPACITY OF WOMEN TO ACCESS SHP AND HEALTH SERVICES

Increase understanding of migration processes and migrant rights. Where migrant women face practical challenges in accessing services such as inconvenient service delivery locations, opening times, and administrative barriers such as documentation requirements, access can be improved providing clear information about entitlements to care and where and how to access it in ways that are accessible to migrants. This requires ensuring that information channels take into account differing literacy levels, language barriers, and are monitoring and providing up-to-date information on policies and programs [19].

Support migrant networks. Migrant networks encompass the interpersonal ties linking kin, friends, and community members in their places of origin and destination. These networks play an important role in determining whether and to what extent immigrants integrate into their host countries, including their access to SHP and health care. Governments have begun to work toward supporting organizational ties within migrant networks, especially those concerned with development activities, remittances, and diaspora entrepreneurship. SHP is another potential area that can be explored to see how migrant networks can support access for migrant women. The Philippine Migrant Health Network was created in 2014 comprising various stakeholder agencies concerned with the advancement of migrant health. The network focuses on increasing access to quality health care services and strengthening regulatory measures for health services for women migrants [19].

6. FINANCING EXPANSION OF SHP FOR WOMEN IN HIGH-MIGRATION CONTEXTS

Both origin and destination countries will require additional financing to extend eligibility for SHP to migrant women or women at risk of migration. Estimating the additional resources needed in each case would require context-specific information about: 1) the size of the population of women that have gaps in coverage (i.e. the number of women at risk of migration or the number of women migrants); 2) the costs of the services currently being provided to these women, including through the public system, private providers, international partner and CSO programs; 3) the mechanisms through which SHP would be expanded to cover them, which might include combinations of subsidizing inclusion in health insurance programs, scaling NGO service delivery, contracting with private commercial providers, and other measures; and 4) the costs of providing appropriate packages of services through these mechanisms.

As LHSS begins work in Honduras, recommendations on sustainable financing of expanded SHP for women at risk of migration will be based on a country assessment that will identify the full range of country-specific factors that must be accounted for in a realistic estimation of financing needs.

For destination countries, order-of-magnitude estimates of the costs of providing SHP to migrant women can be made based on the cost of providing SHP to the destination countries' own populations. The order-of-magnitude estimates set out in Table 1 below are based on the size of the migrant population in each country and current per capita spending on SHP by government and social health insurance programs. This assumes that migrant women are at most only benefiting from a very small proportion of the current expenditure. The estimated annual costs provide an order-of-magnitude estimate of the funding needed to allow the migrant and women migrant populations to have SHP equivalent to the average person in each of the destination countries. They do not take into consideration any other context-specific factors such as the complexity of women migrants' access to services and health needs in the particular destination country contexts, the mechanisms that would actually be used to extend SHP to migrant women, or the costs of services already being provided to them through public sector health centers and clinics, private providers, community providers and international programs.

LHSS's efforts to recommend options for sustainably financing expanded SHP in the Dominican Republic will be based on an in-country assessment that allows all the relevant context-specific factors to be taken into account.

Table 1. Order-of-magnitude estimates of the annual financing needed to provide SHP to migrant populations in selected destination countries

Destination country	Origin country/ countries	Government and social health insurance annual healthcare spending per capita (US$)	Migrants (% of population)	Women as (%of migrants)	Estimated annual cost of health protection for women migrants (US$ million)*	Estimated annual cost of health protection for all migrants (US$ million)**
Colombia	Venezuela	$ 722	3.6%	28.0%	$ 366	$ 1,307
DR	Haiti, Venezuela	$ 394	4.5%	34.7%	$ 66	$ 190
Mexico	NTCA	$ 572	0.6%	53.3%	$ 233	$ 438
Peru	Venezuela	$ 407	2.3%	50.0%	$ 149	$ 298

Source: WHO Global Health Expenditure Database; United Nations Department of Economic and Social Affairs

*The figure in column 6 is calculated by multiplying the figures in columns 3, 4, and 5 by the population of each country (source: World Bank, World Development Indicators).
**The figure in column 7 is calculated by multiplying the figures in columns 3 and 4 by the population of each country.

6.1 MECHANISMS FOR FINANCING EXPANDED ACCESS TO SHP PLATFORMS IN HIGH MIGRATION CONTEXTS

Potential financing mechanisms to meet the additional costs of SHP for migrants and people at risk of migration include both traditional and innovative mechanisms. What is most appropriate will vary from country to country and a combination of mechanisms may be required. This section sets out the evidence on available mechanisms and issues that should be considered in choosing among them.

6.1.1 TRADITIONAL MECHANISMS FOR INCREASING BUDGETARY SPACE TO FINANCE SHP

Traditional mechanisms for meeting the additional financing needs of extending SHP to migrants and people at risk of migration involve increasing budgetary space for health using one of the following methods: raising additional government revenue, raising the priority of spending on SHP for migrants, or reducing inefficiencies in government spending. This study found some evidence on potential for raising additional revenue through increased taxation and other mandatory contributions. These are likely to be the main mechanisms for sustainably increasing the funding for SHP.

Increasing tax revenue. The World Health Report (WHR) of 2010 states that "low- and middle-income countries . . . simply need to raise more [domestic funds.]" The average tax to gross domestic product (GDP) ratio in LAC is 23 percent. Honduras (22), El Salvador (21), Colombia (19), Peru (16), Dominican Republic (13), and Guatemala (12, and lowest in the region) all fall below this average [94]. Some improvement may be achieved through improving tax administration and collection but increases in tax rates and/or an expansion of the tax base are also likely to be needed.

- *Taxes on unhealthy products.* Introducing or increasing taxes on unhealthy products, such as alcohol, tobacco, and sugar-sweetened beverages, ideally has a double benefit. It could reduce consumption of the products, improving health, and generate tax revenue. Colombia increased its tobacco tax in 2016 and expects to generate an additional $350 million in revenue. Some countries have chosen to earmark the revenue from pro-health taxes for SHP, but this is not a promising strategy for financing SHP for migrants. The alternative to earmarking, generally considered better public finance practice, is to include such taxes in general government revenue and allocate it according to national spending priorities. Earmarking of taxes for SHP is discussed further in section 6.2.3.1 on innovative financing mechanisms.
- *Other potential sources of additional tax revenue.* Countries such as Colombia, the Dominican Republic, Haiti, Peru, and Venezuela all have extractive industries that can be taxed to generate government revenue for purposes including financing SHP. Several countries in the region also earn a significant proportion of their income from tourism, which could be taxed to help finance SHP. Tourism represents 16 percent of GDP in the Dominican Republic, 12 percent in Honduras, 11 percent in El Salvador, 9 percent in Peru, 8 percent in Haiti, and 6 percent in Guatemala. Other industries that could be targeted include air travel, currency exchanges, banking, insurance, gaming, agricultural products, and mobile phone usage. We found no specific examples in the LAC region of these industries being taxed more heavily to fund SHP.
- *Removing subsidies.* Some countries have subsidy programs in place for fuel or energy that might be reduced to free up resources that could be dedicated to SHP. This is another case of a double benefit, since the reduction in subsidies would tend to curb energy use with benefit to the environment, while the freed resources could go to health. For example, Indonesia was able to expand its health protection program following a reduction in fossil fuel subsidies [95]. No examples of reallocation of subsidies to the benefit of social protection in LAC were found.

Raising mandatory SHP contribution rates. In countries that collect mandatory contributions from formal sector workers and their employers to finance SHP, contribution rates could be increased to generate revenue to cross-subsidize people in the informal sector, including many migrants. In Colombia, for example, mandatory contributions are used to subsidize the membership of the poor [96]. Such a policy is more likely to be feasible in countries where there is a relatively large formal sector. In Costa Rica, 61 percent of the workforce is in the formal sector, where mandatory contributions can be enforced, and consequently more than 80 percent of the population can be covered through the contributory scheme [97, 98].

6.1.2 INNOVATIVE FINANCING APPROACHES WITH SOME EVIDENCE OF POTENTIAL TO SUPPORT SHP FOR MIGRANTS

This section sets out emerging/innovative financing approaches identified in the literature that have potential to be used to expand access to SHP for women in high-migration contexts. There is limited evidence for many of these approaches, especially in the LAC region, but there are some examples of approaches that could be tested to support SHP for migrant women. Some of these approaches would raise more public financing, some more private financing, and some a combination of the two.

6.1.2.1 CHANNELING REMITTANCES INTO POOLING AND PREPAYMENT MECHANISMS TO REDUCE OOP PAYMENTS

Remittances sent by migrants to their families in destination countries provide a potential source of funding for SHP to reduce out of pocket payments for health services. Remittances comprise more than 20 percent of GDP in some countries (see Table 3 for values for some of the origin countries included in this analysis). Women migrants tend to remit more of their income, and when receiving remittances to use them for family needs, such as food, clothing, housing, education, and health. There is an opportunity to develop remittance-funded health insurance products or to offer the possibility to buy-in to government or private health insurance programs using remittance funds, so reducing the drivers of migration for at-risk populations. This would make the contributions of remittances to health more predictable for the recipient and offer greater financial protection. An example of such a program is the JokkoSanté program in Senegal. JokkoSanté is a digital payments app that gives users points redeemable for drug prescriptions. Migrants sending help to family remaining in Senegal can buy points online and designate them to recipients, ensuring that the latter have access to drugs and use the resources to address health needs. Similarly, in Guatemala, IOM has supported a health insurance scheme whereby migrant workers pay a fee so that their families back home can access a specified health-care system [19].

Table 3. Remittances as a share of GDP in 2019, selected origin countries

Country	Remittances as a share of GDP
El Salvador	20.9%
Guatemala	13.9%
Haiti	22.8%
Honduras	21.5%

Source: World Development Indicators, https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS, accessed December 23, 2020

6.1.2.2 EARMARKING REVENUE FROM SELECTED TAXES TO INCREASE PUBLIC FINANCING FOR SHP

Although LHSS would not recommend this as a sustainable source of financing for extending SHP to migrants, there are examples from outside the LAC region of excise tax earmarking being used to extend SHP to previously excluded groups. The Philippines, for example, increased its taxes on alcohol and tobacco and dedicated the additional revenue to pay premiums for low-income people to join its PhilHealth national health insurance program. The only example of earmarking for social protection in the LAC region is a program in Brazil called FUNRURAL which uses a tax on purchases of rural agricultural outputs to fund a pension plan for the informal sector [99]. Earmarking is generally considered to be poor public finance practice and is unlikely to provide a sustainable source of revenue for SHP for migrants. In the short term it may help protect resources for SHP for migrants and make

such expenditure more politically acceptable, but in the longer term it often leads to reductions in allocations to the health sector from other sources. The advantages and disadvantages of earmarking for health have been well documented [100, 101].

6.1.3 INNOVATIONS THAT ARE UNTESTED FOR SHP

6.1.3.1 SOCIAL AND DEVELOPMENT IMPACT BONDS TO FINANCE SERVICE DELIVERY

A government or donor interested in improving SHP in a high migration context might consider using an impact bond to finance a performance-based contract with health service providers based on their coverage of migrants for specific services. Social impact bonds (SIBs) are public-private partnerships that raise upfront capital from investors to pay for delivery of social services through performance-based contracts. The government repays the investors if and when the project achieves the intended social outcomes [105]. Development Impact Bonds (DIBs) work in the same way, but a donor pays for outcomes. Impact bonds transfer the risk of ineffective social programs from governments or donors to investors and align incentives so that service providers adapt along the way to ensure they achieve agreed upon results. There are multiple examples of impact bonds in Latin America, including in Colombia and Peru, but none for SHP. There is a growing interest in this type of financing in the region as shown by the Multilateral Investment Fund becoming the first development finance institution (DFI) to launch a program for SIBs. A recent IDB study found mixed results in implementation of SIBs but did note that all SIBs have crowded in some financing that would not have gone to social programs otherwise [106].

6.1.3.2 DEBT SWAPS TO RAISE DOMESTIC GOVERNMENT RESOURCES FOR SHP

A debt swap is a method of transforming debt into resources for other social or development causes [103]. Even though there are no examples of existing debt swaps for SHP, debt swaps may have potential to contribute to financing SHP through funding improved service delivery and accessibility for migrants and people at risk of migration. Some international lenders could be interested in granting LAC countries relief from the need to repay loans if the resources freed by doing so were devoted to health protection for migrants. The amount owed on the loan is "swapped" for the agreement to spend the freed money on a desired social program, such as SHP. An example of a similar model is the Global Fund's Debt2Health mechanism, which has facilitated the swap of $152 million in debt held by Australia, Germany, and Spain for health programs in Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Egypt, El Salvador, Ethiopia, Indonesia, Jordan, and Pakistan [104]. There is little evidence available to assess the feasibility of such an approach to SHP for migrants.

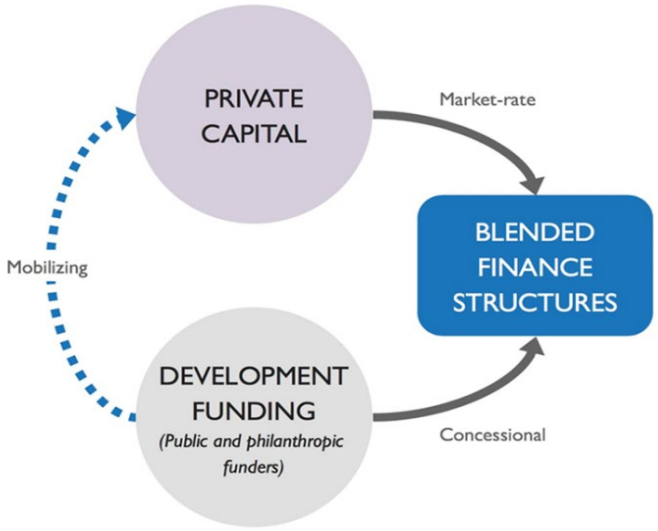
6.1.3.3 BLENDED FINANCE TO CATALYZE PRIVATE INVESTMENT IN INCREASED SERVICE PROVISION

Expanding the availability and accessibility of health services in high migration contexts is likely to require capital investment by private service providers. Blended finance may have potential to catalyze additional investment that could contribute to higher capacity levels and increases in service availability by supporting the acquisition of health equipment and purchases of inventories, for example. This supply

side financing would complement efforts to raise additional demand-side financing through taxation, mandatory SHP contributions and other mechanisms described in this study.

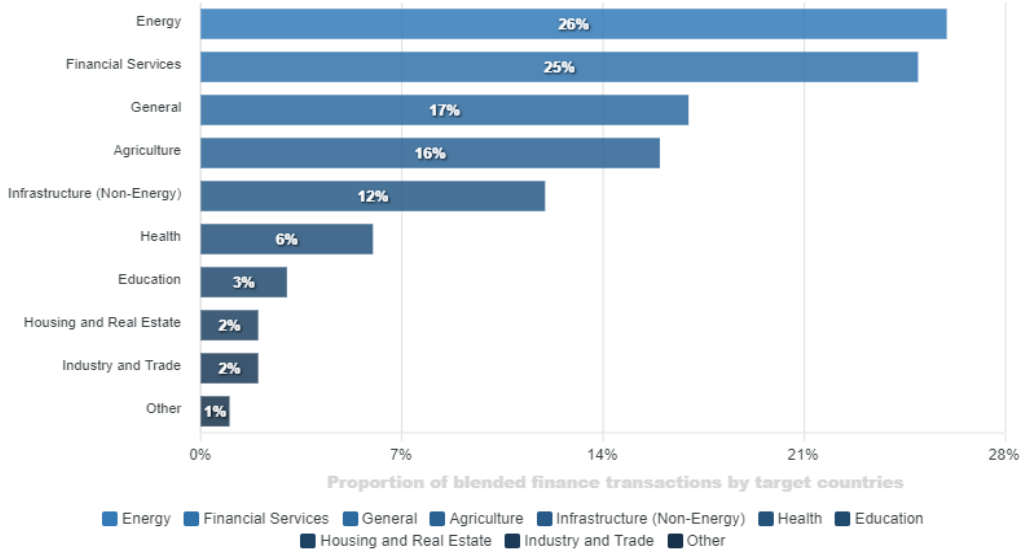
USAID defines blended finance as the "strategic use of development funds, such as those from government aid and philanthropic sources, to mobilize private capital for social and environment results, such as improving infrastructure, education, agriculture, healthcare, and more" [2]. Health care currently accounts for only a small share of blended finance transactions as seen in Figure 3, but private sector health projects could be attractive candidates for this type of funding.

Figure 1. Blended finance



Source: Convergence

Figure 2. Proportion of blended finance transactions by sector



Source: Convergence

6.1.4 MECHANISMS FOR MEETING ADDITIONAL FINANCING NEEDS: CONCLUSIONS

The main sources of sustainable financing for expanded SHP in high migration contexts are likely to be the traditional sources of funding for SHP, such as general government revenues (e.g., by expanding the tax base and improving tax administration) and mandatory contributory systems (e.g., by increasing contribution rates). Innovative financing mechanisms may be attractive supplementary options, depending on country context factors. These factors include the presence of significant extractive industries, which could be taxed, or indebtedness to lenders willing to swap debt for allocation of freed resources from debt relief to social programs. A single source of innovative financing is unlikely to be sufficient to meet gaps in funding for health protection. This means that while innovative financing mechanisms may make important contributions, other complementary sources will be needed to meet the entirety of financing needs. Only a subset of the innovative mechanisms described here has been applied in the LAC region, but most have been used successfully in low- and middle-income countries in other regions.

Blended finance has not been widely used in the health sector. Global health institutions do have a track record of engagement with the private sector and could be doing more in this area. While there is little information on use of blended finance approaches to addressing health needs of SHP for migrant populations, pay-for-results instruments such as DIBs and SIBs may present real opportunities to improve performance and raise financing for migrant SHP. As they begin to explore innovative financing approaches, USAID, other donors, and other development finance institutions have an opportunity to provide support in structuring and participating in such instruments.

7. CONCLUSION

This landscape analysis set out to identify, document, and draw lessons from examples of successful efforts that have led to improved SHP for women in high-migration contexts. Much of the literature focuses on the health outcomes of migrants, and SHP is typically discussed within the context of progress towards UHC and access of migrants, generally, to health services.

Women typically experience lower coverage rates and lower SHP benefit levels, and struggle to access SHP that responds to their needs. Policy, financing and implementation barriers are wide ranging, often reflecting bias—related both to migration status and gender--in migration policy, employment, service provision, and information.

Eligibility often is linked to migration status in the destination country, requiring holding a visa, permit, or other form of "lawful" documentation typically accessible only to a minority of migrants. In most destination countries, migrants who do not hold such documentation are eligible only for emergency or first-aid services that are inadequate to meet their needs. Where migrants hold formal sector jobs, accessible only to regular migrants, they are able to access health services funded by mandatory health insurance contributions.

We found no consistency in the services and SHP mechanisms that migrants and female migrants specifically may be eligible for and use. In some countries they can use all available public services, while

in others there are specific services identified for migrants (sometimes with a focus on women's health needs). In some countries, migrants can only use private commercially provided services that they must pay for out-of-pocket. The eligibility for services may also vary by level of service; for example, migrants in some cases are eligible for primary versus secondary care or maternal and child care versus general care or emergency care versus general, non-emergency care.

Furthermore, eligibility for SHP and healthcare may not translate to use of that care in practice, as migrants may lack information, experience discrimination in service provision or fear negative repercussions of attempting to access state-sponsored services. Finally, COVID-19 has exacerbated pre-existing inequalities and vulnerabilities, including stigmatization and xenophobia and the strain on health system resources. Strategies to improve SHP for women migrants are likely to be more broadly effective if their vulnerabilities and health needs are taken into account in planning, design, and implementation, and raising awareness can ensure that women labor migrants understand and access the SHP available to them.

While there is limited evidence of effective strategies to expand SHP for women migrants, the literature suggests that the most important step that governments can take is to provide migrants with the same legal entitlements as other residents. Colombia's February 2021 announcement to offer temporary protective status to displaced Venezuelans represents a shift in policy for SHP for migrants. The new temporary protective status will guarantee access to the national healthcare system as well as the Covid-19 vaccination plan. IOM Director General António Vitorino said that the "regularization of Venezuelan refugees and migrants in Colombia through the provision of a generous temporary protection status is a key to facilitating their socio-economic integration and access to the national health system and Covid-19 vaccination campaigns" [107].

Financing the expansion of access to SHP for women migrants in the LAC region is likely to require a combination of existing mechanisms - such as additional public financing, mandatory contributions, grant-based aid, and development and humanitarian assistance - and more innovative mechanisms. Potential sources of innovative financing may include new earmarked taxes, remittances, blended financing, debt swaps and performance-based mechanisms such as impact bonds. Remittances, new taxes, and performance-based mechanisms seem likely to be most promising. For a given country, not all innovations will apply. Countries such as Colombia, the Dominican Republic, Haiti, Peru, and Venezuela may be able to explore approaches to tax extractive industries and earmark the revenues for health protection, while debt "swapping" may be more appropriate for countries like El Salvador. Alcohol and tobacco and tourism tax revenues are other potential sources for LAC countries. As interest in blended financing--a relatively new concept in the health sector in LMICs—increases, new approaches and instruments may become feasible.

7.1 EMERGING LESSONS AND RECOMMENDATIONS

Overall, the findings of the literature review suggest that improving SHP for women migrants and women at risk of migration is a complex topic that requires efforts to improve health service delivery and financing, and to promote the rights of vulnerable women. Country experiences with efforts to address the health needs of migrant women vary, and expansion of SHP may be driven by a range of factors, including opportunism, political pressure, and international partner influence. A key question

that remains is how to support countries to achieve the right balance of inclusivity and access, given health sector capacity and financial limitations, as this is an important determinant of how effective and sustainable amendments to systems will be.

The analysis also suggests that the most inclusive SHP for women in high-migration contexts:

- Provides non-contributory social protection benefits and services that are broadly accessible to non-citizens, including undocumented migrants and those on temporary work visas [78]
- Has no legal restrictions and provides for full health coverage regardless of immigration status [68]
- Recognizes and responds with services and information to meet the needs of migrant women [10] including capacity to use health and other services, enhanced risks of migration; discrimination; stigma and cultural restrictions [19]
- Respects, protects, and fulfills the sexual and reproductive rights of migrant women, providing comprehensive SRH services [40]
- Includes tailored initiatives to improve service utilization by migrant women and girls, such as mobile clinics or one-stop centers, and provision of services in a culturally sensitive and gender-responsive manner [68, 86]
- Keeps access separate from immigration enforcement activities to ensure that migrant women with irregular status are not afraid to access them [78]
- Does not entail reporting of migration status to the authorities [108].

There is a significant body of work, largely attributable to international agencies such as the WHO, which proposes that countries can best achieve improved integration of migrants within a broader framework that seeks to improve inclusivity of the health sector more generally, and by seeking to advance UHC and health system sustainability to benefit both nationals and migrants [109, 110].

RECOMMENDATIONS

1. **Governments and other stakeholders, potentially with the support of development partners, should seek to address both migrants' immediate health access needs and long-term improvements in social health protection platforms.** Countries experiencing increased immigration are challenged to implement measures to meet the needs of migrants alongside those of local populations, including the increased demand for health services in both the short and the long term. International donors should support government efforts by strengthening existing government and multilateral networks working on social health protection, health, and migration issues to enhance knowledge sharing, cross-border coordination, and capacity building for governments to respond to increased health demands.

   Many countries, including in the LAC region, have put in place short-term emergency measures to improve access to health services for migrants, including women, but lack longer-term strategies for integration into existing institutional structures and delivery mechanisms of national social protection systems. One potential approach is the design of migrant integration policies and establishment of minimum standards for services for migrant groups.

In the Dominican Republic, LHSS is providing support to explore feasible approaches to improving existing SHP platforms in order to improve coverage for migrants. An in-country assessment will help to understand the impact of legal and policy barriers related to migration status and of efforts to provide health services that meet the specific needs of migrants. This will be critical for determining how feasible proposed SHP amendments are as well as the priority health conditions that must be covered for migrant women, and the capacity of the health system to support more comprehensive SHP.

2. **Governments should seek to integrate migrants into national health systems and policies.** The long-term management of migrant health care is best assured when integrated into existing national policies, with provisions to facilitate the enrollment of migrants into the public health care system. Integration into national health systems can improve services and outcomes for both nationals and migrants, and minimize disruption associated with large-scale flows. The February 2021 policy announced in Colombia represents a new example of this idea.

   The UNHCR points out that reforming health policy to integrate migrants requires both inclusive legislative policies entitling immigrants to health rights, and policies supporting this entitlement by making services appropriate and accessible for the migrant population [109]. Ensuring equitable access requires identifying and removing barriers, which may be associated with legal status and entitlement, or economic, social, or cultural factors [68]. The February 2021 policy announced in Colombia represents a new example of this idea.

3. **Governments and other stakeholders, including development partners, should further explore the potential for private sector, blended finance, or other mechanisms to address the financial challenges of expanding SHP for women migrants.** The landscape analysis has begun to identify approaches to expand health service coverage for migrant women that might be scaled up and sustained using innovative financing tools to augment and encourage increased public spending for health protection. As they begin to explore innovative financing approaches, USAID, other development partners, and development finance institutions have an opportunity to provide support in structuring and participating in instruments.

   LHSS will assess the country's "archetype" based on indicators related to health system status and investment attractiveness to guide the shortlisting of appropriate blended finance instruments; the financing challenge leading to sub-optimal access to SHP for migrants; current sources of financing and cost structures. An analysis will model the potential to generate additional resources that could be considered sustainable. This will enable co-creation of a feasible approach to strengthen capacity for non-traditional financing with local stakeholders, by collaboratively mapping a path for readiness. The India experience of the first development impact bond (DIB) for health services, and on the heels of a recently signed memorandum of understanding (MoU) to develop India's first social impact bond (SIB) for health services, will provide valuable learnings on the feasibility of a blended finance mechanism. Combined with the information in the landscape analysis, this will enable a definition of a menu of financing mechanisms, and recommendations to the government and relevant stakeholders for selecting

an appropriate financing approach.

4. **Governments and other stakeholders, including development partners, should address information gaps.** While there is a large amount of information about migration, including with a focus on the health, there is less information in the literature specific to migrant women and women at risk of migration, or on efforts that countries may be implementing to specifically improve social health protection coverage (rather than health service coverage) for these groups. The systematic collection of data on these issues by governments would allow a better understanding of actual situations and needs; the formulation of more specific, tailored, and quantified responses; and understanding of the effectiveness and impact of country efforts.

ANNEX 1. COUNTRY CASE STUDIES

This section examines evidence about existing SHP for migrants and those at risk of migration by presenting case studies of pairs of origin and destination countries in the LAC region. The purpose is to illustrate representative migration pathways in the region, highlighting flows from three different migration trends. Based on these criteria, three case studies were selected: from Haiti to the Dominican Republic; from Venezuela to the countries receiving the largest numbers of migrants (Peru and Colombia); and from the NTCA countries to Mexico and the United States. To the extent possible, the case studies focus on women.

For destination countries, case studies examine the services for which migrants are eligible, the use of services by migrants, how the services are paid for, the overall health financing and health insurance systems of the countries, and financial sustainability.

For origin countries, case studies cover access and use of health services by populations at risk of migration, the inclusion (or exclusion) of these populations by health insurance programs, and the difference in health and health coverage indicators between the origin and destination countries.

CASE STUDY 1: HAITI TO THE DOMINICAN REPUBLIC

Haiti is the primary source of migrants to the Dominican Republic. United Nations Department of Economic and Social Affairs (UN DESA) data show 491,013 migrants from Haiti comprising 4.5 percent of the population and about 87 percent of all migrants in 2019. Of that number, 34.7 percent were women [13]. In recent years, the Dominican Republic has also been a recipient of Venezuelan migrants and refugees. In December 2020, there were approximately 114,000 Venezuelan nationals in the Dominican Republic [112].

Haitians have migrated across the shared border with the Dominican Republic for more than a century and Dominicans of Haitian descent continue to face discrimination and xenophobia. The pull factors in the Dominican Republic include opportunities to work in the sugar cane industry, principally as cutters, and in other low-skill jobs. The push factors include poverty, violence, environmental degradation, and political instability in Haiti. There are long-standing tensions, including violence and discrimination against Haitian migrants in the Dominican Republic. The Dominican Constitution contains a birthright citizenship provision, but in 2013 the Supreme Court ruled that Haitian migrants and any of their children born since 1929 were "people in transit" and ineligible for citizenship. In 2014, the Dominican legislature legalized some of the people of Haitian origin who had lost citizenship (about 19,000) but this represented only a fraction of the total. About 160,000 people returned to Haiti voluntarily in 2015-2016 and another 54,000 were deported [10,11].

HAITIAN POPULATIONS AT RISK OF MIGRATION

The main drivers of migration across the shared border are poverty and access to health services. Movement of Haitians across the border goes both ways, and is characterized by voluntary and involuntary migration, long- and short-term residence in the Dominican Republic, legal and illegal entry, trafficking, deportations, and a long history of human rights abuses. Border monitoring has shown that chronic diseases, old age, disabilities, pregnancy or lactation, single-headed household, unaccompanied

minors, and visual disability are the main vulnerabilities of Haitians entering the Dominican Republic [113]. Research by PAHO/WHO on the health of Haitian women and children migrants confirms global patterns, as Haitian migrants showed better indicators than Haitians who remained in their home country but worse indicators than native Dominicans [65]. Haitian women have always been present in immigration flows to their neighboring country, and they constitute roughly one-third of current migrant flows. About 45 percent of women migrants from Haiti are between 20 and 40 years old [113].

No specific data could be found on the populations at risk of migration from Haiti to the Dominican Republic. However, we assume that they represent lower income quintiles. Table A-1 below shows selected health indicators for women's health by income quintile for Haiti.

Table A-1. Haiti, women's health indicators by income quintile (2017)

Indicator	Q1 (poorest)	Q2	Q3	Q4	Q5
Percent receiving at least one antenatal care visit	80	91	98	92	95
Percent receiving skilled assistance with deliveries	15	28	44	60	82
Percent of married women with unmet need for family planning	29	25	23	22	16
Percent of married women currently using modern contraception	28	33	37	32	28
Percent of women malnourished (Body mass index<18.5)	14	13	12	11	7
Percent of women with problems accessing health care^	92	87	81	76	63

Source: World Development Indicators. Accessed December 28, 2020

^Problems in accessing health care: Types of problems include; knowing where to go for treatment, getting permission to go for treatment, getting money for treatment, distance to health facility, having to take transport, not wanting to go alone, and concern there may not be a female provider.

HAITIAN MIGRANTS IN THE DOMINICAN REPUBLIC

In the Dominican Republic, Haitian migrants and people of Haitian descent tend to be clustered in bateyes or slum areas with limited infrastructure. Living in conditions of extreme poverty, migrants tend to be illiterate, malnourished, and suffer from preventable diseases. The majority are undocumented, while Haitians born in the Dominican Republic form a large minority in the country across multiple generations. This group, including women, often faces problems in proving Dominican citizenship and accessing services. Large numbers of women migrants work in the agricultural sector, domestic service and in informal-sector trading. None of these jobs offer security, social benefits, or anything above poverty pay. Research suggests that over 20 percent of children living in or around bateyes live with a single mother, while 61.5 percent of households living in extreme poverty are headed by single women [65].

In the Dominican Republic, migrants are eligible for government-provided health care, as the constitution guarantees universal access to anyone, no matter their descent, race, nationality, or immigration status. A 2017 household survey showed that migrant women are more likely to visit a health center than native-born women (73 percent vs. 69 percent). This may be linked to the fact that services are available free of charge at public health centers even for migrants and people of Haitian descent, even though they are unable to access the subsidized national insurance because they do not

have proof of citizenship. The new immigrant survey from the same year (2017) shows that 95 percent of Haitian migrants and 80.9 percent of their descendants lack any type of health insurance [114]. Even though their use of health services appears to be similar to native-born women, migrant women cannot access the allowance of maternity leave covered by social security.

The international response to Haitian migrants into Dominican Republic has included the following:

- A recent shift in U.S. government PEPFAR programming to focus its HIV support efforts almost exclusively on improving coverage of HIV testing and treatment services for individuals of Haitian descent. Likewise, the Global Fund includes migrants as priority population.
- Free legal advice and medical care through a collaboration between the IOM, the Colonia Foundation of Venezuelans in the Dominican Republic and the U.S. Department of State's Bureau of Population, Refugees and Migration (PRM).
- The UNFPA "Champion Mothers Project," aimed at addressing barriers to access of quality SRH and GBV services in border areas between Haiti and Dominican Republic, with a special focus on afro descendant, migrant, and youth populations.

International donors are also programming for migrants from Venezuela, which may have a trickle-down effect for Haitian migrants. For example, the IOM and Colonia Foundation of Venezuelans in the Dominican Republic organized a free health fair with funding from the U.S. Department of State PRM [115].

There are also civil society organizations focused on supporting Haitian migrants. One of the most prominent is Movimiento Socio-Cultural Para Los Trabajadores Haitianos (MOSCTHA), which was founded in 1985 to improve the quality and condition of life and reduce the poverty of Haitian immigrant workers in the Dominican Republic, their descendants, and other vulnerable populations in the Dominican Republic and Haiti. One of their objectives is improve outpatient health services through a set of education, prevention, and advocacy strategies to contribute to the development of healthy lifestyles. Most of their health programming is focused on service delivery.

COMPARISON OF HEALTH COVERAGE INDICATORS

Table A-2 shows comparisons of health coverage indicators published by PAHO/WHO. The two comparable indicators, DTP3 immunization coverage and contraceptive prevalence, show wide gaps between Haiti and the Dominican Republic. The high values for the other indicators for the Dominican Republic suggest that there would be similar wide gaps if the data were available for Haiti. These differences in health outcomes could be both a push factor (Haiti's indicators in Table A-2 and in Table A-1 above for the lowest income quintiles are quite unfavorable) and a pull factor (all of the Dominican Republic's indicators are relatively favorable) for migration from Haiti to the Dominican Republic.

Table A-2. Comparison of health coverage indicators between origin (Haiti) and destination (Dominican Republic)

	DTP3	ANC 4+	Contraceptive Prevalence	Skilled birth attendance	Hospital births
Haiti	72%	Not available[a]	33%	Not available[a]	Not available[a]

	DTP3	ANC 4+	Contraceptive Prevalence	Skilled birth attendance	Hospital births
		67%[b]		42%[b]	39%[c]
Dominican Republic	84%	98%	69%	98%	98%

Source: Pan American Health Organization, PLISA (Health Information Platform for the Americas). Accessed December 12, 2020. [a] Data for these indicators are not available in the PAHO/WHO PLISA data platform. No source was found for hospital births for Haiti. [b] These figures come from the 2016-2017 Demographic and Health Survey (DHS). [c]The figure shown is for health facility births and comes from the 2016-2017 DHS. Note: Data for Haiti DTP3 is for 2017, for contraceptive prevalence is for 2018; data for the Dominican Republic for antenatal care (ANC) 4+, skilled birth attendance, and hospital births is for 2014, for DTP3 is for 2017, and for contraceptive prevalence is for 2018.

A 2020 study found Haitian migrants presented higher coverage of health indicators than Haitians remaining in Haiti, but lower than Dominicans [65]. Using a composite coverage index of eight health indicators, the research found values of 79 percent for Dominicans, 69 percent for Haitian migrants, and 53 percent for Haitians. Haitian migrant children fared better than Dominican children for care seeking for suspected pneumonia, but substantially worse on DTP3 vaccination, and Haitian migrant women and Dominican women were in near equality at high levels (nearly 100 percent) of benefiting from skilled birth attendance. However, the research also found urban-rural inequalities, which were higher for Haitians and Haitian migrants than for Dominicans. Generally, evidence shows migrant women have worse health coverage than residents of the destination country, with possible explanations including language barriers, discrimination, transportation costs, and distance to health facilities. Specifically for Haitian migrants in the Dominican Republic, the research points to one possible explanation of limited access to sexual and reproductive health services, stemming from lack of documentation.

There is also evidence of people crossing the border to access health services. Statistics from the Dominican public health secretary show that, in 2015, almost 10 percent of public hospital patients (consultation and emergency) in the Province of Dajabón were foreigners. The rate is even higher for the primary care centers (35 percent) [116].

HEALTH FINANCING

The Dominican Republic spends $462 per capita on health, representing 6 percent of GDP. It has a social security health system for the formally employed and dependents, a subsidized scheme funded by the government as part of the social security system, and a government-funded health system that aims to serve all of those not covered by social security. Private health insurance covers a small share of the population. The Dominican Republic population also spends directly on health services from its own resources, with OOP spending per capita of about $208 per year. As of 2016 there were 3 million people without health coverage, likely individuals who did not meet the poverty criteria to qualify for social benefits, despite being poor or vulnerable. It is estimated a proportion of these were undocumented individuals, including migrants, but the majority were informal sector workers [117].

The cost of the health services used by migrant women represents about 1.6 percent of total health spending or about $7 of the $462 per capita spending on health. Migrants make up about 4.5 percent of the Dominican population, women migrants are about 34.7 percent of the total migrant population. The IPPMD survey suggests that migrant women use health services at a similar rate to native-born women.

While this is not a large cost burden overall, health services used by Haitian migrants in and around bateyes, where migrants are concentrated, are likely a large share.

Table A-3 shows comparative data on health financing for Haiti and the Dominican Republic. Haiti spends a much lower amount per capita, but a higher percentage of GDP on health than the Dominican Republic. Haiti has only a tiny social security health system, since its formal employment is low. General government spending in Haiti represents only 10 percent of its low total health spending. The population at risk of migration is unlikely to benefit much from government SHP since it is so meager overall and is likely to be heavily dependent on OOP spending for health services of all types. This reinforces the idea that access to health care is a contributor to the decision to migrate.

Table A-3. Health financing indicators for the Dominican Republic and Haiti, 2018

	Percent of total health expenditure					Total health expenditure as a share of GDP	Per capita total health expenditure
	Social health insurance	General govern-ment	Out of pocket	Voluntary Private insurance	External		
Dominican Republic	20%	24%	45%	10%	1%	6%	$462
Haiti	2%	10%	44%	5%	38%	8%	$64

Source: WHO, Global Health Expenditure Database.

CONCLUSIONS

Haiti is the major source of migrants to the Dominican Republic, about one-third of them women. Migrants are eligible for government-provided health care, but there are long-standing tensions, including violence and discrimination against Haitian migrants in the Dominican Republic. The majority are undocumented and even Haitians born in the DR have issues proving their Dominican citizenship and accessing services. A 2020 study found Haitian migrants presented higher coverage of health indicators than Haitians remaining in Haiti, but lower than Dominicans.

One of the biggest barriers to increasing access to healthcare for migrants is cost, but research shows providing health services to migrants has direct and indirect economic advantages for destination countries [118]. However, there is political pressure to not increase coverage of health services for migrants, as it could be perceived as an additional pull factor for individuals at risk of migration, particularly from Venezuela.

CASE STUDY 2: VENEZUELA TO COLOMBIA AND PERU

Venezuela is the major country of origin for migrants to Colombia and Peru. Colombia is the number one destination for Venezuelan migrants. In 2020, 1,729,537 migrants from Venezuela were in Colombia, a significant increase from 23,573 Venezuelan migrants in 2014. Forty-nine percent (852,142) are women and 51 percent (877,395) are men [119]. There is some evidence indicating the gender pattern of migrants may be shifting; between 2015 and 2020 the annual of change of the number of migrants in Colombia increased by 49.6 percent overall, but the annual rate of change for female migrants specifically in Colombia was 51 percent. All migrants from Venezuela made up 3.7 percent of Colombia's

population of more than 50 million in 2019. Women Venezuelan migrants were 1.1 percent of the Colombian population [13].

Peru is another frequent destination for Venezuelan migrants. UN DESA data show that 602,595 migrants from Venezuela were in Peru in 2019. All migrants from Venezuela made up 1.9 to 2.6 percent of the population of more than 32 million in 2019 [13].

While Colombia and Peru have experienced vast increases in the numbers of Venezuelan migrants in recent years, other locations in the region have remained steady between 1990 to 2019 or have experienced a decrease. For example, the Dominican Republic had 14,235 total Venezuelan migrants in 1990 (45.9 percent female) and 3,680 (52.4 percent female) in 2019.

VENEZUELAN POPULATIONS AT RISK OF MIGRATION

Widespread poverty, chronic shortages of food, medicine, and other basic necessities as the result of years of economic mismanagement, corruption, and a sharp decline in oil prices, are all drivers of migration from Venezuela [120]. The effects of the crisis are felt strongly in the health sector with alarming rates of undernourishment, health providers struggling to operate, and scarce supplies, including closures of more than 150 pharmacies. In 2018, the Venezuelan Pharmaceutical Federation announced that 85 percent of essential medicines were scarce and according to a 2019 internal UN document, the lives of 300,000 people are at risk because they have not received needed medicines for more than a year [120]. Additional research from 2018 found 68 percent of hospitals experienced failures in electricity supply and 70 percent in water supply. Independent sources indicate that the rate of infant mortality has increased by at least 30 percent and maternal mortality has increased by 65 percent since the government stopped reporting health outcomes in 2015 [121].

The IOM offers a profile of Venezuelan refugees and migrants present in 11 Latin American and Caribbean countries during 2019, examining their demographics, education levels, employment before and after migration, remittance sending, health conditions and mobility patterns, among other characteristics. Different groups of Venezuelan migrants travel to different destination countries. Within immediate neighbors—Brazil, Colombia, Guyana, and Trinidad and Tobago—Venezuelan migrants tend to be less educated and younger and travel without family. In nearby countries of Ecuador and Peru, migrants also tend to be young, but more than one-third hold a technical degree or higher. In more distant countries such as Argentina, Chile, Costa Rica, Paraguay, and Uruguay, migrants are older and highly educated, with half or more having a bachelor's or master's degree [56].

Across destination countries, Venezuelan migrants say they do not intend to return home—in every country other than Colombia, 5 percent or fewer indicated an intention to return. While 17 percent in Colombia intend to return, 58 percent said they planned to remain in Colombia and 24 percent expressed a desire for onward movement. For the 10 other countries, more than four-fifths said they planned to remain where they were. This is even as they reported experiencing challenges, the most prevalent of which are a lack of financial resources, food scarcity, lack of a sleeping place, insecurity, no transportation, issues with travel documents, lack of information, and health concerns. In Guyana, 80 percent of respondents expressed concern about food insecurity, while 91 percent in Colombia experienced financial problems during travel [56].

No specific information was found on Venezuelan populations at risk of migration and their use of health services, and no data are available on use of health services by quintile. Due to the complicated political situation, it is difficult to access reliable health indicator data from Venezuela. However, it is reasonable to assume that it is low, uneven, and declining, as social services in Venezuela are collapsing. Page et al. in The Lancet indicate that "[t]he economic crisis in Venezuela has eroded the country's health-care infrastructure and threatened the public health of its people. Shortages in medications, health supplies, interruptions of basic utilities at health-care facilities, and the emigration of health-care workers have led to a progressive decline in the operational capacity of health care. The effect of the crisis on public health has been difficult to quantify since the Venezuelan Ministry of Health stopped publishing crucial public health statistics in 2016" [36].

VENEZUELAN MIGRANTS IN COLOMBIA

All migrants in Colombia are supposed to be able to access emergency care at no charge; however, access to non-emergency ambulatory and preventative care is not guaranteed. Ministry of Health Resolution 3015 allows Venezuelan migrants who have a Special Permanency Permit (Permiso Especial de Permanencia--PEP) to contribute to a paid health plan or access services through the subsidized system. UNHCR says that fewer than 40 percent of Venezuelan migrants hold PEP, and according to the Ministry of Health, 181,472 (9.7 percent of 1.8 million) held PEP in 2018. Moreover, as of June 30, 2018, only 28,069 Venezuelan migrants holding PEP were "active" members of the General System of Social Security and Health (SGSSS, the national health insurance program), of which 93 percent belonged to the contributory and 7 percent to the subsidized regime. In its response plan to migration, the MoH said, "It is striking that only 15 percent of the total people with PEP have joined the SGSSS. [This demonstrates] the need to socialize this right with the population with PEP and support the management [systems] that make this procedure feasible" [122].

An additional 442,462 (23.7 percent of 1.8 million) registered Venezuelan migrants (with the RAMV-Registro Administrativo de Migrantes Venezolanos) could potentially obtain the PEP and accompanying health coverage. In early 2020, the Government of Colombia announced that an additional 100,000 Venezuelan migrants would receive PEP [107]. The PEP allows them to regularize their situation in the country, receive wages and be covered by Colombian labor laws and enroll in and benefit from the national social security and healthcare system. Irregular Venezuelan migrants who do not hold formal papers with immigration authorities, including not holding PEP, were only eligible for emergency care [122]. There are specific provisions for women and children, including "De Cero a Siempre" (From Zero to Forever) granting comprehensive care for pregnant women and children in early childhood. As of January 31, 2021, 720,113 PEPs have been granted. Despite the measure of flexibility adopted, there have been Venezuelan migrants who do not meet the requirements [123].

In the first seven months of 2017, a total of 7,766 emergency services and hospitalizations were provided per month to Venezuelans, representing 63 percent of all services used by non-Colombians. For the 15-month period of March 2017 to May 2018, the national health information system showed 69,408 health services used by foreigners (61 percent of whom were Venezuelans). Of these services 59 percent were provided to females and more than half were provided in three border areas: Norte de Santander (35.8 percent), La Guajira (8.8 percent) and Barranquilla (8.8 percent). The information system showed 1,778 births to foreigners in this period, with 86.8 percent Venezuelan. Between August

2017 and June 2018, a total of 348,632 vaccine doses were provided to Venezuelan nationals at a cost of $1.6 million for the vaccines alone, not counting the cost of supplies or delivery personnel [122].

The Colombian Ministry of Health's response plan for the health sector to the migration phenomenon from 2019 called for the following concerning health of Venezuelan migrants:

- Dissemination of procedures for obtaining PEP (for Venezuelans) and inclusion of migrants in the health information system and membership in SGSSS; and
- Definition and management of strategies and resources to address health care for the migrant population who do not have SGSSS coverage [122].

The funding for these initiatives comes principally from two sources: 1) SGSSS contributions, including those from migrants who are contributory members and (2) from the General System of Participation (Sistema General de Participaciones) that centrally funds education and health transfers to local governments to address poor populations [122]. PAHO/WHO reports that "a pool of national resources was established through Decree 866 of 2017 to complement efforts to finance the care offered in Colombia to persons from bordering countries, provided that the necessary conditions are met" [55].

Then in February 2021, in a joint announcement, Colombian president Iván Duque and the UN High Commissioner for Refugees Filippo Grandi announced Colombia would offer temporary protective status to displaced Venezuelans. The new temporary protective status will guarantee access to the national healthcare system as well as the Covid-19 vaccination plan. IOM Director General António Vitorino said that the "regularization of Venezuelan refugees and migrants in Colombia through the provision of a generous temporary protection status is a key to facilitating their socio-economic integration and access to the national health system and Covid-19 vaccination campaigns."

Since May 5, 2021 more than 383,000 Venezuelan citizens (about 22 percent of the total in Colombia by January 31) have begun their registration process to qualify for the Temporary Protection Statute. According to Migration Colombia Director-General Juan Francisco Espinosa Palacios, there have been per day more than 3 million visits to the Migration Colombia website of the Entity, more than 47,000 users have been created, about 15,000 people have been registered, there have been more than 11,000 surveys completed, and there have been more than 12,000 appointments scheduled. Next steps in the process include beginning partnerships with Venezuelan associations, civil organizations, and international organizations [123].

Another specific group of temporary migrants to Colombia from Venezuela are those considered "pendular" migrants living in border areas. In response to the dynamics of the border with Venezuela and taking into account that Venezuelans need to move to Colombia without intending to establish themselves, the National Government has granted the Border Mobility Card as a measure of migratory flexibility for these Venezuelan citizens, who need to stock up on goods and services, to attend medical appointments, and conduct other activities [123]. In 2018 1.6 million Mobility Cards (Tarjeta de Movilidad Fronteriza) had been issued to this group. They are entitled to no-charge emergency health care in the Colombian system but must pay out-of-pocket (or through private insurance that they might hold) for other non-emergency health services [122].

The international response to the surge of Venezuelan migrants into Colombia has included Project Hope, MSF, and other relief agencies supporting health services for migrants to supplement local health systems in border areas. In 2019, The Global Concessional Financing Facility (GCFF) announced a US$31.5 million grant as budget support for Colombia's efforts to facilitate access to jobs and basic social services for Venezuelan migrants and refugees, as well as the communities that are hosting them [124]. The Inter-American Development Bank (IDP) supports the integration of migrant and refugee populations through local governments, including a loan approved in 2020 of which US$9.6 million in additional non-reimbursable resources will be leveraged to fund the healthcare needs of migrants [125]. To support the Temporary Protection Statute, USAID and the IOM in collaboration with Migration Colombia and the Ministry of Finance are supporting incorporation of 500 new staff to support implementation including more than 100 service points, mobile units, and care fairs [123].

VENEZUELAN MIGRANTS IN PERU

Few Venezuelan migrants are eligible for government-provided health care in Peru since only migrants with identity documents (carnets de extranjería) are permitted to use the public health insurance system (SIS). A special regulation in 2017 granted Temporary Residence Permits (PTP) for Venezuelans who entered the country before February 2017, but PTP holders do not get identity documents (carnets de extranjería/immigration cards) and so are not eligible for SIS. There are exemptions to this requirement for pregnant women and trafficked people [7].

A 2018 household survey (ENPOVE) of 2,144 adult Venezuelan migrants living in five cities in Peru (of whom 54.9 percent were female) found that few (6.7 percent) had health insurance. Fewer than half of the respondents used formal health care when ill (24.5 percent of men and 30.6 percent of women), while an additional 57.7 percent of men and 52.5 percent of women visited pharmacies when ill. Native-born Peruvians use formal health care 46 percent of the time when ill. Venezuelans offered the following reasons for not using health services when ill: not having money (64.5 percent); not having health insurance (24.3 percent); self-medicating (12.8 percent); and not having time (8.4 percent). No difference was found in service use between men and women. The survey did not report on what health services are used by migrants but given that few of them are insured (and, thus, not covered by the EsSalud or SIS programs) it is likely that they often use privately provided services for which they must pay out of pocket [126].

The international response to the surge of Venezuelan migrants into Peru has included the following:

- U.S. government support for prevention of gender-based violence, psychosocial services, livelihood assistance, cash assistance, food, employment finding, shelter, HIV services, school supplies, transport, and water supply and sanitation.
- PAHO/WHO support for health system response, vaccinations, and epidemiological surveillance.
- UNFPA support for sexual and reproductive health services, "dignity" kits, prevention of gender-based violence, and family planning.
- Private voluntary organizations such as the Borgen Project support shelter for refugees, and the Hebrew Immigrant Aid Society supports prevention of gender-based violence, mental health services, and economic inclusion for refugees and migrants.

COMPARISON OF HEALTH INDICATORS

Table A-4 shows comparisons of health coverage indicators between Venezuela and the two destination countries. Across all indicators the destinations have more favorable values than Venezuela, but the values for skilled birth attendance and hospital births are highly favorable for all. Colombia's biggest advantage over Venezuela is for DTP3. The biggest gaps where Peru has an advantage over Venezuela are for the preventive DTP3 and ANC 4+ indicators. As noted above, reliable data from Venezuela are difficult to obtain so it is likely that numbers reported for 2017 may not fully represent the true health challenges; as a result, differences in indicators between origin and destination countries are likely greater than they appear in the table.

Table A-4. Comparison of health coverage indicators between origin (Venezuela) and destination (Colombia and Peru)

	DTP3	ANC 4+	Contraceptive Prevalence	Skilled birth attendance	Hospital births
Venezuela	66%	84%	68%	99%	95%
Colombia	92%	90%	75%	99%	99%
Peru	100%	98%	72%	100%	100%

Source: Pan American Health Organization, PLISA (Health Information Platform for the Americas), accessed December 12, 2020. Note: data for Venezuela is for 2017, except for contraceptive prevalence which is for 2018; data for Peru is for 2017, except for ANC 4+ which is for 2014 and for contraceptive prevalence which is for 2018; data for Colombia is for 2015, except for DTP3 which is for 2017 and for contraceptive prevalence which is for 2018.

In addition to comparisons of the health status and health system capacity in origin and destination countries, there are differences in health status between migrants and native-born populations in destination countries. Since March 2017, approximately 60,000 pregnant women from Venezuela have given birth in Colombia, and there have been increases in maternal mortality, low-birth-weight infants and perinatal deaths, and cases of gestational syphilis [127]. There are higher rates of sexual and gender-based violence among migrants, as well as stigma accessing available health services [128]. Despite the Venezuelan MoH providing free antiretroviral therapy (ART) since 1999, there has been a steep decline in the number of people receiving consistent access to treatment in recent years; as of September 2018, approximately 7,700 people living with HIV had left Venezuela in search of treatment in other countries. There are an estimated 2,000 Venezuelans living with HIV in Colombia [129].

The presence of non-communicable diseases and chronic conditions appears lower among migrant populations than native-born populations. For example, in the 2016-2017 National Health Survey for Chile, the percentage of individuals reporting health conditions such as diabetes and hypertension was lower within the migrant population (4 percent and 16 percent respectively) than within the native population (11 percent and 27 percent respectively). In Peru, according to the 2018 Survey of Venezuelan Migrants, only 1 in 10 Venezuelan migrants interviewed reported having a chronic condition [57].

HEALTH FINANCING

Colombia spent $1213 per capita on health in 2019, representing 7.3 percent of GDP. The SGSSS (General System of Social Security and Health) is the major health financing system in Colombia. It has

two components, a contributory regime, and a subsidized regime. The contributory regime is funded by a mandatory formal sector payroll tax of 12 percent of wages (4 percent from the worker and 8 percent from the employer). The subsidized regime covers informal workers, the poor, indigenous populations, and vulnerable groups. Local governments contribute to SGSSS for the subsidized regime on a per capita basis. The subsidized regime also gets some cross subsidy from the contributory regime payments from the formally employed. SGSSS uses the funds to pay for members' (both contributory and subsidized) use of a "mandatory benefits package" of comprehensive primary and secondary services. Public hospitals are paid by local governments on a fee-for-service basis for emergency care and services outside of the mandatory benefits package. SGSSS users of services may pay some co-payments, but usually no more than 10 percent of costs. No co-payments are required for infants under 1 year of age, indigenous populations, displaced populations, rural migrants, and the indigent, elderly, or disabled. Under the subsidized regime there are also no co-payments for mother and child health care (prenatal care, deliveries, and potential complications), health prevention and promotion services, communicable disease programs, high-cost and catastrophic services, medications, urgent consultations, and many specialist services. The ratio of affiliates in the subsidized system (23.95 million) is similar to that of the contributory system (23.91 million). Other OOP spending and private insurance go to services outside of the mandatory benefits package [130].

The health spending on Venezuelan migrants has two dimensions. In the first place, the public expenditure to fund the Venezuelan population in the subsidized regime reached a total of $31.5 million and a per capita close to $212 in the year 2020. The second dimension is the spending on the uninsured population. Between July 2019 and June 2020, 401,468 Venezuelan migrants were treated for emergencies, with a total cost of $68 million and an annual per capita cost of $46.73, higher in women between 15 and 18 years, where the per capita cost is $230.35, the 71% of the health expenditure is concentrated on women. The distribution of spending by territorial entity is concentrated in the following areas: Bogotá (19%), Norte de Santander (13%), Antioquia (12%), Valle del Cauca (6%) and La Guajira (5%). Finally, between 2017 and 2019, a total of 1,812,560 vaccine doses were provided to migrants in this period at the cost of $6.9 million for the vaccines alone, not counting the cost of supplies or delivery personnel [131]. According to the Ministry of Health and Social Protection, between April 2017 and September 2019, the government assigned public hospitals 130,000,000,000 Colombian Pesos for health care of Venezuelan migrants and during that period they invoiced 377,120,715,386 Colombian Pesos [132].

If migrants used health services at a similar rate to native-born Colombians (they do not do so now, but no specific figures for actual use of services by migrants could be found), the cost of the health services used by them would be about 3.6 percent of the total or $35 per capita of the $962 total per capita or $1.7 billion total. Migrant women from Venezuela represent about 1.0 percent of total health spending or about $10 per capita. This is not a large cost burden overall, but the cost of health services used by Venezuelan migrants in geographic areas closer to the border is likely to be a large part of costs locally.

Donor support is critical for the new temporary status for migrants in Colombia announced in February 2021. The next international donors' conference for Venezuelans, set for June 2021, is important for financing, building on the 2021 Refugee and Migrant Response Plan, which appealed for $1.4 billion and received $24 million (as of March 2021) [133].

Peru spent $656 per capita on health in 2014 (as shown in Table A-5), representing 5.5 percent of GDP. The financing system comprises a social health insurance ("EsSalud") that is mandatory for the salaried formal sector and retirees and their dependents (covering about 30 percent of the population). Integral Health Insurance (SIS) managed by the MoH that fully subsidizes care for the poorest but requires voluntary contributions from the non-poor and non-EsSalud (covering 60 percent of the population). By 2021, SIS has reached a coverage of 95 percent of the population of Peruvian citizens, following the passage of a law that extended SIS coverage to all non-insured legal residents. In addition to EsSalud there is spending on the army and police force health insurance programs (covering less than 10 percent of the population) and private insurance (covering less than 10 percent of the population), along with OOP spending by households (amounting to about $190 annually per capita).

The cost of the health services used by migrant women represents about 0.9-1.3 percent of total health spending[1] or about $6 to $9 per capita. This is not a large cost burden overall, but the cost of health services used by Venezuelan migrants in geographic areas closer to the Colombian border where many arrive in Peru is likely to be a large part of costs locally.

Table A-5. Health financing indicators for Peru and Venezuela, 2014

	Percent of total health expenditure				Total health expenditure as a share of GDP	Per capita total health expenditure
	Social security	General government	Out of pocket	Private insurance		
Colombia	62%	13%	15%	10%	7.0	$962
Peru	21%	41%	29%	5%	5.5	$656
Venezuela	9%	20%	63%	2%	5.1	$923

Source: Pan American Health Organization, Health Financing in the Americas.

Venezuela spent about as much per capita on health as Colombia in 2014, but a lower percentage of GDP. It spent substantially more per capita on health than Peru in 2014, but about the same percentage of GDP. Venezuela's government mobilized a low share of overall health spending through mandatory social security contributions and general government spending, so OOP was very high. This situation has likely worsened since 2014 with the decline of the Venezuelan economy. The population at risk of migration from Venezuela is less likely to be in formal employment so less likely to benefit from social security health financing and more likely to depend on OOP spending.

CONCLUSIONS

The OHCHR lists violations to the rights of food and health as the primary drivers of migration from Venezuela [120]. The major policy shift in Colombia announced in February 2021 to offer temporary protective status to displaced Venezuelans represents an enormous change to SHP for migrants. The Colombia example could offer evidence for other countries once implemented. However, social and political challenges remain. For example, since March 2017, approximately 60,000 pregnant women from Venezuela have given birth in Colombia and Venezuelan migrants in Colombia had higher rates of maternal, neonatal, infant and under-five mortality. Politically, some fear the maternal mortality rate is

[1] Venezuelan migrants make up about 1.9-2.6 percent of the Peruvian population, women migrants are about half of the total migrant population. Migrants use health services at a similar rate to native-born populations.

being driven by migrants and fear perceptions of the declining health indicators. Despite official protections in Colombia, xenophobia and discrimination remain issues, as does knowledge about available services.

CASE STUDY 3: NTCA TO MEXICO AND THE UNITED STATES

The Northern Triangle of Central America (NTCA), comprising El Salvador, Guatemala, and Honduras, is a major sub-region of origin for migrants to Mexico and the United States. UN DESA data show that 70,388 migrants from the NTCA were in Mexico in 2019, 53.3 percent of them women (37,550). Migrants from NTCA made up 0.6 percent of Mexico's population. Most of the migrants are in transit to the U.S., but a minority enter and remain in Mexico to work seasonally before returning home [13]. There is little information available about NTCA migrants who intend to pass through Mexico on their way to the United States but remain in Mexico for longer periods of time.

UN DESA data show migrants from NTCA made up 1.0 percent of the U.S. population (3,165,893 migrants from the NTCA) in 2019, 51.4 percent of them women (1,628,215). Historically, there have been more men than women migrants entering the United States from Mexico and Central America. U.S. Border Patrol data shows the number of women crossing the Mexican border more than tripled from 2018 to 2019 to nearly 300,000. Likewise, the numbers are increasing in Mexico; in fiscal year 2012 Mexican authorities apprehended 11,336 women (13 percent of the adult total) and in fiscal year 2017 the number of apprehended women rose to 30,541 (25 percent of the adult total) [134].

NTCA POPULATIONS AT RISK OF MIGRATION

Although motives vary by individual, difficult socioeconomic and security conditions, worsened by natural disasters and poor governance, are among the most important drivers of migration from the Northern Triangle. Several sources mention multiple factors as influences on the decision to migrate, including poverty, violence, reaction to the destruction caused by natural disasters, civil unrest, food insecurity, geographic isolation, discrimination based on minority (non-Spanish speaking) ethnic identity, and lack of economic opportunity. Social norms and lack of legal protections in the Northern Triangle have increased women's migration; for example, gender-based crimes are largely unpunished, women are forcibly recruited to be involved with gang members, and some of the highest rates of femicide in the world have directly contributed to women's decision to migrate [134]. UNHCR reports that unaccompanied minors make up a large portion of those seeking refuge in the United States from the NTCA. Lesbian, gay, bisexual, transgender and intersex' (LGBTI) people are also fleeing violence and persecution in the region. As of November 2019, at least 88 percent of LGBTI asylum seekers from the NTCA reported having suffered sexual and gender-based violence in their home countries [135].

However, there is little in the way of specific data about the availability and use of health services by those at risk of migration in the NTCA. Only Guatemala reported data by income quintile related to access and use of health services by women (see Table A-6). The lowest (Q1) and next-to-lowest (Q2) income quintiles might serve as rough proxies for the disadvantaged women at risk of migration. The indicators on skilled assistance with deliveries and use of contraception show major disadvantages for women in quintiles 1 and 2. Only quintile 5 seems to have a moderately favorable figure for problems

accessing care. The unfavorable indicators for Q1 and Q2 indicate that health care access could be a contributor to the decision to migrate.

Table A-6. Guatemala, women's health indicators by income quintile (2015)

Indicator	Q1 (poorest)	Q2	Q3	Q4	Q5 (least poor)
Percent receiving at least one antenatal care visit	86	88	98	92	96
Percent receiving skilled assistance with deliveries	40	57	79	92	96
Percent currently using contraception (2017)	46	52	62	69	73
Percent of women malnourished (Body mass index <18.5)	2.5	2.6	2.8	3.1	3.3
Percent of women with problems accessing health care	85	80	78	71	58
Source: World Development Indicators, accessed December 28, 2020.					

NTCA MIGRANTS IN MEXICO

Mexico's policy is that foreign-born people are permitted access to health care, irrespective of their migration status, and that emergency care is to be provided at no cost. Migrants in formal sector employment (a small minority) get health insurance coverage from one of the mandatory social security systems (see below for more on the social security systems).

Prior to 2018, there were two ways for informally employed international migrants to obtain insurance coverage through the Seguro Popular system: 1) using their temporary or permanent resident visa as an identification to register for a three-year (renewable) period (which is the same as the rest of the Mexican population); or 2) registering without an identification document for 90 days (non-renewable). The first option is not available to those with "regional visitor" or "regional worker" cards, used by seasonal migrant workers in southern Mexico. The option for visa holders ended in 2018. The second option was explicitly described as a way through which migrants in transit to the United States can be covered by Seguro Popular. Since 2018 Mexico no longer provides for full coverage for immigrants unless they are in formal employment and eligible for social security health coverage. We did not find an explanation for this policy change. Mexico does offer other "first aid" types of services (and referrals when needed to more-substantial services) that are provided to transiting migrants by mobile clinics and transit stations. These services are arranged for by the National Institute of Migration [63].

No information was found concerning the use of health services by NTCA migrants in Mexico. However, such in-transit populations would benefit from a defined, but limited, package of primary care such as protection from and treatment of communicable and water-borne diseases, immunizations, continuity of care for chronic conditions, such as HIV, and maternal and reproductive health services, such as contraception, ante- and post-natal care, and assisted deliveries. No estimate of the costs of these services are available, but they likely would cost much less than Mexico's per capita spending on health.

NTCA MIGRANTS IN THE UNITED STATES

The following information about health insurance coverage is not specific to NTCA migrants to the United States, but applies to migrants generally, since no breakout of the information is available specifically for NTCA migrants. NTCA migrants to the United States are less likely be authorized for health insurance coverage than the overall U.S. migrant population About 23 percent of non-elderly authorized immigrants in the United States did not have health insurance and about 45 percent of non-elderly unauthorized immigrants were uninsured. Immigrants, both authorized and unauthorized, who are employed and whose employers sponsor health insurance may benefit from this coverage. Most immigrants with employer-sponsored health insurance are authorized [136].

Authorized immigrants with "qualified" immigration status are eligible for Medicaid or the Children's Health Insurance Program (CHIP), but in some states migrants must wait five years after obtaining qualified status before enrollment. Some immigrants, such as those with temporary protected status, despite being authorized, do not have a qualified status and are not eligible to enroll. Over half of states eliminate the five-year wait and extend coverage to authorized child immigrants and nearly half extend coverage to pregnant women without a qualified status.

Authorized immigrants can purchase coverage through the ACA Marketplaces and may receive subsidies for this coverage if they are not otherwise insured through employment, Medicaid, or CHIP. The Kaiser Family Foundation says that despite eligibility for ACA Marketplaces, "[m]any lawfully present immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenge" [136].

Some states and local governments fund coverage to some groups of immigrants regardless of immigration status. People with Deferred Action for Childhood Arrivals (DACA) status (18 years of age or older who were brought to the United States as children without qualified status and do not have serious misdemeanors or felonies on their records) are not considered authorized and remain ineligible for coverage options. Undocumented immigrants are not eligible for Medicaid or CHIP or to purchase coverage through the ACA Marketplaces. The undocumented without state or local-government coverage rely on safety net health services, such as community clinics and hospital emergency rooms, and delay or forgo care [136].

COMPARISON OF HEALTH COVERAGE INDICATORS

Table A-7 compares health coverage indicators from NTCA countries with Mexico and the United States. Mexico's indicators are all more favorable than those from Guatemala; they are similar to those of El Salvador; and they are more favorable than those from Honduras only for skilled birth attendance and hospital births. The U.S. indicators are all more favorable than those from Guatemala; they are more favorable than El Salvador for DTP3 and ANC 4+, but otherwise similar; and they are notably more favorable than those from Honduras only for skilled birth attendance and hospital births.

The differences between data from Mexico and the United States and those of the lower (and maybe even middle) quintiles in Guatemala would suggest that health care could be a factor in the decision to migrate.

Table A-7. Comparison of national health coverage indicators between origin (NTCA) and destination (Mexico and United States)

	DTP3	ANC 4+	Contraceptive Prevalence	Skilled birth attendance	Hospital births
El Salvador	85%	82%	67%	100%	99%
Guatemala	82%	43%	51%	70%	69%
Honduras	90%	89%	65%	83%	74%
Mexico	85%	90%	68%	96%	93%
US	95%	92%	67%	99%	98%

Source: Pan American Health Organization, PLISA (Health Information Platform for the Americas), accessed December 12, 2020.
Note: Data for El Salvador is for 2017, except for contraceptive prevalence which is for 2018; data for Guatemala is for 2014 for ANC 4+, 2016 for assisted deliveries and hospital births, 2017 for DTP3, and 2018 for contraceptive prevalence; data for Honduras is for 2012 for ANC 4+ and assisted deliveries, 2017 for DTP3 and hospital births, and 2018 for contraceptive prevalence; data for Mexico is for 2016 for ANC 4+, assisted deliveries, and hospital births, for 2017 for DTP3, and 2018 for contraceptive prevalence; data for the US is for 2015 for ANC 4+, assisted deliveries, and hospital births, for 2017 for DTP3, and 2018 for contraceptive prevalence.

HEALTH FINANCING

Mexico spends $1,122 per capita on health, representing 6.2 percent of GDP. It has two social security health systems for the formally employed in: 1) the private sector (IMSS) and 2) for government employees (ISSSTE) covering about 45 percent of the population. The Social Protection System for Health (Seguro Popular or SSPS) is a voluntary government subsidized program for those not covered by the social security systems, covering about 47 percent of the population. Seguro Popular comprises Popular Health Insurance (PHI) for primary and secondary care and medications, the Fund for Protection Against Catastrophic Health Expenditures, and Medical Insurance for the XXI Century that covers comprehensive services for children under 5. The Mexican population also spends substantially on health services from its own resources. OOP spending per capita is about $516 per year.

It is not possible to estimate the cost of the health services used by migrant women in Mexico. Migrants make up about 0.6 percent of the Mexican population, women migrants are about 53.3 percent of the total migrant population. However, there is no data on health services used by migrants. However, the services that they use (mainly while in transit to the United States) are unlikely to be a major burden on health financing.

The United States spends more on health per capita than any country in the world ($9,403 and 17 percent of GDP in 2014, according to PAHO/WHO, and shown in Table A-8). The majority (55.4 percent in 2019) of the US population is covered by employer-sponsored health insurance. An additional 10.2 percent of the population is covered by directly purchasing private health insurance and 2.6 percent more participate in the TRICARE program for military families. Publicly funded programs include the Federal Government Medicaid program (Medicaid cost is shared with state governments) and CHIP for low-income children, (which, combined, cover 23.9 percent of the population) for the poor and near poor, Medicare program (18.1 percent of the population) for the elderly and disabled, Veterans' Affairs (VA) health program (1.0 percent of the population) (for military veterans), and the Affordable Care Act (ACA) subsidized (subsidies on a sliding scale up to about 400 percent of the poverty line) marketplaces for health insurance coverage for those not covered by Medicaid, Medicare, CHIP, VA, or employer-

based insurance [137]. In total, 92 percent of the United States population has some form of health insurance [138].

There is no source of data on health services used specifically by NTCA migrants or the subset of female NTCA migrants to the United States. However, a study of year 2000 data found that foreign-born adults in Los Angeles County, California, used health services costing 73 percent of average and the undocumented used services costing only half of the average [139]. If Central Americans were covered for health services, their use of the services undoubtedly would be higher than what was reported in the study, but they also would be likely to use more preventive services and make fewer visits to costly emergency rooms when care was delayed, improving their health status, and making the spending on health care more efficient. Since NTCA migrants represent about one percent of the United States population, covering all of them for health care would likely cost no more than an additional one percent (since some, though few, already have employer-based coverage or are eligible for government-funded programs).

However, if all of the estimated 22 million undocumented migrants were to use health services at the same rate as other Americans (and authorized migrants), it would amount to nearly a 7 percent increase in the population fully using health services.

Table A-8. Health financing indicators for Mexico, El Salvador, Guatemala, and Honduras for 2014

	Percent of total health expenditure				Total health expenditure as a share of GDP	Per capita total health expenditure
	Social security	General government	Out of pocket	Private insurance		
Mexico	29%	22%	46%	4%	6.2%	$1,122
US	42%	6%	11%	33%	17.0%	$9,403
El Salvador	26%	40%	19%	5%	6.8%	$585
Guatemala	19%	19%	52%	2%	6.1%	$473
Honduras	11%	39%	43%	5%	8.5%	$400

Source: PAHO/WHO, Health Financing in the Americas.

NTCA countries spend much lower amounts per capita compared to Mexico, but El Salvador and Guatemala spend about the same share of GDP on health care as does Mexico. The NTCA countries spend much lower amounts per capita and as a percent of GDP on health care than the United States, Guatemala, Honduras, and Mexico have particularly high shares of health spending coming from out-of-pocket spending. The populations at risk of migration in all three countries are less likely to benefit from social security spending than average since many migrants come from households that do not have formal sector employment. They also are highly unlikely to be covered by private insurance. The migrants tend to come from geographic areas less well served by government health services and hence are relatively dependent on OOP spending.

CONCLUSIONS

Socioeconomic and security conditions are among the most important drivers of migration from the Northern Triangle. There is no data on health services or cost of services used specifically by NTCA migrants in the US or Mexico. However, it is estimated that if all of the approximately 22 million

undocumented migrants were to use health services at the same rate as other Americans (and authorized migrants), it would amount to nearly a 7 percent increase in the population fully using health services.

ANNEX 2. INTERNATIONAL AND REGIONAL RESPONSES TO MIGRATION

INTERNATIONAL FRAMEWORKS

Globally, countries are working to develop sustainable responses to increased and more complex mass migration processes underway around the world. This section highlights examples of key international norms and frameworks that the IOM says "provide governments and partners with a reference point when working towards identifying effective national practices and considering possible common areas of action at supra-national and global levels" [140]. These include longstanding international commitments that directly or indirectly address migration such as the International Convention on the Elimination of All Forms of Racial Discrimination of 1963 (Art. 5. e, iv); the 1967 revised Protocol Related to the Status of Refugees; the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families of 1990 (Arts. 28,43,45); and the United Nations Convention Related to the Status of Refugees, 1951.

Since the adoption of the Universal Declaration of Human Rights (1948), states have committed to guaranteeing the right to social protection for migrants, irrespective of their migration status. The International Convention on the Protection of the Rights of All Migrant Workers and the Members of Their Families was adopted by the United Nations (UN) General Assembly in 1990 in response to the prevalence of migrants, especially those who are unskilled and undocumented, working under limited social protection, with poor access to health and other social services, and at risk of exploitation. As of 2016, it was ratified by only 48 Member States, most of whom are source countries of international migration. Article 25 of the Convention – which indicates that migrant workers shall enjoy treatment (health) not less favorable than that which applies to nationals – has yet to be fully implemented [78].

In its general recommendation No. 26 (2008) on women migrant workers, the Committee on the Elimination of Discrimination against Women addressed the issues of women migrant workers who travel independently, those who migrate as dependents of their spouses and those in irregular situations. It outlined the responsibilities of states to implement gender-responsive and rights-based migration policies, involve women in policymaking, safeguard remittances sent by women migrant workers, collect data disaggregated by gender, and lift discriminatory bans on women's freedom of movement [141].

The 2018 Global Compact for Safe, Orderly and Regular Migration (Global Compact for Migration) encourages UN member states to establish or maintain non-discriminatory national social protection systems and to assist migrant workers at all skills levels to have access to social protection in countries of destination. The Global Compact for Migration also calls for ensuring the portability of social security entitlements and earned benefits [69]. A gender perspective is mainstreamed in the Global Compact, with the intention of recognizing women's "independence, agency and leadership in order to move away from addressing migrant women primarily through a lens of victimhood" [40].

Specific to health, the World Health Assembly Resolution WHA61.17 (2008) promotes migrant-sensitive health policies and equitable access to health promotion, disease prevention and care for migrants, without discrimination on the basis of gender, age, religion, nationality or race. Decision EB140

(9) updates the resolution, strengthening the guiding principles to promote better health for refugees and migrants [55]. Migrant-inclusive policies and plans should build on national population-based health strategies and be coherent with migrant profiles. The development of migrant-sensitive health-care responses and the monitoring of migrant health, through a Migration and Health in All Policies approach should include measures to: ensure culturally sensitive and linguistically diverse service provision; enable access to primary health care; include non-citizen groups within national disaster preparedness and response plans; and establish reporting mechanisms within routine health information systems for data to plan for migrant needs [109].

In order to support states making good on their international commitments, the WHO has issued normative guidance with respect to migrant health access and access to SHP. For example, the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants advocates for mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning, and promotes migrant-sensitive health policies, and legal and social protection. Key guiding principles to promote the health of migrants include: "[t]he right to the enjoyment of the highest attainable standard of health should be exercised through non-discriminatory, comprehensive laws, and policies and practices including social protection." Further the Framework prioritizes "refugee- and migrant-sensitive health policies, legal and social protection and program interventions that incorporate a public health approach and that can provide equitable, affordable and acceptable access" recognizing that achieving this "may require modifying or improving regulatory and legal frameworks to address the specific health needs of these populations, consistent with applicable national and international laws [142].

The WHO Draft Global Action Plan on Supporting the Health of Migrants (2019-2023) recommends that states focus on six priorities in their national responses to migration. These include long-term public health interventions; continuity and quality of essential health care; mainstreaming refugee and migrant health into global, regional, and country agendas and the promotion of legal and social protection; including through partnerships and inter-sectoral, intercountry and interagency coordination and collaboration; enhancing capacity to address social determinants and accelerating progress towards UHC. Although the action plan was developed in consultation and cooperation with WHO member states, regional economic integration organizations, the IOM and UNHCR, it remains unratified [143].

7.2 LAC REGIONAL ORGANIZATIONS AND FRAMEWORKS

The response of countries in the LAC region to intensified intra-regional migration flows is guided by evolving regional, sub-regional and bilateral agreements, and by regional groupings and frameworks that have been developed both by governments and multilateral agencies. Several of these have aimed to regularize nationals from other countries in the region or have focused on enabling or responding to free movement within the region. However, we found no evidence that regional migration response frameworks consider the specific needs and situation of women migrants. Key regional groupings and sub-groupings are presented below in alphabetical order.

The **Andean Community of Nations (CAN)** has developed various regional integration mechanisms to facilitate migratory labor movement and control, and to protect and assist Andean citizens in other countries. CAN has promoted recognition of national identity documents of residents of member countries and the electronic "Tarjeta Andina de Migracion" to make ingress to member countries more

efficient [144], and has also developed institutional mechanisms, such as the Andean Integration System--comprised of various regional institutions--and the Andean Parliament that acts as a consultative body and can implement political decisions [145, 146]. Furthermore, the Andean Charter for the Promotion and Protection of Human Rights lays out the rights of migrants, including preventing discrimination against Andean migrants in access to health services [147].

The **Andean Health Organization (ORAS-CONHU)** addressed "Migration Management in the Andean Region" in its 2009–2012 Strategic Plan, and stimulated efforts to collect information on the magnitude of migration processes in the region, and on migrant health. The ORAS-CONHU passed a framework on migrant health in their "Plan Andino de Salud en Fronteras 2016-2018" to support integration and in 2018, agreed to create an advisory commission on migrant health tasked with creating a roadmap on coordinating joint actions to address migration challenges in the region [148].

The **Caribbean Community (CARICOM)** is the regional integration and governance mechanism for fifteen member states, primarily of the English-speaking Caribbean. CARICOM member states commit to free movement within the region under the CARICOM Single Market and Economy (CSME) regime. National responses to migrants are guided by the Caribbean Community Agreement on Social Security (1996) and Protocol on Contingent Rights (2018), which entitle migrants from within the region to social security benefits covered by contributory pensions, although access to primary health care is not guaranteed CARICOM promotes and supports a unified and inclusive Caribbean, and operates through a number of regional bodies and platforms focused around technical areas. These include the Pan-Caribbean Partnership Against HIV (PANCAP), which coordinates the regional HIV response and includes a focus on human rights and access to services for migrant and mobile populations. PANCAP's Regional Framework for Migrant Health and Rights is "a roadmap for equitable and non-discriminatory access to health care services for mobile and migrant populations regardless of age, race, color, sex, language, religion, political or other opinion, national or social origin, sexual orientation, gender identity, property, birth or other status" [149]. The Caribbean Public Health Agency (CARPHA) also includes a focus on population mobility and health.

In order to continue promoting regional cooperation and development, the presidents of Colombia and Chile led the establishment of the **Forum for the Progress and Development of South America (PROSUR)** in March 2019 [150]. As Prosur's proposed health sectoral plan also does not include any reference to migrants, improving documentation of PROSUR's objectives, guidelines, or plans regarding migration would be important for understanding the effectiveness of this regional approach [151].

The **Organization of Eastern Caribbean States (OECS).** Headquartered in St. Lucia, the purpose of the OECS grouping is to consolidate a single economic space for enhanced economic growth, social inclusion and environmental protection. The organization's seven full members are: Antigua and Barbuda, Commonwealth of Dominica, Grenada, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and The Grenadines. Anguilla, The British Virgin Islands, Martinique and Guadeloupe are Associate members. In 2020, the OECS developed a social inclusion and social protection framework that includes consideration of migrants and mobile populations [152].

The **Pacific Alliance (Alianza del Pacifico)** of Chile, Colombia, Mexico, Peru aims to increase integration to progress towards the free mobility of goods, services, resources, and people between

countries. The platform strives to drive economic growth, development and competitiveness, achieve greater well-being, socioeconomic equality and promote social inclusion. Initiatives include strengthening the capacities of migration authorities in member countries through the use of information and communication technologies, and the operation of the Platform for Immediate Consultation of Information for Migratory Purposes to facilitate safe migration flows [153].

The **Sistema de la Integración Centroamericana (SICA**) and **Council of Ministers of Health of Central America (COMISCA).** The General Secretariat of SICA in El Salvador serves the member states of: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama and the Dominican Republic as an associate member. To advance regional integration, including migration and free movement, SICA is implementing the Central American Security Strategy and the Action Plan for a Comprehensive Response of Migration in the Region (PAIM- SICA), as well as a regional study on the causes and consequences of migration in collaboration with IOM and other partners. Key related goals include improving the health of migrants and strengthening local governance of migration in border municipalities [154].

The **Southern Common Market (Mercosur)** regional platform passed an agreement on recognition of migrant rights by member states, and this has influenced migration laws in Argentina and to a certain extent, Chile. The creation of the Specialized Migration Forum, comprising labor ministers and officials of national migration authorities, provided an avenue to share ideas and promote policy consensus, ultimately resulting in the adoption of Argentina's "Patria Grande" program for the regularization of Mercosur nationals by member countries. Additional efforts specific to labor migration are described under Drivers of Women's Migration [155].

Similarly, the **Union of South American Nations (Unasur)** aimed to promote the cultural, political, and economic integration based on the recognition, respect, and inclusion of people who had not been the prime beneficiaries of previous integration processes [156]. The regional treaty laid out objectives regarding migration, including a regional citizenship initiative, going as far as to create the Working Group on South American Citizenship, tasked with creating a road map and conceptual report to explore what citizenship would look like. In addition, Unasur called for the reciprocal recognition of the rights of member state residents and promoted regional cooperation on migration based on human and labor rights and the harmonization of policies [157]. Beginning in 2018, however, LAC countries began to suspend or withdraw their membership from Unasur for various political reasons, including in response to the unfolding crisis in Venezuela.

Regional commitments

The commitment of LAC countries to regional solidarity in providing support for migrants is evidenced in high-level regional commitments including:

- The **Ministerial Declaration in Mesoamerica (2017) and Resolution of the Andean Countries on Health and Migration (2018)**.
- The **Declaration of Quito on Human Mobility of Venezuelan Citizens in the Region** was issued in 2018 by eight LAC countries (Argentina, Chile, Colombia, Costa Rica, Ecuador, Paraguay, Peru, and Uruguay), and calls for adapting policies, programs, and legal frameworks to

promote and protect the health of migrants, and for the inclusion of migrant health in national and local policies and programs [158].

- The **2020 Regional Refugee and Migrant Response Plan (RMRP)** was launched by UN agencies, including the UNHCR and IOM, as part of the Quito process. The plan is a coordination and fundraising tool for 137 organizations working across the region aiming to reach Venezuelan refugees and migrants and host communities**.** Actions span 9 key sectors**:** health, education, food security, integration, protection, nutrition, shelter, relief items and humanitarian transport, and water, sanitation and hygiene [112].
- The IOM-supported **Conference on Migration (SACM) or Lima Process** mechanism allows for important consultation and exchange events in the priority areas of: human rights of migrants regardless of their status; understanding migration in relation to development; strengthening cross-country dialogue and political coordination; highlighting migrants' contributions to welfare and cultural enrichment; and promoting civil society participation [159].

Health sector responses in the region are also guided by a number of PAHO/WHO resolutions aimed at ensuring the health of migrant populations: PAHO/WHO Gender Equality Policy (2005); Health and Human Rights (2010); Health, Human Security, and Well-Being (2010); Plan of Action on Health in All Policies (2014); Plan of Action for the Coordination of Humanitarian Assistance (2014); the Strategy for Universal Access to Health and Universal Health Coverage (2014); Resilient Health Systems (2016); Health of Migrants (2016); and Plan of Action on Disaster Risk Reduction (2016).

PAHO/WHO member states approved the regional Strategy for Universal Access to Health and Universal Health Coverage as an overarching framework for the health system to promote equity and protect the health and well-being of migrants. PAHO/WHO guidance proposes to achieve integration of migrants into health systems through a collaborative framework that builds on and highlights the relationship between migration and development, emphasizing the need to address public health for migrants to consolidate regional and national health outcomes, and achieve universal health coverage (UHC) and the Sustainable Development Goals (SDGs). The "Health of Migrants" policy guidance is particularly salient in its focus on regulatory and legal frameworks, national health policies, and programs to address health inequities that affect migrants and to ensure equitable access to financial protection and health services; and to coordinate programs and policies on health issues in border areas. The proposed interventions incorporate approaches based on health equity, gender and ethnic equality, and the right to health [110].

7.3 LAC COUNTRY RESPONSES TO MIGRATION

The regional frameworks and commitments described above provide a strong foundation for the regional solidarity observed in LAC countries' responses to regional migration crises. The literature documents experiences from the LAC region that show how national efforts to establish migration policy frameworks have evolved over time, many along with or in response to regional and sub-regional agreements and commitment, such as the regional integration goals of Mercosur [155].

Exhibit 7. LAC country approaches to migration

Country	Migration policy
Argentina	Issues residence permits based on criteria including employment and family reunification. Applies the Agreement on Residence for Nationals of the States Parties and Associated States of Mercosur. Venezuelans can enter without a passport and can receive temporary residence with their national identification cards and after two years, are eligible for permanent residence.
Brazil	Grants a two-year temporary residence, with conversion to permanent residence, and fee exemption in some cases.
Chile	Grants the Democratic Responsibility Visa that must be processed In Venezuela. Launched an Extraordinary Regularization Process for all nationalities. Temporary visas are divided into three categories: subject to a contract, study or temporary.
Colombia	Requires a passport (valid or recently expired), Venezuelans who live in the border region also have the option of applying for a Border Mobility Card (Tarjeta de Movilidad Fronteriza, or TMF), which only requires them to furnish a national identity document.
Costa Rica	The 2009/2010 immigration reform policy sought to "organize migration laws according to human rights perspective" in order to allow migrant's access to the welfare system and public services. This committed the country to the social inclusion of immigrants and established a regularization process that requires migrants to have social insurance to obtain regular status. Allows flexible application of immigrations laws, including expediting the issuance of visas to Nicaraguans following the April 2018 onset of the political crisis, making legal movement easier for those fleeing the country.
Dominican Republic	Takes into account the abilities and skills of applicants for temporary residence or work permits. The visa is issued after verification that the qualifications of candidates match the profile and needs of the requesting company. Temporary residents may apply for permanent residency after five years of continuous residence.
Ecuador	Grants temporary residence if economic solvency is proven. Grants Unasur nationals with Unasur visa two-year temporary residence. Ecuador appears to have the largest proportion of irregular migrants of 11 LAC countries.
Mexico	Issues temporary and permanent resident cards to applicants of asylum, for humanitarian or public interest reasons.
Panama	Grants residency permits that encompass provisional permits, permanent residence, temporary residence, temporary visitor, extensions and others. Recognizes passports that have expired within the past three years, allowing a greater number of Venezuelans living in Panama to open bank accounts and conduct other official procedures.
Peru	Grants the Temporary Residence Permit (PTP) for Venezuelans who entered the country before February 2017.
Uruguay	Grants permanent residence to nationals of Mercosur member states, including Venezuela.

ANNEX 3. METHODOLOGY

The landscape analysis was conducted through 1) desk-based literature review and 2) stakeholder interviews. This section first describes the methodology used for the literature search, followed by the stakeholder interviews and additional research for a more in-depth look at promising practices identified by the literature review and interview.

7.3.1 PEER-REVIEWED LITERATURE

We used the following databases to identify peer reviewed literature: EBSCO, PubMed, Academic Search Complete, EconLit, MEDLINE Complete, USAID Development Experience Clearinghouse, and World Bank Open Knowledge Repository. The team began by using the general search terms: "health protection migrants" or "health protection migrant women" or "migrant women access to health" or "migrant women access to social health protection" or "migrant health" or "drivers of migration" or "gender drivers of migration" or "health drivers of migration". This initial review was followed by more specific searches that combined the general terms with "LAC", "Central America", "Venezuela", "Haiti", "Dominican Republic" to ensure that we captured both the global and LAC contexts. Articles published in the last 10 years (after 1 January 2010) were reviewed. When a search returned fewer than 500 results, a member of the study team scanned each title to determine whether the article was related to the research questions. If the study team member decided that an article could be relevant, the full abstract was reviewed to determine whether to include the article for full text review. When a search returned more than 500 results, the first 100 were scanned to determine relevance.

The study team identified 180 published articles for full text review, from over 9,811 returned results, and scored each for relevance on a scale of 1 to 5 (from not relevant at all to highly relevant). Criteria for determining relevance include the following:

- Describes any strategies/initiatives with the goal of increasing SHP in high-migration contexts;
- Includes specific reference to migrant women or women in origin countries;
- Describes the outcomes of any strategies/initiatives with respect to improving SHP for migrant women or women in origin countries;
- Describes any enabling or inhibiting factors that facilitated improved SHP;
- Includes country data or examples.

7.3.2 GRAY LITERATURE, BRIEFS, AND WHITE PAPERS

The study team scanned websites of international agencies for relevant unpublished literature, white papers, and research briefs. The general search terms used were "health protection migrants" or "health protection migrant women" or "migrant women access to health" or "migrant women health" or "migration and gender" or "health migration" or "drivers of migration" or "gender drivers of migration" or "health drivers of migration". The team searched reports, publications, press releases, blog posts, and conference proceedings on the official websites of the following agencies and organizations: USAID Development Experience Clearinghouse, and World Bank Open Knowledge Repository. World Health Organization (WHO), International Organization for Migration (IOM), World Bank, Inter-American Development Bank (IDB), Pan American Health Organization (PAHO/WHO), United Nations High

Commissioner for Refugees (UNHCR), International Labor Organization (ILO), United Nations Economic Commission for Latin America and the Caribbean (ECLAC), Organization for Economic Co-operation and Development (OECD), and Organization of American States (OAS), and UN Women.

The team used a similar process to identify unpublished or gray literature as was used for published results. The team entered search terms into the websites' search function. We reviewed the abstract or executive summary of a report or white paper, if one existed, for selected titles determined to be relevant.

7.3.3 KEY INFORMANT INTERVIEWS

Based on a mapping of agencies working on issues related to migration, women's health, and SHP in the LAC region, and in consultation with USAID, nine agencies were identified for key informant interviews.

7.3.4 ADDITIONAL RESEARCH

The team conducted additional targeted research to generate information on specific promising practices or programs identified through the literature review of key informant interviews.

7.3.5 SYNTHESIS AND ANALYSIS OF FINDINGS

We summarized and extracted findings from the literature review into an excel spreadsheet and sorted these into categories derived from articles with a relevancy rating higher than a 3. We developed categories based on recurrent themes in the data that focused, to some extent, on actions taken by governments and/or shown to directly impact access to SHP and to health services by women in high-migration contexts.

We reviewed transcripts from the key informant interviews to identify common themes and grouped information accordingly under them. Relevant information from stakeholder interviews is largely presented in this report through text boxes to provide detail on current efforts in the LAC region. Information provided by informants also helped to guide additional research efforts to gather information on specific programs.

ANNEX 4. KEY INFORMANT INTERVIEWS

Based on findings from the literature review, the team developed an initial mapping of agencies working on issues related to migration, women's health, and SHP in the LAC region. The mapping identified regional and sub-regional governance bodies, multi-lateral agencies, and NGOs working at the regional level. In consultation with the USAID LAC Bureau, the team identified nine priority agencies with which to conduct key informant interviews. Following an initial email introduction from USAID, the team contacted focal points from each agency to request an interview. Interviews were scheduled and conducted with agencies. In most instances, a team or respondents representing different streams of the agency's work participated in the interview.

Interviews were guided by the following questions, developed in consultation with USAID:

1) How is your agency supporting LAC countries to provide SHP for women migrants or women who may be at risk of migration in origin countries?
2) Do you know of any countries that have made progress in expanding SHP for migrant women?
3) Can you identify any emerging good practices in expanding SHP?
4) Do you know of any cross-border or multi-country approaches to expand SHP for migrant women?
5) What is the role of regional and sub-regional platforms in addressing migrant SHP needs?
6) How does your agency engage with regional and sub-regional governance bodies?
7) Do you know of any CSOs or INGOs involved in efforts to expand SHP for migrant women?
8) Do you participate in, or know of, any multi-agency networks or coordination bodies?

Agency	Participant	Designation and contact information	Contact information
IOM	Aleksander Arnikov	Regional Migration Health Specialist for the Americas	aarnikov@iom.int
PAHO/WHO	Catharina Cuellar	Gender and Health Advisor	cuellarc@paho.org
	Candelaria Araoz	Health Systems and Services Advisor	araozc@paho.org
	Camila Polinori	Consultant, Health Systems and Services	polinorcam@paho.org
UNAIDS	Alejandra Corao Castes	Regional Senior Programme Adviser	coraoa@unaids.org
	Adriana Ponte	Refugees and Migrant Affairs Officer	PonteAD@unaids.org

Agency	Participant	Designation and contact information	Contact information
UNFPA	Victoria Comacho	Regional Technical Advisor in Sexual and Reproductive Health	vcamacho@unfpa.org
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