HEALTH SYSTEMS PROFILE
HONDURAS

MONITORING AND ANALYZING HEALTH SYSTEMS CHANGE

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Acronyms

AIN-C	Comprehensive Community Care for Children
ARV	Antiretrovirals
BCH	Central Bank of Honduras
CALAGUA	National Technical Committee for Water Quality
CESAMO	Medical and Dental Health Center
CESAR	Rural Health Center
CESCCO	Center for Contaminant Study and Control
CIM	Interinstitutional Drug Committee
CLIPER	Peripheral Emergency Clinic
CMI	Maternal and Infant Clinic
CNBS	National Banking and Insurance Commission
CNCD	Chronic Noncommunicable Diseases
COMISCA	Central American Health Ministers Board
CONARHUS	National Human Resources for Health Board
CONASA	National Drinking Water and Sanitation Board
CONASATH	National Occupational Health Committee
CONASIDA	National HIV/AIDS Committee
CONCCASS	Ministry of Health Quality Advisory Board
CONCOSE	Ministry of Health Advisory Board
CONSALUD	National Health Council
COTIAS	Interinstitutional Technical Committee for Environment and Health
DAIA	Ensured Availability of Contraceptive Supplies
DR-CAFTA	Dominican Republic-Central American Free Trade Agreement
DRSS	Dimensions of the Steering Role of the Ministry of Health
EAP	Economically Active Population
ENDESA	National Demographic and Health Survey
ENESF	National Epidemiological and Family Health Survey
EPBSS	Basic Health Services Package Delivery
EPH	Permanent Household Survey
EPHF	Essential Public Health Functions
EPI	Expanded Program on Immunization
FONAC	National Convergence Forum
GDP	Gross Domestic Product
HDR	Human Development Report
HET	Specialty Hospital
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HR	Human Resources
HRN	Hospital Regional del Norte
HSR	Health Sector Reform
IDB	Inter-American Development Bank
IHADFA	Institute for Prevention of Alcoholism, Drug Addiction, and Drug Dependence
IHNFA	Honduran Agency for Children and Families
IHSS	Honduran Social Security Institute
IMCI	Integrated Management of Childhood Illness
INE	National Institute of Statistics
LME	List of Essential Drugs
MDG	Millennium Development Goals
MIRA	Integrated Management of Environmental Resources
NGO	Nongovernmental Organization
NHA	National Health Authority
PAHO/WHO	Pan American Health Organization/World Health Organization
PAISFC	Comprehensive Family and Community Health Services Program

PENSIDA	National Strategic Plan for AIDS
PLHA	People Living with HIV/AIDS
PMRTN	Master Plan for National Reconstruction and Transformation
PNGCA	National Air Quality Management Plan
PNM	Honduran National Drug Policy
PRAF	Family Assistance Program
PRIESS	Comprehensive Health Sector Reform Program
PRS	Poverty Reduction Strategy
RAMNI	Accelerated Reduction of Maternal and Newborn Mortality
RAS-HON	Honduran Water and Sanitation Network
RESSCAD	Dominican Republic-Central America Health Sector Meetings
RRAS-CA	Central American Regional Water and Sanitation Network
SAICM	Strategic Approach to International Chemicals Management
SANAA	Autonomous National Water Supply and Sewer System Service
SECPLAN	Honduran Ministry of Planning
SEFIN	Honduran Ministry of Finance
SERNA	Honduran Ministry of the Environment and Natural Resources
SIAFI	Financial Management System
SIC	Honduran Ministry of Industry Trade and Tourism
SIDA	Swedish International Development Authority
SIECA	Secretariat of Central American Economic Integration
SINEIA	National Environmental Impact Assessment System
SS	Honduran Ministry of Health
STD	Sexually Transmitted Disease
TB	Tuberculosis
TDA	Open Unemployment Rate
TFR	Total Fertility Rate
UCOS	Community Health Units
UECF	Coverage and Financing Expansion Unit
UMSS	Ministry of Health Modernization Unit
UNAH	National Autonomous University of Honduras
UNAIDS	Joint United Nations Program on HIV/AIDS
UNAT	Technical Analysis Unit
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNS	United Nations System
UPEG	Management Planning and Evaluation Unit
UPNFM	Francisco Morazán National Pedagogical University
US	Health Units
USAID	United States Agency for International Development
WB	World Bank
WTO	World Trade Organization

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Executive Summary

The Republic of Honduras is located in the center of the Central American isthmus, bordering Guatemala and Belize in the northeast, El Salvador in the southwest, and Nicaragua in the southeast. The government has three branches: executive, legislative, and judicial. Presidential elections are held every four years. The country is divided into 18 departments, which include 298 municipalities. In 2007 the population numbered 7,536,952. Some 52% of the population was located in urban areas, and population density was 67 inhabitants per km^2. The broad base of the population pyramid shows that the country is comprised of primarily young people. Approximately 50% of the population is under 18 years. In 2007, average life expectancy was 73 years.

The epidemiological profile of Honduras is in transition. Infectious diseases, particularly conditions related to the respiratory and digestive systems coexist with chronic degenerative conditions such as cancer and cardiovascular disease, which are more common in the adult population. Diseases such as dengue, tuberculosis, and HIV/AIDS, which are important for epidemiological surveillance due to their high level of transmission, are also present. Injuries due to external causes related to violence (including different types of violence) are also noteworthy. The causes of overall mortality include conditions that begin during the perinatal period as well as the regular occurrence of maternal deaths from preventable causes during delivery and postpartum.

The country has progressed in terms of reducing poverty levels. The Poverty Reduction Strategy (PRS) has been implemented in direct association with the Millennium Development Goals (MDG) since 2000. A basic goal is investment in human capital to reduce poverty and implementation of specific strategies for groups living in extreme poverty. A total of 71% of national employment is in agriculture, trade, and industry. However, the main problem in the Honduran labor market is not unemployment but invisible underemployment, in which low income is associated with low-productivity jobs.

The health sector consists of a public subsector made up of the Ministry of Health (SS), which plays the steering and regulatory role in the sector, and the Honduran Social Security Institute (IHSS), which is responsible for collecting and managing fiscal resources and the required contributions made by workers and employers. The private subsector is formed by for-profit and nonprofit institutions. According to the National Demographic and Health Survey (ENDESA) 2005-2006, 9% of the population is registered in the IHSS, 2.7% has private insurance, and 88.3% is covered by the SS.[1]

In 2005, average public health spending represented 6.7% of GDP. Health was financed primarily by out-of-pocket spending (54%),[2] the National Treasury, international cooperation and, to a lesser extent, by companies.[3] Cooperation resources supplement national efforts for socioeconomic development. However, non-reimbursable international cooperation resources have been reduced.[4] In 2008 the funds donated by the Swedish International Development Authority (SIDA) were withdrawn.

The public sector has 30 hospitals with 5,975 beds at the national level. The private sector has 60 hospitals and 916 beds. The SS is the institution that employs the most physicians and professional nurses, followed by the IHSS. However, the majority of the medical resources are located in the most developed cities.

In the early 1990s the country promoted a health sector reform process within the framework of State modernization and reform. In this context, the national health modernization committee[5] worked on defining a reform proposal based on five specific components: strengthening the steering role of the

[1] ENDESA 2005-2006, p. 265.
[2] A total of 88% of ambulatory patients pay for medical visits with their own resources. Payment is significantly higher for rural dwellers and persons living in households in the lowest income quintile (ENDESA 2005-2006, p. 273).
[3] Many private companies and some public institutions offer their employees private health insurance, while adhering to the requirement to contribute to the IHSS.
[4] See Table 13. Financial resources in the health sector from international cooperation.
[5] Created by Agreement 16-92.

Ministry of Health; progressive integration with the IHSS; comprehensive health services network; decentralization; and equity, efficiency, effectiveness, and social participation as essential requirements for the health care model.

In 1990-2005 there were a series of projects that aimed to strengthen the steering and managerial capacities of the SS, as well as its role as service provider and in actions related to priority programs. The innovations were oriented primarily towards identification of a mechanism to delegate functions to the departmental regions in order to ensure that the population has access to timely and quality health services. Work has also been performed in areas such as improved efficiency in delivery of services, modernization of the hospital network, improved administrative structure of the SS and the IHSS, and greater transparency in procurement and purchasing mechanisms.[6]

The National Health Plan 2021 was prepared in 2001. Its general objective is to improve basic health conditions and health services delivery. The plan emphasizes sectoral reform and increased coverage for delivery of health services. The main initiative of the plan was to transfer responsibilities to the health regions, including budget planning and implementation.

[6] Study of Institutionalization and Governability. The Health Sector in Honduras. World Bank, 2008.

1. CONTEXT OF HEALTH SYSTEM

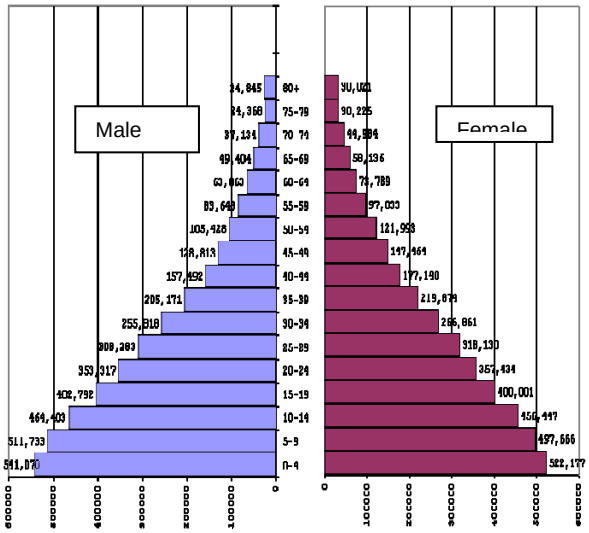
1.1 ANALYSIS OF HEALTH SITUATION

1.1.1 DEMOGRAPHIC ANALYSIS

According to the population census, the growth rate of the population of Honduras decreased in relative terms from 2.98 in 1990-1994 to 2.69 in 1995-1999, and 2.60 in 2000-2004.[7] In 2007 the population was 7,536,952 inhabitants (Table 1).

In general, migration is not a significant factor in population growth, accounting for -1.3 in the period 1990-1994, -2.0 in the period 2000-2004, and -2.2 in 2007. The urban population, which has increased steadily, represented 52.1% of the population in 2000-2004 (Table 1). Over 20% of the urban population is located in the Central District and San Pedro Sula.[8]

FIGURE 1. POPULATION PYRAMID BY AGE AND SEX HONDURAS 2007



Source: INE, Population forecasts 2001-2015.

The population is primarily young, represented by males and females under 18 years of age (49.3%). The adolescent population (12-18 years) accounts for 18% of the total population. The elderly population, which includes adults over 60 years, is a minority (7.5%) that is increasing. This situation has important implications for the supply and demand of health services.

Fertility has declined. The total fertility rate of 5 children per woman in 1989-1991 decreased to 3.3 children in 2003-2006. In spite of this decrease, fertility continues to have an effect on the natural growth rate of the population, which changed by 0.13% between 1990 and 2007. The birth rate and mortality rate are also progressively decreasing. Life expectancy, which is higher for women than for men, has increased steadily (Table 1).

[7] INE, Population forecasts, 2001-2015.
[8] INE, EPH 2007, p. 15.

TABLE 1. DEMOGRAPHIC TREND BY SEX AND SELECTED PERIODS
HONDURAS 1990-2007

Periods/Indicators	1990-1994			1995-1999			2000-2004[1]			2007		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total population (thousands)* (1)	2,321	2,508	4,830	2,882	2,872	5,755	3,341	3,409	6,751	3,473	4,163	7,536
Urban population (1)	42.4	46.5	44.4	46.0	50.4	48.2	49.8	54.4	52.1	49.8	54.5	52.1
Population under 15 years of age (1)	45.2	43.8	44.5	42.9	41.6	42.3	41.7	40.0	40.9	36.5	45.7	41.5
Population 60 years and over (1)	4.9	5.2	5.1	4.9	5.3	5.1	5.1	5.7	5.4	7.3	7.7	7.5
Annual growth rate (1)	2.98	2.98	2.98	2.69	2.67	2.69	2.61	2.59	2.60	2.60	2.59	2.60
Total fertility rate (2)	NA	5.2	5.2* (1989-1991)	NA	4.9	4.9* (1993-1995)	NA	4.4	4.4** (1998-2001)	NA	3.3	3.3** (2003-2006)
Crude birth rate per 1,000 population (1)	NA	NA	36.3	NA	NA	33.3	NA	NA	27.0	NA	NA	29.0
Crude death rate (1)	7.45	5.85	6.65	6.41	4.90	5.66	5.95	4.24	5.09	5.60	4.14	4.7
Life expectancy at birth (1)	64.4	69.2	66.8	66.4	71.4	68.9	67.9	74.1	71.1	69.5	76.6	73.0
Migration balance (3)	-1.5	-1.2	-1.3	-1.7	-1.3	-1.5	-2.4	-1.6	-2.0	-2.1	1.7	-2.2

[1] These figures were calculated based on averages prior to 2004. Source: SS, Bureau of Health Surveillance, draft document, February 2009.
Sources: SECPLAN.
(1) Population forecasts 1988-2050. INE, Population forecasts 2001-2050.
(2) *National Epidemiological and Family Health Survey (ENESF) 2001, p. 46. **National Demographic and Health Survey (ENDESA) 2005-2006, p 60. (3) Permanent Multipurpose Household Survey, 1990-2005.
NA: Not applicable.

In Honduras there are eight culturally distinct ethnic groups: Lencas, Pech, Garifunas, Chortis, Tawahkas, Tolupanes or Xicaques, Miskitos, and an English-speaking black population. According to the 2001 census, this population accounts for 460,000 inhabitants. The areas inhabited by the indigenous population are some of the most deprived areas in the country, with limited access, minimal basic infrastructure of services, subsistence economies, and environment problems.

1.1.2 EPIDEMIOLOGICAL ANALYSIS

The epidemiological profile of Honduras is characterized by the presence of communicable or infectious diseases related to access to water and basic sanitation. There are also noncommunicable diseases, including chronic conditions such as cancer and cardiovascular disease, which are more common in the adult population. Conditions caused by violence associated with lifestyle (including different types of violence) comprise another important group.

Child Health

Incidence of low birth weight[9] in children born in hospitals has not changed significantly. It was 10.1% in 1990-1994, 7.8% in 1995-1999, and 7.6% in 2005-2006.[10] This figure increased to 11.7% in 2007. Prevalence of moderate to severe nutritional deficiencies (weight for age deficit in children 12-59 months of age) was 21.4% in 1991, increased to 24.3% in 1996, and decreased to 11.4% in 2005-2006 (Table 2).

[9] SS, Hospital Care Bulletin, Data on children born in hospitals.
[10] ENDESA 2005-2006.

Breastfeeding is a widespread practice. According to ENDESA 2005-2006, 95% of Honduran children have breastfed at some time and 43% of children under 2 months of age received exclusive breastfeeding.[11] Nevertheless, prevalence of exclusive breastfeeding in children under 3 months of age was 42.4% in 1996 and 34% in 2005-2006 (Table 2).

Honduras has also progressed with regard to vaccine-preventable[12] diseases. Advances have been made in eradication of wild poliovirus (1989); elimination of measles (1997) and rubella (2002); as well as control of diphtheria, neonatal and non-neonatal tetanus, Hib meningitis, and tuberculosis. These achievements are the result of increased vaccination. Over 90% coverage has been attained in the past 15 years.

Women's Health

The age-specific fertility rate for females aged 15-19 years was 136 live births per 1,000 women in 1993-1995 and 137 live births per 1,000 women in 1998-2000.[13] This figure decreased to 102 live births per 1,000 women in 2003-2006 (Table 2).

Delivery care by trained staff increased steadily from 53.8% in 1990-1994 to 55.2% in 1995-1999, and 66.9% in 2005-2006. A total of 64% of mothers received care by physicians and 3% by nurses. There were significant differences between women living in urban (90%) and rural (50%) areas. There was a high percentage of home deliveries in women aged 35 years or more (42%), especially multiparous women with six or more children (58%). This situation poses a high risk, indicating that women living in rural areas have less access to delivery care by trained staff. [14]

Communicable Diseases

Dengue is still highly endemic. A total of 3,530 cases were recorded in 1990-1994, 19,766 cases in 1995-1999,[15] and 18,303 cases in 2000-2004. This trend changed in 2007, when there were 24,660 new cases (Table 2). There is evidence of circulation of 4 serotypes of dengue. The first cases of dengue hemorrhagic fever were recorded in 1995. The prevalence rate of dengue hemorrhagic fever was 12.8 cases per 100,000 inhabitants in 2002. The rate increased to 24.7 in 2005.[16]

There were 52,100 cases of malaria in 1994. This figure decreased to 46,740 cases in 1999 and 15,696 cases in 2004. The trend continued in 2007, when 13,913 cases were recorded. The annual prevalence rate of tuberculosis has decreased steadily from 94.6 cases in 1991 to 91.7 cases in 1995, and 47.1 cases in 2004 (Table 2).

[11] ENDESA 2005-2006, pp. 177, 180.
[12] SS, Outpatient Care Bulletins, 1990- 2005. (UPEG draft document, p. 10).
[13] This means that 137 out of every 1,000 females in the 15-19 years age group have already had at least one child.
[14] ENDESA 2005-2006, pp. 143, 144, Table 9.6, p.146.
[15] SS, Hospital Care Bulletin, Data on children born in hospitals.
[16] MDG Honduras, Second Country Report 2007, p. 88.

TABLE 2. POPULATION MORBIDITY AND RISK FACTORS, SELECTED PERIODS HONDURAS 1990-2007

Periods/Indicators	1990-1994	1995-1999	2000-2006	2007
Prevalence of low birth weight (1)	10.1*	7.8*	7.6** (2005-2006)	11.7***
Annual prevalence of moderate or severe nutritional deficiencies in children under 5 years (deficient weight for age in children aged 12 to 59 months) (3)	21.4* (1991)	24.3* (1996)	11.4** (2005-2006)	NA
Prevalence of exclusive breastfeeding at 120 days of age (%) (4)	NA	42.4* (1996)	34.0** (2005-2006)	NA
Fertility rate in adolescent women (per 1,000 women) (2)	136* (1993-1995)	137** (1998-2000)	102*** (2003-2006)	NA
Deliveries with assistance of trained health personnel (%)(5)	53.8	55.2	66.9 (2005-2006)	NA
Annual confirmed cases of vaccine-preventable diseases (6)	9,655	4,803	4,970	5,326
Confirmed cases of dengue (7)	3,530	19,766	18,303	24,660***
Annual confirmed cases of malaria (8)	52,100 (1994)	46,740 (1999)	15,696 (2004)	13,913***
Annual prevalence of tuberculosis (9)	94.6 (1991)	91.7 (1995)	47.1 (2004)	NA
Annual incidence of HIV/AIDS (new cases x 100,000) (10)	25.5	28.3	21.0	15.6
Male/female HIV/AIDS case rate (11)	1.3 (1994)	1.0 (1999)	0.9 (2004)	1.1
Annual incidence of malignant cervical cancer (12)	2,444	4,242	4,672	5,147

Sources: (1) Ministry of Health (SS), Hospital Care Bulletins, 1990-2004.
**National Demographic and Health Survey (ENDESA) 2005-2006, p. 157.
(2) *ENESF 1996, p. 61; **ENESF 2001, p. 48; ***ENDESA 2005-2006, p. 60.
(3) ENESF 2001, p. 318; **ENDESA 2005-2006, p. 193.
(4) *ENESF 1996, p. 421; **ENDESA 2005-2006, p. 181.
(5) SS, Health in Figures 1997-2001 (draft document). MDG Honduras 2007. Second Country Report, p. 65.
(6) SS, *Outpatient Care Bulletins 1990-2005 (draft).
(7) ***SS, Hospital Care Statistical Information Bulletin, 2007. Tegucigalpa, 2007.
(8), (9), (11) Government of Honduras/UNDP. Millennium Development Goals. Honduras 2007. Second Country Report (pp. 77, 85-88, 97).
(10). SS, General Bureau of Health Surveillance, Dr. Edith Rodríguez.
(12) SS, *Outpatient Care Bulletins, 1990-2005.

A reduction in incidence of HIV/AIDS has been recorded since 1990-1994. In this period, incidence was 25.5 cases of HIV/AIDS per 100,000 inhabitants. This figure increased to 28.3 in 1995-1999 and decreased to 21 in 2000-2005 and to 15.6 in 2007. Since transmission is primarily heterosexual (84.6%), this has affected the "feminization" of the pandemic. It has also had an impact on the increased number of infected newborns, which is the group that has increased the most in recent years.

Chronic Diseases

Hypertension and diabetes are the first and the sixth causes of specialized care, respectively. Although there is no complete database, it is evident that chronic diseases are the leading cause of morbidity and mortality at the national level. As a result of the high cost of care, limited response by the health services, and lack of promotion of healthy lifestyles, introduction of a comprehensive approach to chronic noncommunicable diseases is urgently needed.[17]

[17] IHSS. Presentation of non-transmissible chronic disease (NTCD) situation in the framework of PRERESSCAD. Ministry of Health: Evaluation first semester 2007. Available at: http://new.paho.org/resscad/index2.php?option=com_docman&task=doc_view&gid=126&Itemid=192.

General, Maternal and Infant Mortality

The population forecasts show a steady decrease in the total mortality rate**,** from 6.7 deaths per 1,000 inhabitants in 1990-1994 to 5.7 deaths per 1,000 inhabitants in 1995-1999. General mortality was 4.9 in 2005 and 4.8 in 2007. Hospital mortality (case-fatality) associated with tuberculosis[18] increased from 4.0 in 1991 to 5.2 in 1999, then decreased to 1.7 in 2005. There have been fluctuations in AIDS-related mortality, which was 4.9 in 1990-1994, decreased to 1.9 in 1995-1999, and then increased to 3.1 in 2000-2005 (Table 3).

TABLE 3. POPULATION MORTALITY RATE ACCORDING TO CAUSE[19]
HONDURAS 1990-2007

Period	General (1)	Maternal (2)	TB (3)	AIDS (4)	Malaria (5)
1990-1994	6.7*	182 (1990)	4.0 (1991)	4.9	0.0
1995-1999	5.7*	108 (1997)	5.2 (1999)	1.9	0.0
2000-2005	4.9** (2005)	119/110[20] (2000)	1.7 (2005)	3.1	0.0
2007	4.8**	NA	NA	NA	0.0

Sources: (1) * SECPLAN, Population forecasts 1988-2000; **INE, vital statistics, population forecasts 2001-2015.
(2) SS, Research on maternal mortality and women of childbearing age, 1997, 1999.
(3) MDG (2007) p.87.
(4) SS, Department of Control of STD/HIV/AIDS, 2005 (draft).
(5) SS, Hospital Care Bulletins (refers to hospital mortality).

There has been a significant decrease in maternal mortality**,** from 182 deaths per 100,000 live births in 1990 to 108 deaths per 100,000 live births in 1997.[21] Fifty per cent of maternal deaths occur during delivery and immediate postpartum. These deaths are related to preventable causes such as bleeding (47.1%), pregnancy-related hypertensive disorders (19.4%), and infections (15.2%).[22]

Infant mortality has also decreased steadily, from 36 deaths per 1,000 live births [23] in 1991-1995 to 34 deaths per 1,000 live births in 1996-2000, and to 25 deaths per 1,000 live births in 2001-2006. The reduction in neonatal and postneonatal mortality, which decreased significantly during these periods, contributed to this trend. There are marked differences between urban and rural inhabitants in all age groups that show the vulnerability of rural inhabitants (Table 4A).

[18] Recorded in hospitals.
[19] The data shown is the data available for the year indicated in this time period.
[20] MDG Honduras, Second Country Report 2007, p. 64.
[21] Research on maternal mortality and women of childbearing age in Honduras, Report 1997, Ministry of Health, 1999. MDG Honduras, Second Country Report 2007, p. 64. Data shown is the data available for the year indicated in this time period.
[22] SS/PAHO, Honduran Health Services System Profile, April 2001, p. 8.
[23] The data shown is the data available for the year indicated in this time period.

TABLE 4A. INFANT AND CHILD MORTALITY RATE BY YEAR AND AREA OF RESIDENCE HONDURAS 1991-2006

Years*	Neonatal (0 to 28 days)	Post-Neonatal (28 days to 11 months)	Infant (0 to 11 months)	Post-Infant (1 to 4 years)	Child (12 to 59 months)
1991-1995 (1)	19	17	36	13	48
1996-2000 (1)	19	15	34	11	45
2001-2006 (2)	16	10	25	7	32
Area of residence (1) (1996-2000)					
Urban	15	14	29	8	36
Rural	22	16	38	13	51
Area of residence(2) (2005-2006)					
Urban	16	8	24	6	29
Rural	20	13	33	11	43

Sources: (1) SS, ENESF 2001, pp. 244, 245.
(2) INE, ENDESA 2005-2006, pp. 122, 124.
* Based on all experience (exposure time) in 1991-1995 /1996-2000. ENESF 2001, p. 244.

Comparison of the leading causes of death in children under 5 years according to the three epidemiological surveys conducted in the last two 5-year periods shows that "conditions originating in the perinatal period (birth trauma, asphyxia, prematurity)" were the primary causes of mortality in infants and children under 5 years. This indicates that, in spite of the increase in institutional deliveries, there are still serious problems in delivery care (Table 4B).

TABLE 4B. DEATHS IN CHILDREN UNDER 5 YEARS BY CAUSE OF DEATH AND AGE AT DEATH HONDURAS 2005-2006

Cause of death	Neonatal (0 to 28 days)	Post-Neonatal (28 days to 11 months)	Infant (0 to 11 months)	Child (0 to 59 months)
Disorders originating in perinatal/ prematurity periods	39.6	0.4	26.3	23.3
Intestinal infectious diseases (IID)	0.9	23.6	8.6	12.6
Acute respiratory diseases (ARD)	4.9	37.8	16.1	17.0
Birth defects	12.5	11.0	12.0	10.9
Other infections	10.3	0.9	7.1	7.5
Other causes	2.8	4.4	3.3	4.2

Source: INE, ENDESA 2005-2006, p. 131.

1.1.3 MILLENNIUM DEVELOPMENT GOALS

Honduras was one of the 189 countries that signed the Millennium Declaration.[24] Eighteen targets and 48 indicators to be evaluated on a regular basis until 2015 were established in order to measure and monitor the commitments signed. Two monitoring and follow-up reports were prepared with the support of the United Nations. These reports made an important contribution to the uneven distribution and delays in information available at the national level, particularly in the social sectors. A summary of the efforts made by Honduras to achieve the health-related goals is shown below. The following goals were considered: 1) reduce child mortality; 2) improve maternal health; 3) combat HIV/AIDS, malaria and other diseases; and 4) ensure environmental sustainability.

[24] The Declaration was signed in September 2000.

TABLE 5. HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS
HONDURAS 2007

MDG	Institution(s) responsible	Standardized databases*	Up-to-date information	Identification of gaps in 2015**	Identification of actions***	Strategic Plan 2015****	Budget allocation
MDG 4: Reduce child mortality **Target 5: Reduce by two- thirds, between 1990 and 2015, the under-five mortality rate**	Ministry of Health and Honduran Social Security Institute with the support of specialized UN agencies such as UNICEF, PAHO, WHO, UNFPA, other countries with good relations and international NGOs	ENDESA vital statistics INE Mortality rate of children under 5 years Percentage of children under 2 years vaccinated against measles Percentage of children under 5 years with appropriate vaccination for their age Mortality of children under 5 years Infant mortality rate	Infant mortality 1991-1995: 36 deaths per 1,000 live births 2001-2006: 23 deaths per 1,000 live births Neonatal mortality: 1991-1996: 20 deaths per 1,000 live births 2001 and 2006: 14 deaths per 1,000 live births Postneonatal mortality: 15 deaths per 1,000 live births was reduced to 9 deaths per 1,000 live births Post-infant mortality: 14 deaths per 1,000 live births in 1991 was reduced to 6 deaths per 1,000 live births in 2006 Child mortality 1991-1996: 48 deaths per 1,000 live births 2001 and 2006: 30 deaths per 1,000 live births 92% of children under 5 years were vaccinated against BCG, polio, DPT and measles in 1991; 95% in 2004 (DPT/HB/Hib and MMR were added in 2000)	MDG: 12 deaths per 1,000 live births PRS: 18 deaths per 1,000 live births If the trend observed between 1991 and 2006 continues, neither the MDG nor the PRS goal will be achieved By 2015 a rate of 18 deaths per 1,000 live births would be achieved, which is compatible with the PRS goal but not with the MDG 27 deaths per 1,000 live births in children under 5 years 21 deaths per 1,000 live births in children under 1 year	Improved action by the Ministry of Health in the steering of national policy Reduce the economic, social, and environmental factors associated with infant mortality Initiative to reduce maternal and infant mortality New management models in maternal and infant clinics Implementation and follow-up of IMCI strategy at the national level Implementation and follow-up of AIN-C strategy Follow-up infant health communication plan Accredit hospitals of the Friends of Children Hospital (IHAN) initiative (Includes the Babysitting Mother Strategy) Supplement micronutrients in women of childbearing age (iron, folic acid, vitamin A) and children under 5 years Systematize and implement the maternal-infant morbidity and mortality surveillance system Design and implement the IMCI AIN-C quality assurance standards Implement institutional oral rehydration therapy rooms Develop human resources to improve the quality of care for women and children Basic health services package delivery (EPBSS) in remote locations Permanent offer of health services in all public, private, and Social Security health facilities at the national level Introduction of new vaccines: MMR, Hib, and HB Mass vaccination campaigns for eradication and elimination of vaccine-preventable diseases Active epidemiological surveillance of 11 vaccine-preventable diseases Introduction of new vaccines: MMR Active participation by civil society and the community	Maternal and infant mortality strategic plan 2010 EPI 1991-1995, 1996-2000, 2001-2005 five-year plans	Allocation by programs with national and international funds Over 90% of EPI funds will be national funds as of 2002. SS will purchase 100% of vaccines and syringes with national funds International contribution of 6-9% in the past 3 years

MDG	Institution(s) responsible	Standardized databases*	Up-to-date information	Identification of gaps in 2015**	Identification of actions***	Strategic Plan 2015****	Budget allocation
MDG 5: Improve maternal health **Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate**	Ministry of Health, Honduran Social Security Institute, Honduran Family Planning Association, and National Institute of Women	No official data since 1997, when the last survey of mortality in women of childbearing age was conducted Estimates are only available for 2000, provided by INE and WHO/UNICEF/ UNFPA Maternal mortality rate Percentage of institutional deliveries Rate of contraceptive use	Maternal mortality 1990: 182 deaths per 100,000 live births 1997: 108 deaths per 100,000 live births Institutional deliveries 1990: 35% 2005: 69% Prenatal care 1996: 83.,9% 2005-2006: 91.7% Women with partners that use contraceptive methods 1991-1992: 46.7% 2005: 65.9%	MDG: 46 maternal deaths per 100,000 live births 28.3% institutional deliveries and 12.3% family planning If the current trend continues, the goal will not be achieved INE estimates of maternal mortality rate for 2000: 119 deaths per 100,000 live births WHO/UNICEF/UNFPA estimates: 110 deaths per 100,000 live births Increasing trend of use of modern contraceptives Regular use of condom: 1991-1992: 2.9% 2005-2006: 3%	Maternal mortality surveillance program Comprehensive care program, including actions that tend to reduce pregnancy in adolescents and multiparous women Increased access to effective planning methods for women of childbearing age Improved access to quality obstetric and gynecological services Wide-scale implementation of quality emergency obstetric care strategy Improved access to health services in remote and scattered populations Prevention of high-risk pregnancies and pregnancy spacing strategy Identify and promote application of new maternal child health insurance plans Open and equip new health and IMC units with new management models in priority departments Update personnel on maternal neonatal care standards Systematize and implement referral and transportation system (including radio communication network) Implement women's communication plan at the national level prioritizing departments with higher maternal mortality Implement individual, family and community strategies in priority departments Implement appropriate initiatives to provide incentives for prenatal care, postnatal care, pregnancy spacing visits (PRAF vouchers) Implement the ensured availability of contraceptive supplies (DAIA) strategy Provide training on family planning methods (e.g., VSC with local anesthesia, post-obstetric IUD, vasectomy) in SS hospitals Supervise, monitor and evaluate maternal and infant care in the services network and the new management and financing models IMCI follow-up in the 20 departmental regions Follow-up 1800 AIN-C communities	Maternal and infant mortality strategic plan 2010	Allocation by program of national and international funds, primarily with national funds Funds from women's comprehensive care program in 2000-2004

MDG	Institution(s) responsible	Standardized databases*	Up-to-date information	Identification of gaps in 2015**	Identification of actions***	Strategic Plan 2015****	Budget allocation
MDG 6: Combat HIV/AIDS, malaria and other diseases **Target 7: Have halted and begun to reduce the spread of HIV/AIDS by 2015**	Ministry of Health, IHSS National HIV/AIDS Committee (CONASIDA) With financial support from the Global Fund	Permanent registries for the HIV/AIDS Control Program ENDESA 2005-2006 CONASIDA PENSIDA II medium-term evaluation UNAIDS World Bank Number of new cases Incidence rate per 100,000 inhabitants Male/female ratio Number of deaths ARV coverage	**HIV/AIDS** AIDS incidence rate per 100,000 inhabitants: 1980's: 8.3 1998: 32.9 2005: 13.8 Cases 1985-2005: 22,847 Sexual transmission: 91.3% Mother/child: 5.3% Transfusion: 0.1% Unknown:3.8% Male/female ratio 1986: 2.3 1998: 1.0 2004: 0.9 Prevalence in pregnant women 2004: 0.46% **TUBERCULOSIS** Prevalence per 100,000 inhabitants 1990: 77.7 2005: 45.9 2005: 59% men 41% women TB-related deaths 1990: 215 2005: 122	Primarily in 20-39 years age group Higher levels of infection: Male homosexuals: 13% Sex workers: 11% Prisoners: 8% Garifunas: 8.4% High-risk condom use related to educational level and income ARV coverage 2003-2005: 52% of HIV/AIDS patients Lack of studies seeking to determine the causes of higher incidence of tuberculosis in relatively developed areas such as the metropolitan area of San Pedro Sula	Multisectoral national policy led to national and local plans and programs Adoption of State, civil society, and international cooperation partnership policy Sexual and reproductive health education Action targeting vulnerable groups Organization of 21 comprehensive health care centers (CAI) Blood bank regulation Enactment of special legislation Implementation of DOTS strategy for tuberculosis detection and cure (promoted by WHO in 1995) Services for HIV-positive pregnant women to reduce mother-child transmission STD syndromic management strategy Comprehensive care strategy for persons living with HIV/AIDS (PLHA) Strengthen intra- and intersectoral coordination of actions to prevent and improve PLHA quality of life Promote community participation and organization that ensures an effective and timely response for the most vulnerable groups living in conditions of extreme poverty Strengthen civil society capacity for timely use of mechanisms created to monitor, report and follow up on violations of human rights in HIV/AIDS Conduct scientific research on STD, HIV/AIDS with gender focus in the biomedical, epidemiological, social, economic, cultural, anthropological and technological fields at the local, regional and national levels Basic health services package delivery (EPBSS) in remote locations Strengthen the laboratory network Include private medicine sector in active surveillance	PENSIDA III national strategic AIDS plan National health plan Poverty reduction strategy Tuberculosis control program	Resources provided by Ministry of Health, Global Fund, and others

MDG	Institution(s) responsible	Standardized databases*	Up-to-date information	Identification of gaps in 2015**	Identification of actions***	Strategic Plan 2015****	Budget allocation
Target 8: Have halted by 2015 and begun to reduce the incidence of malaria and other severe diseases	Ministry of Health: national malaria program	Permanent registries of control programs Number of cases Prevalence per 100,000 population Number of deaths	**MALARIA** Cases: 1990: 53,095 2005: 14,968 Prevalence: 1990: 1,131 2005: 206 Population at risk 1998: 85.3% 2004: 75.5 Deaths 1998 to 2004: 0 **DENGUE** Cases: 1995: 27,575 2002: 32,269 2006: 7,783 Prevalence: 1995: 507 2002: 482 2006: 105 Prevalence by type 1995: Conventional: 506 Hemorrhagic: 0.28 2002: Conventional: 468.9 Hemorrhagic: 12.9 2004: Conventional: 251.8 Hemorrhagic: 33.5 Deaths associated with dengue hemorrhagic fever: 2002: 17 2003: 11 2004: 2 2005: 6	95% of malaria cases in 2004 were caused by *Plasmodium vivax* 5% were attributed to *Plasmodium falciparum* Departments with highest incidence in 2004: Atlántida: 9,582 cases Colón: 4,402 Olancho:3,274 Gracias a Dios: 2,112 Yoro: 825 Bahia Islands: 584 Determining causes: poverty, rural-urban migration, unplanned urban growth, inadequate housing, overcrowding, low educational level, and low perception of risk by the population, reflected by limited community participation in vector control	Adopt of Global Malaria Control Strategy (1992) and Roll Back Malaria in the Americas initiative (WHO, 1998) Develop sanitary infrastructure construction to protect the environment Promote participation in prevention actions by local authorities and the community Target work in the municipalities and endemic areas	Vector-borne disease control program	Ministry of Health and international cooperation resources

MDG	Institution(s) responsible	Standardized databases*	Up-to-date information	Identification of gaps in 2015**	Identification of actions***	Strategic Plan 2015****	Budget allocation
Target 10: Halve by 2015 the proportion of people without sustainable access to drinking water and basic sanitation services	Ministry of Health, SANAA, and local governments	INE: multipurpose household permanent survey Percentage of population with sustainable access to drinking water Percentage of population with sustainable access to basic sanitation	Sustainable access to drinking water: 1990:84% 2004: 87% Sustainable access to sanitation: 1990: 50% 2004: 69%	Limited access for marginal urban populations Rural-urban gap in access to sanitation: 2005: 85.1% of urban households vs. 76.4% of rural households (measured by use of simple pit or hydraulic closure latrines). Floods and natural disasters can affect achievement of water and sanitation-related goals	Consolidation of legal and institutional framework, national water resource use policy, general water law that regulates use and management of water resources at the national and local levels, promotion of territorial planning and legislation, management of water-producing basins, delimitation of basins, microbasins, and effective protection of protected areas are required		Ministry of Health, SANAA, local government, PRS, and private non-profit organization resources

Source: Millennium Development Goals. Second Country Report Honduras 2007.

1.2 HEALTH DETERMINANTS

1.2.1 POLITICAL DETERMINANTS

Honduras is a sovereign country under the rule of law that was established as a free, democratic, and independent republic in order to ensure the justice, freedom, culture, and economic and social wellbeing of its inhabitants.[25] Each government lasts for four years, after which elections are held for the president of the executive branch, lawmakers, and municipal mayors. In the most recent elections, the electoral process was characterized by abstention, which was attributed to the decreased credibility of the traditional political parties. Street protests led by different workers' organizations from the public, private, and community sectors occur on a regular basis. These protests seek to pressure for resolution of problems such as the high cost of living and demands made by trade unions.

Enactment of the State Modernization Law (1991)[26] led to restructuring of government institutions and creation of modernization units in different institutions. The health sector modernization unit assigned to the Ministry of Health maintained a low profile characterized by limited association with the intermediate and higher levels of government and did not strengthen its role until 2007 when it began promoting sectoral reform. Within the framework of State modernization, several programs and projects seeking to promote State reform have been implemented. These programs have been financed with national funds obtained through bank loans (e.g., World Bank, Inter-American Development Bank) and donations from governments (e.g., SIDA, USAID).

In order to access debt cancellation mechanisms, specific actions related to reducing financial deficits and improving public finances management were required. In health, advances were introduced in the deconcentration process with the creation of State offices in the departments (18) and metropolitan (2) areas. However, operationalization of decentralization and improved administrative efficiency and management are still pending areas. Although efforts have been made to improve access, quality, and management of services, these have been incipient. No substantive progress has been made and the rights of citizens are not considered as such.

In 2007, 60.2% of Honduran households were below the poverty level. In addition to insufficient income, inequitable distribution of income is a determining factor for poverty. In order to address these problems, the country defined a Poverty Reduction Strategy (PRS) (2001). Preparation and implementation of this strategy has implied increased participation by the population and allocation of resources obtained by foreign debt settlement to the poorest municipalities. The programming structure of the PRS includes six areas: equitable and sustainable economic growth, reduction of poverty in rural and urban areas, investment in human capital, strengthening protection for specific groups, and an area designed to ensure the sustainability of the strategy.

Since the PRS was introduced, the most active area has been investment in human capital, which accounts for nearly 60% of investment. Most of the investment has been assigned to the education (52%) and health (30%) sectors. A smaller percentage has been allocated to strengthening social protection for specific socially disadvantaged groups.[27] In order to implement the strategy, the government has created an office managed by a national committee. An advisory group has also been formed, and sectoral meetings have been organized so that government, civil society, and international cooperation can work together to reach a consensus on creating policies and plans to implement the PRS. There is clear and specific linkage and alignment of the PRS with the MDG.

[25] Constitution of the Republic, Article 1, 1982.
[26] Decree 190-91 of 11 December 1991.
[27] Secretariat of the Presidency, Progress Report on PRS, Honduras 2005.

1.2.2 ECONOMIC DETERMINANTS

Gross domestic product (GDP) increased steadily between 1990 and 2005 as a result of consolidation of foreign trade (i.e., increased exports). The decrease in inflation from 20.9 in 1990-1994 to 19.0 in 1995-1999 and 8.4 in 2000-2005 contributed to improved purchasing power for the population. The per capita income of the population increased in the three 5-year periods. The wide-scale entrance of women on the job market was noteworthy. In 1995-1999, females were the head of 25.3% of the households. In 2000-2005 this figure increased to 28.2%[28] (Table 6).

In 1990 foreign debt accounted for 116.7% of GDP and 313.7% of exports. Export-related service was calculated at 14%. In 1995-1999, debt was equivalent to 84.1% of GDP and 196.7% of exports. The relationship between debt and GDP decreased to 60.4% in 2000-2005. Debt service was US$ 1,673.6 million in 2007 (US$ 2,154.7 million in 2006), corresponding to a debt amortization for the public sector in the amount of US$ 1,279.8 million, of which US$ 74.7 million (5.3%) was paid. The remaining amount (US$ 1,205.1 million) corresponded to adjustments and cancelations from the HIPC and Multilateral Debt Relief (MDRI)[29] initiatives. As a result, there were higher levels of expenditures for the most vulnerable social sectors and groups.

TABLE 6. ECONOMIC INDICATORS
HONDURAS 1990-2005

Indicator	1990-1994	1995-1999	2000-2005
Per capita GDP in constant prices (US$) (1990) (1)	702.7	1,027.4	1,215.7
Per capita public spending (US$) (2)	179.7	159.9	163.0
Total public spending/GDP (3)	25.0	29.9	35.5
Economically active population (EAP) (thousands) (4)	NA	2,177	2,861
EAP from 15 to 59 years (thousands) (5)	NA	2,012	2,218
EAP from 15 to 59 years employed (thousands) (6)	NA	1,813	2,099
Public health spending/GDP (7)	2.7	2.9	3.7
Annual Inflation rate (8)	20.9	19.0	8.4
Remittances (% GDP) (9)	NA	3.5	9.0
Percent foreign debt/GDP (10)	116.7	84.1	60.4
% households with female head (11)	23.4	25.3	28.2

Source (s): (1), (8), (9), (10): Central Bank of Honduras: Honduras in Figures.
(2) (3) (7): Secretary of Finance: General Bureau of Budget.
(4) (5) (6) (11): INE, Permanent Multipurpose Household Survey (EPHPM).

The economically active population (EAP) is steadily increasing. In May 2007 this population represented 38% of the working-age population. A total of 34.3% of the EAP are women and 66.7% are men. With regard to employment, most jobs are in the agricultural (35%), trade (21%), and industry and manufacturing (15%) sectors.[30]

Open unemployment affects 3.1% of the EAP. Women are the most affected group. Open unemployment rate for women (4.1%) is higher than for men (2.5%).[31] Unemployment is a primarily urban problem. The regular migration of persons from rural areas to the city and the limited capacity of the labor market to integrate this workforce have probably contributed to this problem. The open unemployment rate is estimated at 4.1% in urban areas and 2.1% in rural areas. Higher levels of unemployment occur in the young population. Nearly half (49.4%) of the total 87,375 unemployed persons in Honduras are under 24 years of age.

[28] INE, Multipurpose Household Survey, May 1995-2007.
[29] Central Bank of Honduras, 2007 Report.
[30] INE, EPH 2007, p. 16.
[31] INE, EPH 2007, pp. 61,104.

TABLE 7. OPEN UNEMPLOYMENT RATE
HONDURAS, 2007

Indicators	EAP	Unemployed	Open unemployment rate
National	2,860,866	87,375	3.1
Urban	1,373,212	55,924	4.1
Rural	1,487,654	31,450	2.1
Man	1,879,092	47,165	2.5
Women	981,774	40,209	4.1

Source: INE, Household Survey 2007, pp 18, 104.

One of the main problems of the Honduran labor market is invisible underemployment, in which low income is associated with low productivity jobs. In 2007 the invisible underemployment rate was 33.2% at the national level and 44.7% in the rural areas. This situation has contributed to migration by the population to other countries. It is reflected by the increase in family remittances, which are the third source of household income after salary income (48%) and self-employed income (33%). Remittances represent 12% of the per capita income in the rural areas and 10% in the urban areas.[32]

1.2.3 SOCIAL DETERMINANTS

In 1991-2005 the percentage of poor households ranged between 74.8% and 65.3%. In 2007 a total of 60.2% of households were below poverty level. A total of 4,021,683 persons were affected by poverty in 2007. The severity of the poverty is reflected by the fact that 2,537,117[33] persons live in extreme poverty. A total of 1,714,835 of 7,529,403 inhabitants live in households with per capita income of 1 dollar or less per day and 1,370,246 (80%) of these persons live in rural areas.[34]

TABLE 8. HOUSEHOLDS BY POVERTY LEVEL
HONDURAS 1991-2007

Households by poverty level (%)					
Period	Number of households			Poverty	
	Total	Non-poor	Poor	Relative	Extreme
1991	100	25.2	74.8	20.6	54.2
1992	100	30.1	69.9	22.5	47.4
1993	100	32.5	67.5	22.4	45.1
1994	100	32.8	67.4	20.4	47.0
1995	100	32.2	67.8	20.4	47.4
1996	100	31.3	68.7	15.0	53.7
1997	100	34.2	65.8	17.4	48.4
1998	100	36.9	63.1	17.5	45.6
1999	100	34.1	65.9	17.3	48.6
2001	100	35.5	64.5	17.0	47.4
2002	100	36.1	63.9	18.8	45.2
2003*	100	34.9	65.1	18.1	47.0
2004*	100	35.8	64.2	19.7	44.6
2005*	100	34.7	65.3	18.2	47.1
2006*	100	38.2	61.8	19.3	42.5
2007*	100	39.8	60.2	24.3	35.9

Source: INE, 34th Permanent Multipurpose Household Survey, May 2007, p 124.
* Only includes the households that declared income.
Note: 2000 Survey not performed due to closure of General Bureau of Statistics and Census.

[32] INE, EPH. May 2007.
[33] CESCCO, p. 123.
[34] CESCCO, p. 125.

According to the Honduras Human Development Report 2003, national levels of development have increased steadily. There are also marked development gaps at the interdepartmental and municipal levels, as well as gender-related differences.

A total of 96.8% of the population had access to drinking water in 1990-1994. Access decreased to 93% in 1995-1999 and to 86% in 2000-2005. Coverage was lowest in rural areas. Access to excreta disposal systems increased from 80.5% in 1990-1994 to 86.6% in 1995-1999. This figure was only 61.7% in 2000-2005. The situation improved in 2007, when it increased to 85.1%. These variations were associated with natural disasters that ravaged the country and difficulties reaching levels of coverage from before Hurricane Mitch (Table 9).

TABLE 9. SOCIAL INDICATORS, SELECTED PERIODS
HONDURAS 1990-2007

Periods	Position according to HDR (1)	Dwellings with access to drinking water (%) (2)	Dwellings with access to excreta disposal services (%) (3)	Illiterate population (%) (4)	Crude primary education rate (5)	School dropout rate (6)	Child labor Rate (7)
1990-1994	NA	96.8	80.5	25.4	109.0	12.4	NA
1995-1999	NA	93.0	86.6	20.1	106.7	9.5	15.0
2000-2004	116[35]	86.0	61.7	19.3	113.2	3.0	14.5
2007	NA	86.6	85.1	17.5	113.0	2.6	14.5
Zonas geográficas							
Urbana	ND	94.5	56.0	9.9	ND	ND	12.0
Rural	ND	71.5	49.0	28.0	ND	ND	17.0

Sources: (1) UNDP, Human Development Reports.
(2) (3) (7) INE, Permanent Multipurpose Household Survey, May of respective years.
(4) (5) (6) Ministry of Education, UPEG, Department of Statistics.

Educational advances have been achieved especially with regard to literacy and access to primary education. The illiteracy rate decreased to 19.3% in 2000-2004 and 17.5% in 2007.[36] Illiteracy was 18% higher in rural areas than in urban areas, which reflects the limited access of rural inhabitants to education. Child labor is a problem that affects children living in poverty affected by determinants such as lack of income and inequitable distribution of income. According to the statistics, 410,290 persons were in this situation in 2007 and 72% were rural residents.[37]

The Gini coefficient of household income (work income) was 60% in 1960, 56.1% in 2001, and 58.9% in 2005.[38] The efforts to achieve greater equity in distribution of wealth have been insufficient. Eighty per cent of households receive only 36.8% of the national income while the wealthiest 20% receive 63.2%.[39]

Social violence has contributed to citizen insecurity, which is one of the problems faced by Honduran society. This phenomenon has increased significantly in the last 10 years. The homicide rate was 49 per 100,000 inhabitants in 2004.[40] According to data provided by the National Commissioner for Human Rights, 10,279 violent deaths were recorded in Honduras between 2006 and 2007. A total of 6,280 of these deaths were homicides. Firearms were used in 77% of crimes, followed by knives and other arms. The other violent deaths were due to additional causes such as traffic accidents.

[35] Position 116 of 177 countries. Available at: http://www.undp.un.hn/PDF/informes/2006/cap_1.pdf.
[36] INE, Permanent Multipurpose Household Survey, May 2007.
[37] INE, EPH, May 2007.
[38] Millennium Development Goals Honduras 2007, Second Country Report, p. 8.
[39] Secretariat of the Presidency, UNAT.
[40] General Bureau of Criminal Investigation, Honduras 2004.

1.2.4 ENVIRONMENTAL DETERMINANTS

The main environmental determinants that affect health are poor management of solid and hazardous waste, air pollution, and water pollution.[41] Respiratory and skin conditions, diarrhea-related morbidity and mortality, as well as other conditions are related to these determinants.

Honduras has made significant progress in at least two environmental determinants by increasing access to drinking water and adequate excreta disposal.[42] However, effective action plans that address the problems of air pollution and adequate final disposal of solid and hazardous waste have not been developed. This is reflected by the limited number of sanitary landfills that operate in the municipal areas. Approximately 3.7% (11 municipalities) have adequate final disposal sites. The other municipalities have outdoor municipal dumps or dispose of waste on public roads or in small uncontrolled dumps.

The loss of air quality at the national level is not known at this time. The only clear case of decline in air quality shown by the monitoring data was that of the city of Tegucigalpa; main contributing factors include obsolete motor vehicles, deficient road system, industrial emissions, forest fires, and burning solid waste. These factors were more important as a result of the topographical characteristics of the city.

According to the Honduras Health Costs of Environmental Damage study conducted by the World Bank in 2007, the costs associated with environmental factors that affect health account for nearly four billion lempiras.[43] This study also points out that 90% of diarrheal diseases are due to lack of access to drinking water and poor health and hygiene. It has been estimated that 1,050 premature deaths and approximately 3 million cases of diarrheal disease in children under 5 years can be attributed to these causes.

Several governmental institutions are responsible for environmental issues: the Ministry of the Environment and Natural Resources (SERNA)[44] is the regulatory entity for the environment. It is responsible for compliance and enforcement of environmental legislation in Honduras as well as global coordination and development of the national environmental policies set forth in the General Environmental Law enacted in June 1983. Implementation and execution of the administrative aspects of environmental policies are assigned to the city halls whereas the Honduran Environmental Enforcement Agency and the Honduran Environmental Protection Agency are responsible for the legal aspects of such policies. The Ministry of Health is responsible for design and implementation of environmental sanitation programs as well as coordinating activities with other bodies, public or private institutions, and local governments.

The regulatory bodies for the environment on the national level are SERNA, through the Center for Contaminant Study and Control (CESCCO), and the Ministry of Health, through the Environmental Risk Factors and Surveillance Unit and the Drinking Water Quality Control and Surveillance Unit of the Bureau of Health Surveillance.

CESCCO has four strategic lines of work: research on environmental pollution problems that affect water quality, environmental microbiology, ecotoxicology, air quality, and chemical contaminants (pesticides and metals); environmental surveillance; management of chemical substances; and delivery of water quality services.[45] CESCCO functions as the focal point for the Stockholm Convention on Persistent Organic Pollutants (POPs), the Basel Convention on Control of

[41] Information provided by the Center for Contaminant Study and Control of the Ministry of the Environment and Natural Resources.
[42] State Report and Environmental Perspectives, GEO Honduras 2005. Prepared by the Ministry of the Environment and Natural Resources (SERNA) and the United Nations Environment Program (UNEP).
[43] Honduras Health Costs of Environmental Damage, p. 3.
[44] General Public Administration Law.
[45] Information provided by CESCCO.

Transboundary Movements of Hazardous Waste, and the Strategic Approach to International Chemicals Management (SAICM) initiative.

The Ministry of Health conducts different actions to identify and monitor environmental indicators related to the health of the population. It is a member of committees such as the Honduran Water and Sanitation Network (RAS-HON), Central American Regional Water and Sanitation Network (RRAS-CA), National Environmental Impact Assessment System (SINEIA), National Technical Committee for Water Quality (CALAGUA), Interinstitutional Technical Committee for Environment and Health (COTIAS) (which has been inactive in recent years), and the Four-Party Committee for Regulation of Polluting Gases and Vehicle Exhaust Emissions. The Ministry also intervenes in matters related to food and beverage safety, conducts surveillance and quality control of drinking water, monitors the main environmental risk factors, regulates food and beverages, and is a member of the hazardous waste surveillance committees established in health facilities, particularly hospitals.

The legal mechanisms that regulate and control environmental pollution problems are described in the respective sections regarding violations and penalties of the corresponding regulations. Air pollution (emission of harmful gases) is described in the regulation on polluting gases and motor vehicle exhaust emissions.[46] Disposal of sewage and solid waste from hospital facilities, including elimination of toxic and radioactive products, is under the provisions of the regulation on management of hazardous solid waste generated in health facilities, the Health Code, and its general regulation on environmental health, which coordinates the provisions of the radiological protection regulation with SERNA.

The Ministry of Health conducts permanent surveillance of the pollution of drinking water through the provisions of the national technical standard for drinking water quality. Laboratory test results are required from the operating agencies or service providers (e.g., water boards, municipalities, private operators, water bottlers, ice manufacturers, storage tanks). Honduras has had a technical standard for sewage disposal since December 1997. SANAA monitors some parameters of the Choluteca River in the cities of Tegucigalpa and Comayagüela, as well as specific studies conducted by CESCCO.

In the framework of the Dominican Republic-Central American Free Trade Agreement, USAID is supporting preparation and review of 8 regulations, including the regulation for emission control by fixed sources, regulation for environmentally rational management of hazardous chemical substances in Honduras, as well as review of the solid waste regulation and the national regulation on sewage disposal and recycling, through the MIRA project.

The problems related to elimination of existing toxic and radioactive products are under the legislation of the regulation for management of hazardous waste generated in health facilities; regulation on registration, use and control of pesticides and related substances, Agreement No. 642-98, and the fertilizer control regulation. Water pollution is regulated by the technical standard for drinking water quality, the technical standards for sewage disposal to recipients and the sewage system, and the Drinking Water and Sanitation Law, which seeks to guarantee access to drinking water by the population.

SERNA, through CESCCO, is also leading implementation of a National Air Quality Management Plan (PNGCA) that was designed with the collaboration of the Mario Molina Center of Mexico, World Bank, multi-donor funds from the European Union, United Nations Development Program, and other cooperating agencies. The PNGCA proposes implementation of five action strategies for reduction of air pollution: sustainable transportation; clean and efficient energy; clean and competitive industry; ecological restoration; and development of capabilities, information systems, and awareness.

[46] Issued in 2001. It is not being applied.

2. FUNCTIONS OF THE NATIONAL HEALTH SYSTEM

2.1 STEERING ROLE

The steering role is the exercise of the substantive responsibilities and competencies with regard to public health policy by the National Health Authority (NHA). These competencies have been assigned to the NHA in the context of the relations between the government and society. According to the Constitution, they cannot be delegated. Steering of the sector is considered to be a priority in the health sector reform and modernization process. It is exercised through different dimensions, which include six main areas:

- Conduct/lead: guide sectoral institutions and mobilize actors and social groups to support national health policy.
- Regulation: design and guarantee compliance with the regulatory framework that protects and promotes health.
- Harmonization of service delivery: promote complementarity between providers and user groups to ensure equitable and efficient extension of health care coverage.
- Guarantee of assurance: guaranteed access to a defined set of universal and equitable health services or specific plans for special population groups.
- Orientation of financing: guarantee, monitor, and modulate the complementarity of resources from several sources to ensure equitable and timely access to quality health services by the population.
- Performance of essential public health functions (EPHF): monitor the conditions that strengthen public health practice and become reality in the service delivery process at the local level, which includes municipalities and their services network in Honduras.

In the process of strengthening the steering role of the NHA, two evaluations of the steering role dimensions of the Ministry of Health (DRSS) have been conducted. The first evaluation was performed in 2005 and the second was conducted in 2007. The measurement scale used was: 76%-100% optimal performance, 51%-75% above average performance, 26%-50% below average performance, and 0%-25% minimum performance.

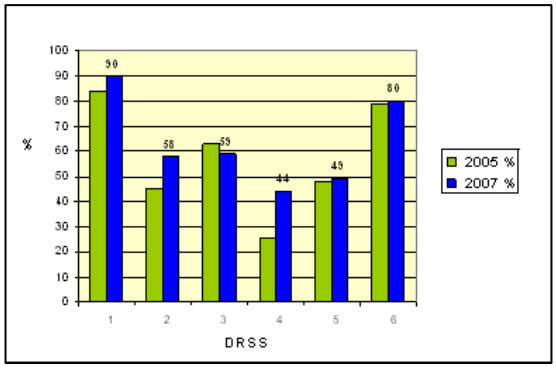
This exercise in evaluation of DRSS performance was only conducted in eight of the 20 health regions in Honduras, which represent 40% of the total. The results are shown in Table 10:

TABLE 10. STEERING ROLE PERFORMANCE EVALUATION IN 8 DEPARTMENTS HONDURAS, 2005 AND 2007

No.	DRSS	2005	2007	Difference
1	Conduct/Lead	84	90	6
2	Regulation	45	58	13
3	Harmonization of service delivery	63	59	-4
4	Guarantee of assurance	25	44	19
5	Orientation of financing	48	49	1
6	Performance of EPHF	79	80	1
	TOTAL	57	63	6

Source: DRSS evaluation, 2005-2007.

FIGURE 2. STEERING ROLE PERFORMANCE EVALUATION IN 8 DEPARTMENTS, HONDURAS 2005 AND 2007



Source: SS, Health services access program.

The dimensions with the highest performance in both periods (2005 and 2007) were conduct/lead and performance of essential public health functions (EPHF). The harmonization of service delivery and regulation dimensions achieved an average performance score, whereas the guarantee of assurance and orientation of financing were the dimensions with the lowest performance.

This trend of improved DRSS performance in the 8 health regions is a result of regular technical and financial support in the organizational development process and work at the intermediate and local levels to improve the health system within the framework of reform and decentralization.

In this regard, there is a need to promote an interactive process (central-intermediate-local levels of NHA) based on rational coordination principles to strengthen the steering role in the sector as part of national health policy and its competencies. The increased capacity of the NHA at the central and intermediate (departmental and metropolitan) levels is also important for management and strengthening of the respective subnational levels.

2.1.1 MAPPING OF THE NATIONAL HEALTH AUTHORITY

According to article 149 of the Constitution of the Republic, the executive branch, through the Ministry of Health, exercises the “health authority” and coordinates all public activities of centralized and decentralized agencies in the health sector through a national health plan that grants priority to the neediest groups. According to the Health Code (1991), the institutions in the sector include:

- Secretariat of State in public health office
- Secretariat of State in government and justice offices
- Secretariat of State in work and social welfare offices
- Secretariat of State in public education office
- Secretariat of State in natural resources office
- Secretariat of State in planning, coordination and budget offices
- Honduran Social Security Institute
- National water supply and sewage system service
- Autonomous agencies assigned activities by their own legal system
- Municipalities, with respect to their legally mandated duties
- Public and private agencies, including national or foreign as well as international agencies, authorized to perform public health consultancy, cooperation, or activities by virtue of law, agreement, or treaty.[47]

[47] Ministry of Health (1999), Health Code and General Environmental Health Law, article 5.

Ministry of Health responsibilities with regard to sectoral leadership and regulation cannot be delegated. They also include overseeing delivery of services, financing, assurance, and the EPHF in conjunction with other governmental and nongovernmental institutions and organizations.

2.1.2 CONDUCT/LEAD

The mission of the Ministry of Health (SS)[48] as NHA is to "prepare, design, control, monitor, and evaluate national health programs, policies, and plans; promote, lead, and regulate construction of healthy environments and improvement of the living conditions of the population; develop and strengthen a culture of life and health; generate health intelligence, care for health needs and demands; guarantee the safety and quality of goods and services of sanitary interest and intervene in risks and threats to collective health."

The Ministry of Health, based on the constitutional mandate and its steering role, has issued sectoral policy guidelines that include health management, regulation, promotion, and guarantee functions; favor prevention and adequate use of resources with equity, efficiency, transparency and quality; and ensure participation by different actors from the national and local levels.[49]

Each government has prepared its health plans and policies in response to the national needs identified and international commitments. A National Health Plan was prepared in 2005 and an agreement was reached for implementation by 2021. The plan is a political tool as well as a strategic management and planning instrument. As such, it seeks to facilitate management, harmonization and alignment of national resources and work, as well as international cooperation in the health sector. Priority programs and objectives of the health sector are described below.

TABLE 11. NATIONAL HEALTH PLAN 2021
HONDURAS

Priority health programs	
Program	**Objective**
Health sector reform	Promote construction of a national health system capable of improving the health of the population, responding to the legitimate expectations of the population, providing financial protection against the costs of poor health, advancing universal health insurance, ensuring equity and transparency of financial distribution and care, and facilitating active participation in health management as a social product by all involved.
Maternal and infant health and nutrition	Reduce the risk of death for mothers and children due to causes related to pregnancy, childbirth and puerperium, and in children under 5, due to prevalent childhood diseases.
Promotion of health and prevention of risks and health conditions linked to the life cycle	Promote healthy environments and lifestyles that help improve quality of life and reduce the risk of disease and death for adolescents, adults, older adults by implementing a comprehensive, inclusive and transparent approach.
Communicable disease control	Reduce the risk of endemic communicable diseases in the population with a gender approach.
Chronic non-communicable diseases	Systematize actions that target non-communicable, chronic, and degenerative diseases to prevent a rise to levels that pose public health problems.

Source: Government of Honduras, Advancing toward Medium-term Sectoral Planning. Multiannual PRS Implementation Plan 2006–2009. II Health Sector p. 31 and ff., May 2005.

[48] General Public Administration Law, article 29.
Agreement 5582, 29 December 2005. Manual of Organization and Functions. Secretariat of State in health office.
[49] Ministry of Health (1999), Health Code and General Environmental Regulation, chapter I, article 3, p.1.

The NHA promotes consensus through the Honduran National Health Council (CONSALUD), a consultation and advisory body on reform and consolidation of the national health system and social security; the National Occupational Health Committee (CONASATH), which coordinates public and private actions with regard to occupational health; the National Drinking Water and Sanitation Board (CONASA), which acts as an authority for political management, coordination, and social consensus-building with regard to drinking water and environmental sanitation; and the National HIV/AIDS Committee (CONASIDA), a high level agency for interinstitutional coordination and management and an interdisciplinary entity for general policy-making with regard to HIV/AIDS.

The National Human Resources for Health Board (CONARHUS) is a political and technical agency at the national level in the health sector that is responsible for coordinating policies, plans, programs and projects for management of human resources development in the sector. It includes three levels: political and regulatory, technical and operational, and advisory services.

The Ministry of Health also has a Ministry of Health Advisory Board (CONCOSE) created by the General Public Administration Law, which includes the Secretary, Assistant Secretaries, and the Director General,[50] as well as the heads of other agencies, and a Ministry of Health Quality Advisory Board (CONCCASS), an advisory services and consultation agency that promotes actions focusing on improvement of the quality of health services.

The Ministry of Health participates as a representative at the meetings of the Central American Health Ministers Board (COMISCA); special meetings of the Central American and Dominican Republic Health Sector (RESSCAD); meetings of the Ministers of Health of the Central American countries within the framework of the Puebla-Panama Plan; conferences and committees led by PAHO (World Health Assembly, planning and programming committees, Pan American Sanitary Conference); and meetings of the World Bank, International Development Association, Global Fund, UNAIDS (Latin American and the Caribbean horizontal technical cooperation group), as well as Hemispheric Summit of Health and Environment and SIECA-WTO (Customs Union) meetings to consider subjects related to tariff barriers and differences in the framework of the free trade agreements.

The NHA stimulates and promotes participation by civil society in identification of problems, planning and implementation of actions in the field of health, preparation of standards, and promotion of actions that seek to favor health promotion and prevent health problems. The SS has developed several information systems in order to fulfill its mission.

Within the framework of the separation of functions and the search for equity, accessibility of services, and efficiency, the SS has participated in the development and implementation of new management models that favor private sector participation in the delivery of services financed primarily with public funds, as well as the development of management agreements as instruments for regulation of financing and control mechanisms to measure quality and efficiency. It has also implemented innovations in areas such as contractual mechanisms and purchase and payment methods. These models are being evaluated.

Access to health services has increased steadily in the last three 5-year periods. The groups with the most access to health services are children under 5 years and persons aged 50 years or over. Improved access is reflected by increased use of primary care services. However, this data only provides a general idea of access, since it does not consider the services offered by the for-profit private sector or different NGOs that offer services on an ongoing basis through regular medical brigades (Table 12).

[50] General Public Administration Law, article 34.

TABLE 12. ACCESS TO MINISTRY OF HEALTH SERVICES BY AGE AND LEVEL OF CARE HONDURAS 1990-2008[51]

Indicators	Access*
Period	
1990-1994	81.0
1995-1999	83.5
2000-2005	86.6
Population group (2006-2008)[52]	
Children under 5 years	61.9
Persons 5-14 years	23.1
Persons 15-49 years	43.2
Persons 50 years or older	57.4
Level of care (2006-2008)[53]	
Primary care	61.2**
Secondary care	38.8

Source: Outpatient Care Bulletins, Ministry of Health.
*Estimated based on first yearly visit.
**Estimated based on first visit plus future visits.

In order to harmonize and align international cooperation, the sectoral committee, technical committee, and CESAR committee have been established. This has benefited increased knowledge of international cooperation entities in Honduras and medium-term sectoral planning. The government and the cooperating entities have maintained the PRS as the cornerstone of planning, focusing their actions on fulfillment of its goals and objectives within the framework of the international agreements.[54] The Bureau of International Cooperation was created as a unit responsible for coordinating international cooperation through the regulation on organization, operation and competence of the executive branch (article 42). The preparation of projects is defined by considering the guidelines set forth in the Health Plan and current government policy.

International cooperation with reimbursable funds decreased in 1995-1999 and increased in 2000-2005. Non-reimbursable funds increased significantly in 1995-1999 as a result of the assistance received after Hurricane Mitch. This figure remained steady in 2000-2005 and decreased in 2006-2008 (Table 13).

TABLE 13. RESOURCES IN THE HEALTH SECTOR FROM INTERNATIONAL COOPERATION (US$), HONDURAS 1990-2008

Periods/ Resources	1990-1994	1995-1999	2000-2005	2006-2008*
Reimbursable (1)	171,554.88	134,044.59	191,609.33	27,118,968.12
Non-reimbursable (2)	NA	109,304,273.00	108,911,376.42	40,476,303.28
Total	171,554.88	109,438,317.59	109,102,985.75	67,595,271.40

Sources: (1) Ministry of Finance, General Bureau of Public Credit.
(2) Secretariat of International Cooperation (SETCO), 2008.
(3) Health budget administrative document, Ministry of Finance, 2006, 2007, 2008.
Note: Paris Club funds were not available in 2006 and HIPC funds were not available in 2007.

[51] Access = No. of visits for the first time/No. of inhabitants x 100. This indicator is used for the purposes of this document, even though it is not the most relevant. Management Monitoring and Evaluation System (SIMEG) 2008, Annex 3, p. 53.
[52] Average for 2006-2008 based on AT2/Department of Statistics/SS, Hospital Care Bulletin, p. 20.
[53] Coverage= Number of visits for the first time + Number of future visits / Number of inhabitants x 100.
[54] Monterrey Forum (2002), Declaration of Rome (2003) and Paris Forum (2005), among others.

In order to align international cooperation, a Multi-Annual PRS Implementation Plan 2006-2009 was prepared in 2003 and 2004. This plan, which was prepared in consultation with civil society and the advisory group, was supported by coordination and financing from the Inter-American Development Bank. It includes the initial proposals to implement long-term sectoral programs rather than isolated projects that are not linked to national priorities.

2.1.3 REGULATION

Honduras has a legal[55] and institutional framework for policy development and strengthening of institutional capacity for public health regulation and control. The legal framework assigns regulation and control functions to the Ministry of Health through the Bureau of Regulation. Regulation is defined as "the set of actions through which the State, via the authorized public institutions, approves, issues, updates, interprets, applies and enforces compliance with the mandatory legal, technical, and administrative standards to be followed by all individuals and legal entities that provide or receive goods and services of sanitary interest."

For regulation of water and sanitation, the Drinking Water and Sanitation Sector Framework Law was issued in March 2003. This law led to a new institutional organization with separation of service planning, operation, and regulation functions. It established decentralized management of the municipalities, water boards, and other civic organizations. The National Drinking Water and Sanitation Board (CONASA), which performs sectoral coordination and planning functions, was created by this law. The Ministry of Health is a member of the board.

To guarantee and improve quality of individual and collective health services,[56] the NHA authorizes installation, expansion, modification, transfer, and operation of public and private health care facilities. Sanitary regulations for operation of public and private facilities have been defined for this purpose. Drug registration and quality control, as well as supervision of drug manufacturing laboratories, also contribute to this aim. Regulatory and inspection functions have focused more on Ministry of Health hospital facilities. The private sector has been included to a limited extent.

Some work has been done to identify the profile of the health workforce. However, there are still misinterpretations with regard to training for specialists. Moreover, NHA intervention in certification of technical and auxiliary level professionals is an issue that has not been resolved.

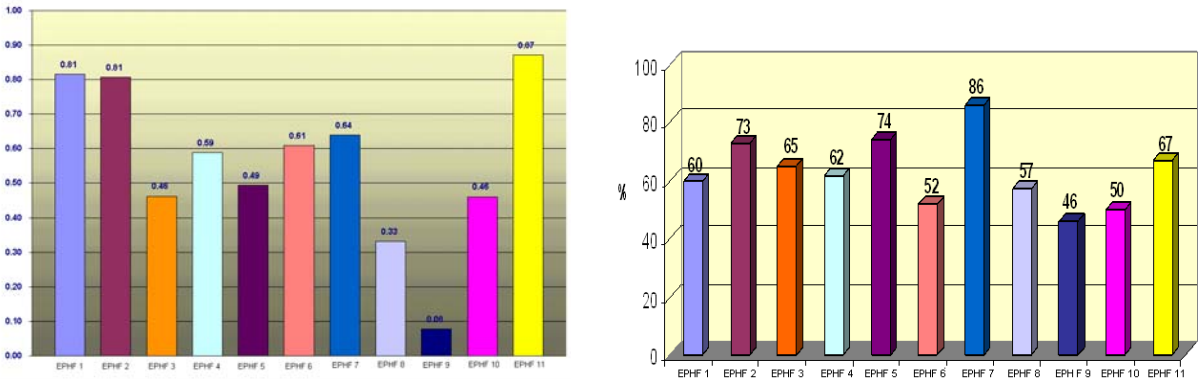
2.1.4 PERFORMANCE OF THE ESSENTIAL PUBLIC HEALTH FUNCTIONS

The EPHF were described and measured in Honduras for the first time in 2001. Subsequent measurements were performed at the national level and in eight departments in 2004. The measurements indicated that there is a need to strengthen monitoring, evaluation and analysis of health status (EPHF 1), human resources development and training (EPHF 8), development of policies and institutional capacity for public health planning and management (EPHF 5) and, finally, promotion of equitable access to health services (EPHF 7). Results of the measurements performed in 2001 and 2004 at the national level are shown in the graphs below.

[55] Decree PCM-008-97, article 67, subsection 1.
[56] Health Code, articles 157-171.

FIGURE 3. EPHF MEASUREMENT RESULTS
HONDURAS 2001 and 2004

2001 **2003**



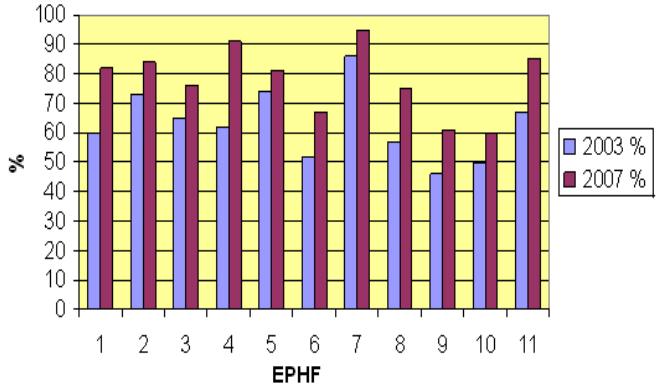
Source: SS, Health services access program.

In 2007 the third measurement of EPHF performance was conducted in eight health regions of the Ministry of Health (40% of total). The results are shown in the following comparative table for 2003 and 2007.

TABLE 14. EPHF PERFORMANCE PROFILE IN 8 DEPARTMENTS
HONDURAS 2003 AND 2007

No.	EPHF	2003	2007	Difference
1	Monitoring, evaluation and analysis of health status	60	82	22
2	Surveillance, investigation and control of risks and threats to public health	73	84	11
3	Health promotion	65	76	11
4	Social participation in health	62	91	29
5	Development of policies and institutional capacity for public health planning and management	74	81	7
6	Strengthening of public health regulation and enforcement capacity	52	67	15
7	Evaluation and promotion of equitable access to necessary health services	86	95	9
8	Human resources development and training in public health	57	75	18
9	Quality assurance in personal and population-based health services	46	61	15
10	Research in public health	50	60	10
11	Reduction of the impact of emergencies and disasters on health	67	85	18
	Overall performance	63	78	15

FIGURE 4. COMPARISON OF EPHF PERFORMANCE IN 8 DEPARTMENTS HONDURAS 2003 AND 2007



Source: EPHF measurement, 2003-2007.

In 2007 the overall average for the 11 EPHF was 0.78, falling within the quartile of optimal performance. The best performing functions were EPHF 7 (95%); EPHF 4 (91%); EPHF 11 (85%); EPHF 2 (84%); and EPHF 1 (82%). The results show the need to strengthen the EPHFs in the short term with regard to quality assurance (61%), public health research (60%), and public health regulation and enforcement capacity (67%). Comparison of overall results from 2003 (63%) and 2007 (78%) shows 15% improvement in EPHF performance at the intermediate level of the NHA, with emphasis on the aforementioned EPHF. In order to address gaps in human resources training, ongoing capacity building has been provided for all health staff according to their work area. Coordination and partnerships with human resources training schools are also being strengthened. These results show that there is an urgent need to reconsider monitoring EPHF performance. EPHF implementation results in improved public health practice and improved steering role of the NHA, particularly at the intermediate and local levels.

2.1.5 ORIENTATION OF FINANCING

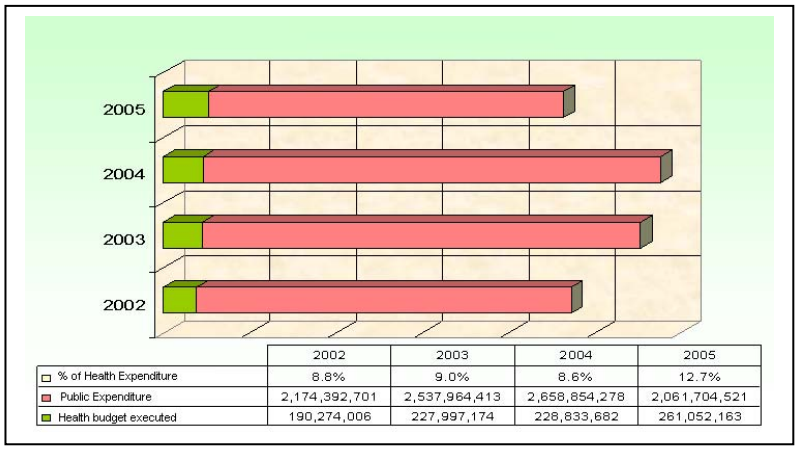
Health expenditures by the central government in 2005 included the Ministry of Health; Honduran Social Security Institute (IHSS); Honduran Social Investment Fund (FHIS); Ministry of Defense; Honduran Institute for Prevention of Alcoholism, Drug Addiction and Drug Dependency (IHADFA); Honduran Agency for Children and Families (IHNFA); Francisco Morazán National Pedagogical University (UPNFM); and National Autonomous University of Honduras (UNAH). Such expenditures amounted to L 7,137,379,036. Sources of financing included national funds (91.6%) and international cooperation (8.4%).

TABLE 15. BUDGET EXECUTED BY HEALTH SECTOR BY SOURCE OF FINANCING HONDURAS 2005

Sources of financing	2005
National Treasury	6,257,217,772
Debt settlement	158,230,333
Recovered funds	72,591,329
Donations	49,766,463
Total national sources	**6,537,805,898**
Loans	564,355,309
Donations	35,217,829
Total international sources	**599,573,139**
Total	**7,137,379,036**

Source: Health expenditures and financing study, 2007, p. 11.

FIGURE 5. MINISTRY OF HEALTH BUDGET EXECUTED/TOTAL PUBLIC SPENDING (US$) HONDURAS 2002-2005



	2002	2003	2004	2005
% of Health Expenditure	8.8%	9.0%	8.6%	12.7%
Public Expenditure	2,174,392,701	2,537,964,413	2,658,854,278	2,061,704,521
Health budget executed	190,274,006	227,997,174	228,833,682	261,052,163

Source: UPEG (2008), Health System Profile, fourth draft, pp. 48-49.

The budget allocated by the Ministry of Health in 2002-2005[57] reflected an overall growth of 31.3%. There was a steady increase in per capita expenditure from US$ 28.4 in 2002 to US$ 32.6 in 2004 and US$ 50 in 2005. At the end of the 2004 fiscal year, expenditures by the Ministry of Health accounted for 8.6% of the total government expenditure.[58]

The NHA does not have mechanisms to monitor financing of the other institutions in the sector, although national account studies have been conducted. There is limited capacity to negotiate needs with the Ministry of Finance. Moreover, creation of solidarity funds has not been promoted. In 2008 a total of L 7,390,092,736.00 in financing was provided by the following sources:

TABLE 16. HEALTH BUDGET BY SOURCE OF FINANCING (LEMPIRAS) HONDURAS 2008

No.	Source of financing	Amount (Lempiras)
1	National funds	6,183,113,710.00
2	Credits	486,550,726.00
3	Donation	62,928,500.00
4	Paris Debt Club (settlement)	209,934,300.00
5	HIPC	466,395,300.00
	Total	7,390,092,736.00

Source: Ministry of Health budget proposal, 2008, UPEG.

Sixty five per cent of national funds were allocated to the salaries of 17,699 health workers in 2008. In spite of its "financial weight" in the system, both numerically and in terms of expenditures, the health system response to the needs of the population is deficient. The next largest category of investment in the budget was hospital supplies and medicines. This is due to the hospital-centric approach to health care widely accepted in Honduras.

2.1.6 GUARANTEE OF ASSURANCE

In Honduras there are two assurance mechanisms that provide health services. Public insurance, which operates through the IHSS, offers a system with coverage for all health risks for insured

[57] Performance data up until December 2006 is considered for 2005.
[58] From fourth draft document of health system profile.

policyholders that contribute to the system and maternity services and care for children up to 11 years of age for indirect beneficiaries. IHSS coverage for disease and maternity has increased in terms of population. However, since the entire population does not need IHSS health services, the actual coverage is less.

There are 11 companies that offer health insurance. These companies are regulated by the National Banking and Insurance Commission (CNBS).[59] The main purpose of the commission is to monitor the operations and solvency of insurance institutions operating in the country under the Insurance and Reinsurance Institutions Law[60] and the regulations issued to control the operation of entities such as insurance companies, intermediaries, and adjusters. The law establishes penalties for failure to comply with the obligations that must be fulfilled by intermediaries (i.e., dependent agents, independent agents, brokerage firms). According to this law, insurance intermediaries that fail to comply must pay financial penalties.[61] The solvency margin regulation[62] ensures the availability of services.

The NHA does not participate in regulation or control of private health insurance providers. Such companies offer their services through agreements that must comply with the provisions of the Code of Commerce. Private insurance with voluntary enrollment provides medical benefits and employment disability in accordance with individual or collective agreements. In some cases, this insurance may limit services or increase the percentage of copayments in order to receive benefits. Its main source of financing is payment by the beneficiary, corporate contributions up to the price of the plan for group insurance, and the copayments associated with the plan. The frequency of payment is usually annual, although some companies accept monthly or quarterly payments. The total population coverage is not known. However, it is known that in recent years there has been a significant increase in the number of persons that purchase private health insurance.

Honduras has a segmented and fragmented health system. In this system, there is cross-financing since the population enrolled in the IHSS or another health insurance system can use the services offered in public and/or private nonprofit facilities. This is a common practice, particularly for subspecialties.

2.1.7 HARMONIZATION OF SERVICE DELIVERY

The NHA has worked to harmonize the action plans and management models with regard to delivery of health services for decentralized or non-convergent public agencies. This task has been developed more in the SS services network, although there have been some experiences in the IHSS. Fragmentation of delivery of services in the public health subsystem has important territorial dimensions. For example, the health services offered in rural areas are limited significantly by the weakness of the referral and counter-referral mechanisms. Although initial efforts have been made to prevent fragmentation and promote equity and access, such efforts are in the process of evaluation and consolidation.

In 2000-2005 work was performed on reviewing and defining basic health care standards. Nevertheless, control is limited to a restricted number of public and private facilities. Efforts to integrate primary, secondary and tertiary levels of care have not been successful. This is shown by the high level of demand for basic services in high complexity hospitals at the national and regional level and the lack of guarantee that an adequate response will be provided for referrals to different levels of care.

[59] Decree 155-95.
[60] Decree 22-2001.
[61] Insurance Institutions Law, art. 122, numeral 1, numeral 11,Title IV (From Mediation Contracts and Bonds, Chapter II, Insurance and Bond Mediation).
[62] Resolution 019/06/01, 2004.

2.2 FINANCING

According to the results of the Health Expenditures and Financing in Honduras 2007 study, health expenditures accounted for 10,538 million lempiras (US$ 553.6 million) in 2005. This represented 6.7% of the GDP for this year. Overall, 67.9% was public spending and 32.1% was private expenditures. The total average expenditure per inhabitant was L 1,491 (US$ 78). A total of L 1,010 (US$ 53) was public spending and L 481 (US$ 25) referred to private expenditures (Table 17).

TABLE 17. HEALTH EXPENDITURES (LEMPIRAS)
HONDURAS 2005

Item	Amount
Health expenditures (millions of lempiras)	10,538
Health expenditures/GDP (%)	6.7
Public spending/ health expenditures (%)	67.9
Private spending/ health expenditures (%)	32.1
Average expenditure per inhabitant (lempiras)	1,491
Average expenditure per inhabitant (US$)	78

Source: Health expenditures and financing in Honduras 2007 study.

Financial resources were allocated to the different budget programs according to health policies and priorities. Although it was intended to strengthen prevention and primary care, the budget allocated to continuous medical care in hospitals was larger due to the high demand for primary care services in hospitals and the cost of specialized interventions.

The estimates show that, overall, positive achievements have been made in the efforts to increase the coverage of health services. The percentage of the population without access to health services has decreased (Table 18).

TABLE 18. HEALTH SYSTEM COVERAGE
HONDURAS 1990-2005

Periods	Population covered by health system (%)	Population covered by SS (%) (1)	Population covered by IHSS (%) (2)	Population covered by private sector (%)	Population without coverage (%)
1990-1994	81.0	57	11.0	13.0	16.8
1995-1999	83.5	59	16.5	13.0	16.5
2000-2005	86.6	60	13.7*	13.0	13.4

Sources: (1) Ministry of Health, Outpatient Care Bulletins, 1990-2005.
(2) IHSS Department of Statistics registries.
*Reduced due to inspection of the database, which had not been cleaned.

2.3 DELIVERY OF SERVICES

The institutions that offer health services have introduced forms of outsourcing in the sector, particularly in procurement of specialized services. This has also occurred more recently in delivery of primary care to populations that do not have access to health services. Both the SS and the IHSS have developed innovative experiences in this field, some of which have been more successful than others. Use of outpatient health care services in SS facilities has increased by 66.5%, from 5,050,412 in 1990-1994 to 8,074,785 in 2000-2005 (Table 19).

TABLE 19. USE OF MINISTRY OF HEALTH FACILITY SERVICES (VISITS)
HONDURAS 1990-2005

Age	1990-1994	1995-1999	2000-2005
Under 1 year	583,215	667,657	724,844
1-4 years	1,029,656	1,234,017	1,416,192
5-14 years	745,809	890,981	1,287,648
15-49 years	2,250,363	2,498,798	3,669,869
50 years or older	441,369	592,453	976,232
TOTAL	5,050,412	5,883,906	8,074,785

Source: SS, Outpatient Care Bulletin.

Use of outpatient health care services in IHSS facilities increased from 1,345,722 in 1990-1994 to 2,035,517 in 2000-2005. Coverage for the under-5 group has been increasing in the more recent years, which can be attributed to the expansion of national coverage to 9 additional cities in 2005.

TABLE 20. USE OF IHSS SERVICES (VISITS)
HONDURAS 1990-2005

Age	1990-1994	1995-1999	2000-2005
Under 5 years	323,261	235,256	384,418
5-11 years	NA	5,467	100,277
14 years or older	1,022,461	981,994	1,550,822
TOTAL	1,345,722	1,222,717	2,035,517

Source: IHSS, Department of Statistics registries.

2.3.1 SUPPLY AND DEMAND OF HEALTH SERVICES

The following table shows the distribution of the SS and IHSS public health service networks.

TABLE 21. NUMBER OF HEALTH FACILITIES AND CAPACITY
HONDURAS, 2008

Resources	Number	Centers per 1,000 inhab.	Beds	Beds per 1,000 inhab.
Ministry of Health hospitals	28	0.003	5,059	0.642
IHSS hospitals	2	0.0002	916	0.116
Private hospitals (nonprofit and for-profit)	60	0.007	151	0.019
Private clinics (nonprofit and for-profit)[63]	1,079	0.136	NA	NA
CMI (SS)	57	0.007	NA	NA
CESAMO (SS)	380	0.048	NA	NA
CESAR (SS)	1,018	0.129	NA	NA
CLIPER (SS)	4	0.0005	NA	NA
Peripheral clinics (IHSS)	8	0.0008	NA	NA
Dental clinic (IHSS)	1	0.0001	NA	NA
Physical medicine and rehabilitation (IHSS)	2	0.0002	NA	NA
Elderly (IHSS)	1	0.0001	NA	NA
Family counseling	14	0.001	NA	NA
Community childbirth clinic (SS)	9	0.001	NA	NA
Community childbirth clinic (IHSS)	1	0.0001	NA	NA
Maternal shelters (SS)	8	0.001	NA	NA

Sources: Ministry of Health Bureau of Hospitals IHSS, UPEG, 2008.

[63] Data from 2005. Private sector data from 2002.

Primary care provided by the SS includes rural health centers (CESAR) and medical and dental health centers (CESAMO), which are located throughout the country, providing care and/or referral for patients that require these services. Referrals usually send patients to the area and regional hospitals.

SS hospitals are classified in three groups: cardiology institute (1), national hospitals (5), and regional hospitals (22). National hospitals receive referrals for the first level of complexity. Regional hospitals receive referrals for the second and third level of complexity. The basic services provided by regional hospitals include hospitalization (i.e., medicine, surgery, pediatrics, obstetrics and gynecology) as well as outpatient visits and emergency care.

The IHSS has 2 hospitals, located in San Pedro Sula and Tegucigalpa, as well as 8 peripheral clinics, 1 dental center, 2 physical medicine and rehabilitation centers, and 1 center for the elderly.

2.3.2 DEVELOPMENT OF HEALTH WORKFORCE

The entity that provides training for human resources in health is the National Autonomous University of Honduras (UNAH). The Catholic University has also begun to offer medical degrees, initially in San Pedro Sula and then in Tegucigalpa.

Supply and Distribution of Human Resources

TABLE 22. HUMAN RESOURCES IN PUBLIC INSTITUTIONS HONDURAS 1990-2008

Institution	1990-1994			1995-1999			2000-2005			2006-2008		
	Phys.	Nurse	Assist. Nurse	Phys.	Nurse	Assist. Nurse	Phys.	Nurse	Assist. Nurse	Phys.	Nurse	Assist. Nurse
SS	2,152	788	6,586	1,664	785	4,927	1,883	922	5,436	2,323	1,242	5,975
IHSS	393	129	580	373	140	561	417	137	557	471	244	692
Total	2,545	917	7,166	2,037	925	5,488	2,300	1,059	5,993	2,794	1,486	6,667

Source: Ministry of Health and IHSS-UPEG registries.

The Ministry of Health is the institution that employs most physicians and professional nurses, followed by the IHSS. The ratio per 10,000 inhabitants increased from 1990-1994 to 1995-1999, and remained steady in 2000-2005. Similarly, the ratio of professional nurses per 10,000 inhabitants increased slightly from 1990-1994 to 1995-1999. The decrease in 2000-2005 was related to failure to comply with professional association membership as a requirement for job eligibility, particularly in the private sector.[64] The ratio of general practitioners vs. specialists increased from 1.1 in 1990-1994 to 1.7 in 2000-2005. The medical resources were located primarily in the most developed cities.

[64] Source: President of School of Professional Nurses.

TABLE 23. HUMAN RESOURCES INDICATORS
HONDURAS 1990-2008

Type of human resources	Period			
	1990-1994	1995-1999	2000-2005	2006-2008
Ratio of physicians per 10,000 inhabitants	7.9	8.8	8.9	10.1
Ratio of professional nurses per 10,000 inhabitants	2.8	3.2	3.0	3.0
Number who have completed graduate-level training in public health	22	57	70	90
Number with graduate-level degrees in public health	0	14	19	14[65]
Number of public health schools	1	1	1	1
Number of universities with Master's Degree in Public Health	1	1	1	1

Sources: Honduras School of Medicine, School of Professional Nurses registries; UNAH, Graduate School of Public Health.

TABLE 24. HUMAN RESOURCES IN THE HEALTH SECTOR
HONDURAS 1990-2005

	1990-1994			1995-1999			2000-2005		
		Specialists			Specialists			Specialists	
	General	Public Health	Others	General	Public Health	Others	General	Public Health	Others
NATIONAL TOTAL	1,798	149	1,649	2, 126	158	1,968	2,221	159	2,062

Source: National Autonomous University of Honduras. Student Registry Department.

2.3.3 MEDICINES AND OTHER HEALTH PRODUCTS

In Honduras there is an official National Drug Policy (PNM) that was updated in 2001. In addition, there is an implementation plan that establishes the activities, responsibilities, budget and timetable. The subregional drug policy for Central America and the Dominican Republic was reviewed and adapted to the Honduran reality in 2008.

The Ministry of Health is the drug regulatory authority. It has a regular budget that is guaranteed by the government and supplemented by collection of fees for the drug registration process. There are also legal provisions that regulate authorization of the operation of manufacturers and wholesale drug distributors, as well as import and export of medicinal products.

There are legal provisions that regulate prescribing practices and authorize pharmacy operation. The law requires the pharmacist to be present during pharmacy operating hours in health facilities at all levels of care, for the SS as well as the IHSS, and private establishments that sell medicines.[66] Use of the generic name in prescriptions issued by national hospitals has been mandatory since 1990.[67]

In Honduras the price of medicines is not controlled. Only the profit margin for importers and retailers is regulated. The profit margins for pharmaceutical products are controlled by the Ministry of Industry, Trade and Tourism (SIC) under the Bureau of Production and Consumption. The legislation that applies to this activity is the Consumer Protection Law, which stipulates the profit margin for medicines and pharmaceutical products for human consumption.

[65] The number of MPH graduates in 2009 was 47. Cumulative data provided by Dr. Astarte Alegría.
[66] Art. 79, Agreement No. 206, La Gaceta No.30841, 4 November 2005. Art. 167, Health Code and General Environmental Regulation, 1999
[67] Honduras, 1990. Bibliographic reference for the regulation.

TABLE 25. MEDICINES BY SELECTED INDICATORS HONDURAS 1990-2005

INDICATOR	Periods		
	1990-1994	1995 -1999	2000-2005
Total number of pharmaceutical products registered	2,254	5,185	8,374
Brand name drugs (%)	92.6	86.7	85.9
Generic drugs (%)	7.4	13.3	14.1
Public health spending allocated to drugs (%)	15.6	13.76	16.3

Source: SS, Bureau of Regulation.

The basic list of medicines for Honduras is elaborated by an ad hoc national committee. The list, which was updated in 2003 and includes 397 active ingredients, is used by the SS. The IHSS also has a list updated based on scientific evidence, which offers clinical guidelines for the three levels of care.

Drug Supply

Drugs are supplied to the SS by a centralized process that includes involvement of government technical agencies and civil society. The process is conducted under the Interinstitutional Drug Commission, a drug procurement entity created by presidential decree in late 2006. The National Convergence Forum (FONAC), the Catholic Church, the National Anticorruption Board, the National AIDS Forum, and the Honduran School of Medicine are members of the commission.

The IHSS purchases drugs through a centralized process that is separate from the SS. Procurement by the Ministry of Health is limited to drugs in the basic list, which is equivalent to a list of essential medicines (LME). The IHSS limits its purchases to the list of drugs established by the institution.

Drug procurement is conducted within the framework of the State Contracting Law, which endorses open and private bids, and direct purchases. The SS also purchases drugs using the regional procurement mechanisms guaranteed by law for procurement of strategic public health products through the PAHO/WHO Revolving Fund established in 2002.

2.3.4 EQUIPMENT AND TECHNOLOGY

Honduras has not defined a policy that ensures maintenance of public health facilities and equipment, which negatively impacts the licensing process of SS health facilities. The main obstacles to granting licenses to these facilities include:

- 87% of hospitals do not have the required documentation or the daily supplies needed.
- 53% of the hospitals inspected have deficient facilities.
- 50% of hospitals do not have the minimum medical equipment required for operation.[68]

In order to improve the physical conditions and availability of essential equipment, hospitals have formed support committees with civil society organizations to assist in the resolution of the aforementioned problems.

[68]Bureau of Regulation, 2008.

TABLE 26. EQUIPMENT IN IHSS FACILITIES
HONDURAS, 2008

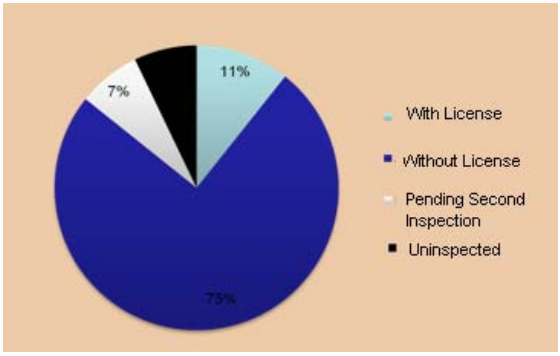
Technology	HET	HRN	%
Neonatal ICU equipment	x	x	100
Pediatric ICU equipment	x	x	100
Adult ICU equipment	x	x	100
Laboratory	x	x	100
Hemodialysis	x	x	100
Operating rooms	x	x	100
Magnetic resonance imaging	x	x	100
Electroencephalogram	x	x	100
Dual computerized axial tomography	x	x	100
Digital mammography	x	x	100
Computerized electromyograph	x	x	100
Neurological stimulator	x	x	100

Note: HET: Specialty Hospital, HRN: Hospital Regional del Norte.
Source: Assistant Director's Office of Statistics, IHSS 2008.

2.3.5 QUALITY OF SERVICES

There are 25 public hospitals in Honduras, 75% of which do not have sanitary licensing. Only 3 hospitals have sanitary licensing: Hospital San Francisco de Asis in Olancho, Hospital Gabriela Alvarado in El Paraíso and Hospital Juan Manuel Galvez in Lempira.

FIGURE 6. LICENSING OF SS HOSPITALS
HONDURAS 2008



Source: Annual evaluation 2008, Bureau of Regulation.

The SS Bureau of Regulation is in charge of accreditation for public and private facilities that offer health services. There is a regulation that stipulates the legal framework for supervision of health care facilities and the instruments required to conduct this task. Work has been conducted to define standards and regulations to ensure quality of services.

Accreditation and control mechanisms focus on infrastructure and equipment conditions and do not address human resources training and capacity. Human resources are primarily support staff such as nurse's assistants. In recent years this staff has been receiving training in private schools. The operational capacity of the bureau is limited due to the lack of human and financial resources, and the weakness of the health regions in performance of this activity.

The SS has a quality assurance department that develops the National Continuous Quality Improvement Plan according to three strategies: a) user satisfaction improvement; b) improvement of the technical and scientific quality of care provided by health care professionals; and c) optimization of use of resources. Actions have been implemented in 19 of the 20 departmental health regions. Moreover, interventions are planned in Ocotepeque, where there are continuous quality improvement committees as well as improvement teams and process facilitators. A total of 23 of the 28 public hospitals have a user care functional unit.

The SS has formed the Quality Advisory Board (CONCASS)[69] with the objective of promoting "development of the institutional subsystem of total quality in the Ministry of Health, focusing on continuous quality improvement processes and delivery of health care services with emphasis on the national and local priorities defined in the national health policy." It also has a plan to develop and implement a comprehensive strategy to institutionalize the continuous quality improvement program, which was implemented in January 2005 and has been introduced in 8 area hospitals and 7 departmental regions.

FIGURE 7. PROGRESS IN CONTINUOUS QUALITY IMPROVEMENT IN HEALTH REGIONS HONDURAS 2008

No.	DEPARTMENTAL HEALTH REGION	INTERVENTIONS IN MANAGEMENT PROCESSES			INTERVENTIONS IN CLINICAL PROCESSES			PROGRESS
		Hosp	CMI	CMO	Hosp	CMI	CMO	
1	Atlántida	2			2		7	
2	Choluteca	1			1		4	
3	Colon	2			2	2	3	
4	Comayagua	1			1	5	29	
5	Copan	1			1	2	31	
6	Cortes							
7	El Paraíso	1			1	3	14	
8	Francisco Morazán					1	2	
9	Gracias a Dios	1			1	1	5	
10	Intibucá	1			1	1	16	
11	Islas de la Bahía	1						
12	La Paz	1			1	2	20	
13	Lempira	1			1	5	27	
14	Metropolitana de SPS	2			2	2	4	
15	Metropolitana de Tegucigalpa	3			2		5	
16	Ocotepeque							
17	Olancho	1			1	5	2	
18	Santa Bárbara	1			1	1	7	
19	Valle							
20	Yoro	3			1	6	3	
TOTAL		**23**			**19**	**36**	**179**	

Work with limited support

In progress and in need of support

Not started and/or in need of strong support

Source: National quality assurance program evaluation, 2008.

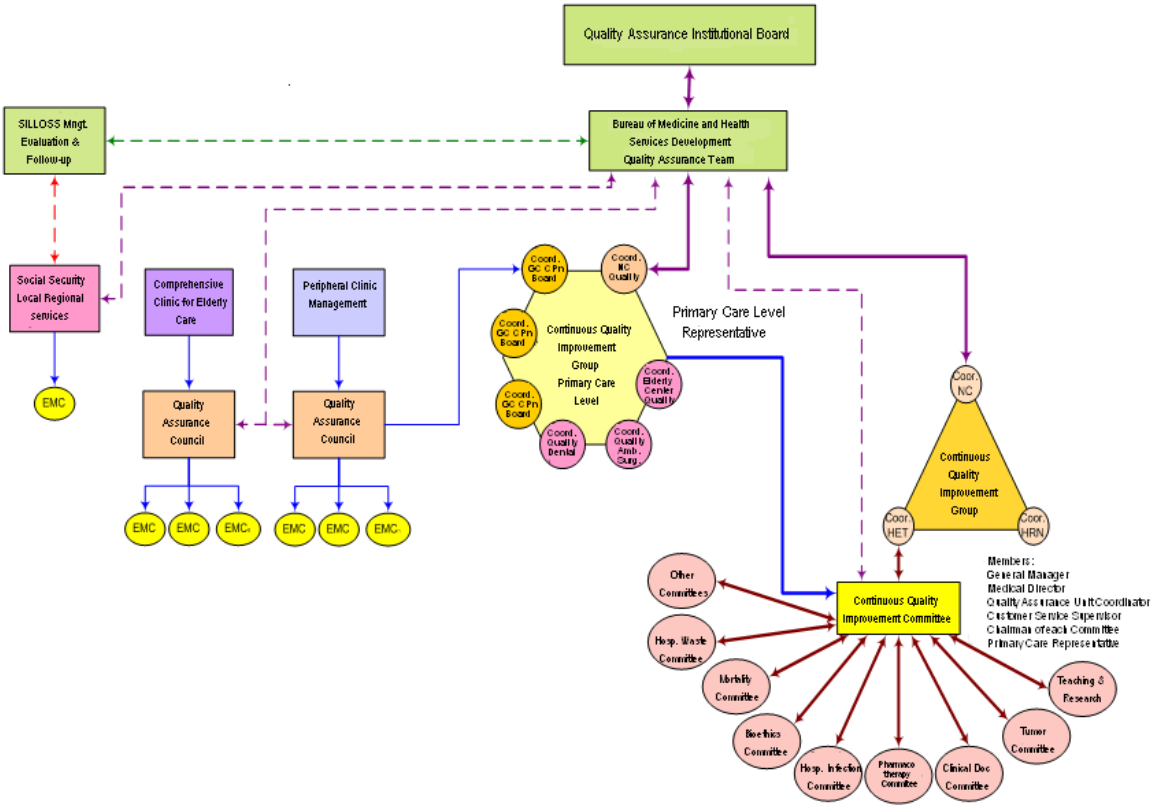
The mechanisms for filing claims have been established by the appropriate laws. There is a Consumer and Human Rights Enforcement Office as well as a National Commissioner for Human Rights that can file claims against State institutions. Nevertheless, the population does not make claims due to the lengthy process involved and the limited capacity to respond to its demands. There are no standards to measure performance in terms of training or number of human resources, adequate financial resources, or supplies and technology.

The IHSS has an institutional quality assurance system. This system has its own principles with regard to the development process and strengthening Social Security in Honduras: universality, solidarity, equality, obligatory, participation, specialization, unity.

[69] Executive Decree No.3616, La Gaceta, 15 December 2004.

The following priorities were established for the respective areas for 2006-2010: (1) health services for the insured population: health promotion, comprehensive care for the elderly, occupational health, maternal and child care, sexual and reproductive health, infectious diseases, HIV/AIDS, expansion of coverage, establishment of a family-centered approach to health in the health programs and actions; (2) administration: strengthen the administrative and financial capacity of the IHSS, support conversion of the current health services management model, development of Social Security human resources; (3) organizational development: organizational modernization strategy, proposal of a new organizational structure (organization chart) and an organizational culture based on principles and values.

FIGURE 8. IHSS QUALITY ASSURANCE SYSTEM
HONDURAS 2005



Source: IHSS quality system structuring plan, 2005. National Bureau of Medicine, IHSS.

2.4 INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM

Institutional mapping of the health system indicates that there is a management and regulatory entity that performs the functions of financing, insurance, and delivery of services in conjunction with other actors from the central, local and municipal area. The IHSS regulates and inspects its own financing, insurance, and delivery of services separately from the functions of the NHA (Table 27).

TABLE 27. INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM

Functions/ Organization	Steering role		Financing	Insurance	Delivery
	Management	Regulation and control			
SS	X	X	X	X	X
IHSS		X	X	X	X
SEFIN			X		
Ministry of Labor			X	X	X
Armed Forces				X	X
NGOs			X		X
Municipalities			X		X
HR training institutions			X		
Private insurance companies			X	X	
Private providers			X	X	X
International cooperation			X		

3. MONITORING PROCESSES OF CHANGE AND REFORM

Since the early 1970's, Honduras has implemented different strategies to guarantee access to health services for the population. The strategies have sought primarily to extend coverage, improve administration and management, optimize local planning, establish local health systems, and improve access to and quality of services.

These strategies have been linked to several international events such as the Alma-Ata Conference (1978), which promoted primary health care; the Ottawa Charter (1986), which supported policies to create healthy environments, personal attitudes, and reorientation of health services; the Adelaide, Australia Declaration (1988), which emphasized access to healthy food and nutrition for all and reduction of the risks related to alcohol and tobacco consumption; the Bogota, Colombia Meeting (1992), which focused on problems related to health and development, and promoted creation of a culture favorable to health and lifestyle changes through information, education, and participation by the population; and more recently, the Beijing, China Conference (1995), which emphasized gender equity, health promotion, knowledge acquisition, and participation by the population.

In the early 1990s, a health sector reform process was promoted in Honduras in the context of State modernization and reform. Within this framework, the national health modernization committee[70] worked on defining a proposal of transformation of the system based on five specific components: strengthening of the steering role of the Ministry of Health; progressive integration with the IHSS; comprehensive health services network; decentralization; and definition of "equity, efficiency, effectiveness, and social participation."

In 1994 the government declared that "the central element of health system reform and modernization would be national access to the health services program,"[71] which was introduced in 1995. The activities supported by this program sought to increase the capacity of health human resources, local governments, and among community representatives. Another approach was to promote participation and active contribution by local governments and the community in planning, management of services, and health promotion. In several cases the program activities contributed to and facilitated other local development initiatives outside the health sector. In the operational aspect, this process was used to promote participation by local governments in the definition of diagnoses and preparation of municipal plans, which occurred in 86% of the municipalities in Honduras. These plans sought to reduce or resolve the health problems of the population.

The New Health Agenda (1998) was an additional reform attempt. The proposed objectives were oriented towards decentralization of the health care system, including reorganization of the SS; strengthening of the policy-making capacities of government and health sector planners; improvement of care in terms of equity; increased access for the poor; and development of fee policies for users with the resources to pay. Reorganization of the services network by forming 18 departmental bureaus and 2 metropolitan health bureaus (Central District and San Pedro Sula) was proposed for this purpose.

Hurricane Mitch (October 1998) caused severe damage to the social and productive infrastructure of Honduras.[72] As a result, the government was forced to reconsider national objectives. It established a national reconstruction policy that created areas for extensive participation by civil society through creation of the National Convergence Forum (FONAC) and the National Reconstruction Board. The Master Plan for National Reconstruction and Transformation (PMRTN) was prepared, which considered four issues: economic recovery with productive employment, combating poverty, promotion of human development, sustainable conservation of natural resources, and strengthening democratic participation.

[70] Created by Agreement 16-92.
[71] Financed with Swedish cooperation funds.
[72] In addition to the loss of thousands of lives, destruction of the road system, productive and educational infrastructure, 23 hospitals and 123 health centers were completely or partially damaged.

In health, the PMRTN identified the following strategies: strengthening the role of the State in health; social security reform aimed at achieving universal health insurance; system modernization by separating the financing, insurance and services delivery functions; innovations in the management model; development of initiatives with participation by actors from the government and civil society; and contributory financial reform.

The PMRTN identified as priorities preventive medicine and treatment, nutrition, health education, and drinking water and environmental sanitation services. The management model emphasized deconcentration and decentralization, and favored social participation. Studies on health status according to living conditions and financing (national and regional health accounts) were commissioned to support the reform process. Furthermore, efforts were made to adapt the legal framework[73] and to develop management and services delivery models. Implementation of the PMRTN in the health sector was an opportunity to give continuity to local processes introduced by the previous government (1994-1997) and implement novel experiences in service delivery models managed by the municipalities.

The National Health Plan 2021, which was in 2001, used the Poverty Reduction Strategy as a framework. Its general objective was to improve basic sanitary conditions and health services delivery. The main initiatives of the Plan were related to institutional development of the SS, including organization of 20 health regions; steering role strengthening; modernization of the services network; institutional development of the IHSS, with the separation of its basic functions; improvement of hospital management; and extension of coverage of services. The structure of the 20 health regions[74] was established in 2004.[75]

This was one of the most significant results of the reform process. Responsibility, including planning and implementation of the budget allocated, was transferred to the health regions. The new regionalization also facilitated participation by local governments and the community in health services management. Nevertheless, there were several problems with this organization. There were significant differences between the regions in terms of budget and resources, which hindered development of the functions they were attributed by law. Agreement 895[76] transferred responsibility for strategic planning, monitoring and evaluation of health surveillance and policies to the regions. However, these functions were difficult to perform due to insufficient financial and human resources.

In this context, innovative experiences seeking expansion of coverage were developed. Decentralization of health services delivery was introduced through agreements with municipal associations, local governments, city halls, grassroots community organizations, and some NGOs. The agreement established the responsibilities of the parties, the portfolio of services, and the financing method. New models were implemented in 29 health units in 10 municipalities in order to provide services for approximately 130,000 inhabitants. Traveling teams also implemented expansion of coverage by entering into agreements with NGOs or other private providers with per capita payment mechanisms. In 3 years services were provided to 60,000 families in 1,142 rural communities, in the 95 poorest municipalities in Honduras.

Through the agreement, providers are remunerated for promotion, prevention, and treatment provided. At the community level, community health units (UCOS) offer prevention and promotion. The main activities conducted by the rural health centers (CESAR) are basic prevention, promotion, treatment and rehabilitation for individual and collective health. The medical and dental health centers (CESAMO) and maternal and infant clinics (CMI) are at the level where care is provided for medical needs. Work is conducted at each level to refer patients to the appropriate level of care (Table 28).

[73] Enactment of Health Code.
[74] The SS is organized in 18 departmental sanitary regions that are the same as the administrative division of the country and 2 metropolitan sanitary regions (Central District and San Pedro Sula).
[75] Agreement 895, 18 May 2004.
[76] Articles 3, 4 and 5.

TABLE 28. CURRENT SS MANAGEMENT AND DECENTRALIZED CARE AGREEMENTS, HONDURAS 2008

#	Hospitals	Maternal and infant clinics
1	Santa Teresa	Erandique
2	Enrique Aguilar Cerrato	Marcala
3	Roberto Suazo Córdoba	Lajas
4	Juan Manuel Gálvez	Candelaria
5	Occidente	Siguatepeque
6	Escuela (gynecology and obstetrics)	La Libertad
7	Leonardo Martínez (maternity)	Camasca
8	San Felipe (maternity)	Corquin
9		Minas de Oro

Source: Undersecretary of service networks, 2008 evaluation.

The new models for delivery of services with decentralized management were designed to be mechanisms to achieve equitable and accessible health services. Some relevant aspects of these experiences are:

a) Permanent drug supply;

b) Improved infrastructure and equipment as well as fulfillment of the required licensing standards;

c) Increased coverage for approximately 400,000 persons who did not have access to health services through care at facilities and regular delivery of health services by traveling teams in marginalized communities;

d) Increase in institutional childbirth;

e) Contribution to reduction of maternal mortality rate;

f) Increase in preventive activities (e.g., pap smears, detection of respiratory symptoms, child vaccination, water quality surveillance);

g) Improvement in application of comprehensive health care standards for women and children under 5 years;

h) Increase in local capacity to manage and provide health services, achieving integration of the public and non-public sectors;

i) Development of quality improvement cycles for services with the support of community committees, which contributes to promotion of community participation and organization.

Hospital Modernization Program

An important aspect of the sectoral reform in 2002-2006 was development of the hospital modernization program in SS hospitals. The Comprehensive Health Sector Reform Program (PRIESS) financed by the Inter-American Development Bank was implemented in 12 hospitals. Three hospitals received financing from the World Bank through the Pro-Reform Program. This program included three components: technical assistance; management training; and investment projects. The first two actions aimed to develop hospital efficiency (increased productivity and improved performance of resources), advances in quality of care (reduction of hospital mortality rates and waiting lists for patient treatment in the different specialties), as well as improvement in financing solvency (improved budget management, containment of expenditures, and sales of services).

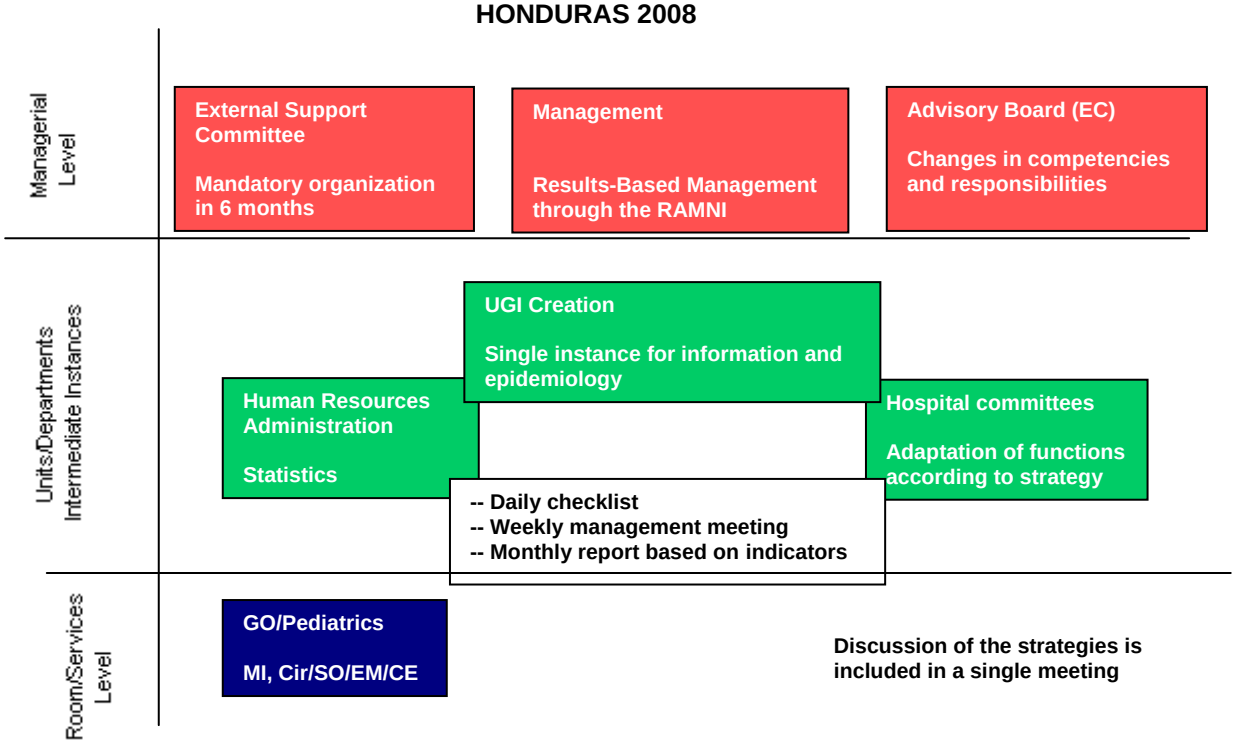
The new hospital management model considered the creation of new management and administrative structures; introduction of new planning and management instruments

(management information systems, strategic plan, and preparation of managerial organization charts); coordination of management support organizations; preparation of hospital improvement plans; signing performance agreements; and gradual and progressive transfer of SS resources and responsibilities to the hospitals.

The results of the hospital modernization program have been modest. To date, the relationship between the SS and the hospitals has not been redefined. Management agreements, which are the mechanism to define incentives and performance evaluation criteria, have not been signed. In addition, procurement processes and human resources selection and recruitment are still centralized and politicized.

As part of the reform process, the political level of the SS has included reorganization of hospital management in the institutional development plan. This is planned for implementation in 2009 according to the following scheme:

FIGURE 9. MANAGERIAL CHANGES IN SS HOSPITALS
HONDURAS 2008



Source: National evaluation meeting presentation, 2008.

The Honduran Social Security Institute

In 1990-1994 expansion of coverage for IHSS health services was introduced through establishment of agreements between the SS and the IHSS. Consequently, beneficiaries were able to visit SS health services in cities without IHSS coverage.

In 1995-1999, the IHSS developed a reform process oriented towards financial consolidation. This process emphasized separation of the health and pensions systems with regard to administration and financing; creation of an occupational hazards program; increased contributions; institutional

modernization, which entailed process reengineering and management automation; and strengthening the IHSS as an insurance entity and not as a service provider. The IHSS has achieved the most progress with regard to the first item. The accounting records of the two systems have been separated, although there are still problems related to debts incurred in the past by the health system from the pensions system.

Creation of the occupational hazards program was important. This system was previously financed by workers' and employers' contributions. It currently receives financing from direct contributions by employers. In order to improve the financial status of the IHSS, an increase in the maximum contribution was approved in 2004. This contribution was set at L 4,800.

In regards to institutional modernization, processes have been implemented such as individual accounts, which provide information related to credits earned by beneficiaries, and the information management system, which supports decision-making. Administrative processes have also been redesigned. No significant progress has been made with regard to consolidation of the IHSS as an insurance entity. The increased income has led to a strengthening of the IHSS' role as service provider. This is reflected by the direct delivery of new services (e.g., tomography, magnetic resonance, coronary care, among others).

In order to improve the quality and efficiency of service delivery, the IHSS has worked on restructuring and modernization of its two hospitals with resources from the World Bank and its own funds. A results-based resource assignment system (management by objectives) has been designed. Coverage has been expanded in 16 cities at the national level through local social security systems (SILOS). More recently, a pilot program for primary care with "family health teams" has been conducted in San Pedro Sula. This implies procurement of services from private clinics that establish agreements with the IHSS, which are paid on a per capita basis.

The IHSS has begun to provide services for persons that work in the informal sector of the economy through approval of the progressive membership regulation by its Board of Directors. This regulation requires the formal organization of workers or membership in a cooperative. With the model of subrogation of services and other innovative strategies in the procurement and delivery of services, the IHSS can respond to increased demand. The comprehensive family and community health services program has also been implemented in 20 IHSS health units at the national level in 11 cities. This program is based on the values, principles and components of primary health care.

3.1 EFFECT ON HEALTH SYSTEM FUNCTIONS

TABLE 29. PROCESSES OF CHANGE AND EFFECT ON HEALTH SYSTEM FUNCTIONS HONDURAS 1990-2008

Periods	1990-1994		1995-1999		2000-2005		2006-2008	
Subsectors	**Public**	**Social Security**	**Public**	**Social Security**	**Public**	**Social Security**	**Public**	**Social Security**
Steering role	Promulgation of Health Code (1991) Creation of National Health Modernization Committee Strengthening of SS steering role Restructuring of SS, with three Undersecretaries		PMRTN open to participation by different actors	Institutional modernization	Establishment of 20 health regions	Continuation of institutional modernization	As continuation of institutional modernization, new care and management models with non-public providers were established	
Financing		Financial consolidation				Separate accounting records Institutionalization of risk management Contribution limits are surpassed	Update SIAFI with physical and financial goal evaluation module	
Insurance							Decentralized care models with per capita financing for specific population groups	Comprehensive family and community health services PAISFC program
Delivery of services	Comprehensive nature of services network. Decentralization. Definition of "quality, equity, efficiency, effectiveness, social participation, and sustainability" as essential model requirements	Progressive integration with IHSS Extension of insurance	Beginning of first decentralization activities led by the access project and the municipalities	Progressive integration with IHSS Increase in direct and subcontracted services offered	Continuation of access project Hospital modernization Expansion of supply of direct and subcontracted services	Increase in direct and subcontracted services offered Insurance accepted		Increased coverage through IHSS PAISFC program

Source: SS/SIDA, A decade of contributions to human and social capital by health sector reform. Health Services Access Program.

Health sector reform is defined as a "process of gradual and progressive transformation of the national health system that seeks to produce substantive changes in the different authorities and functions of the sector with a view to increasing equity with regard to benefits, efficient management, and the effectiveness of its actions, thereby achieving satisfaction of the health needs of the population." [77]

In 1990-2005, there was a set of projects with the aim of strengthening the SS, both in its steering role and management capacity, as well as its role as service provider and the actions of some priority programs. Most of the projects were conducted by the SS. They are part of a global policy that seeks to modernize the State and strengthen social areas with financing from loans by the World Bank, the Inter-American Development Bank, and foreign debt settlement resources.

The innovations have been oriented primarily towards identification of a mechanism to delegate functions to the departmental regions in order to offer the population more accessible and effective services. Efforts have also been made in areas such as improved efficiency in delivery of services; modernization of the hospital network; improvement of the administrative structure of the SS and the IHSS; and increased transparency with regard to the acquisition and procurement mechanisms.[78]

3.2 EFFECT ON GUIDING PRINCIPLES OF THE REFORMS

Equity: The experiences conducted have improved access to health services for the population excluded from the system. Coverage increased by 2.5% from 1994-1999 to 1990-1994. There was a 3.1% increase in 2000-2005. The population with the highest coverage was children under 5 years (87.6%), followed by persons 50 years or older (57.4%). The SS opened 181 centers in traditionally marginalized areas in 2002-2005. This led to a 3% increase in SS coverage between 1990 and 2005. Similarly, the IHSS increased coverage from 11% in 1990-1994 to 13.7% in 2000-2005, and 20% in 2008.

The gaps in the number of physicians and nurses per 10,000 inhabitants have not been bridged. The staff is still primarily located in the most developed cities. Although the number of beds has increased, the ratio per 1,000 inhabitants has not changed since 1999 (0.88). However, the opening of area hospitals in the different department capitals in 1990-1994 favored access to this resource for poor population groups.

Effectiveness: There is evidence that the new management models have effectively contributed to reduction of maternal and infant mortality indicators in the locations where they have been implemented. In general, maternal and infant mortality has decreased steadily due to regular emphasis over the years on care for children under 5 years and women of childbearing age. Maternal mortality decreased from 182 deaths per 100,000 live births in 1990 to 108 deaths per 100,000 live births in 1997. Neonatal mortality decreased from 19 deaths per 1,000 live births in 1991-1995 to 16 deaths per 1,000 live births in 2001-2006. Moreover, the higher levels of education attained by Honduran women in the past 15 years have contributed significantly to reduction of these indices. There is no evidence of a decrease in mortality related to breast cancer and uterine cancer in women. Incidence of malaria and tuberculosis has declined. Mortality associated with tuberculosis and HIV/AIDS has decreased with new treatment regimens.

Efficiency: The indicators for risk factors related to access to water and basic sanitation have improved. However, no improvement has been recorded in solid waste management and environmental pollution. Access to water in 1995-1999 (93%) was lower than in 1990-1994 (96.8%). Access to excreta disposal systems decreased between 1990-1994 (80.5%) and 2000-2004 (62%). In 2007, 86.6% of the population had access to water. Therefore, although efforts have been made

[77] Taken from Conceptual, Political and Strategic Framework of Health Sector Reform, Ministry of Health, 2008.
[78] Study of Institutionalization and Governability, Honduran Health Sector, World Bank, 2008.

in this area, coverage is lower than it was prior to Hurricane Mitch. Access to basic sanitation in 2007 was 85.1%, which is higher than the figures recorded in 1990-1994 (80.5%). However, there is no direct relationship between the reform process and the water and sanitation achievements. The public health budget has increased. Although there is evidence of increased contributions to preventive programs, treatment of disease still accounts for the highest percentage of care.

Sustainability: The different activities within the framework of the reform process have had external financing. Increased coverage for primary care currently has debt settlement funds. Therefore, it is expected to be sustainable. Creation of the Coverage Expansion and Financing Unit (UECF) has favored alignment of international cooperation with regard to SS policies and objectives within the framework of the reform process. Local experiences of co-management of services have contributed to greater legitimacy for the institutions that provide public health services.

Social participation: Work has been conducted for many years to promote social participation. The Access Project contributed to promoting participation at the municipal level by favoring the transition from individual volunteers (e.g., malaria workers, health guardians) to broader participation in the decentralization process. Community organizations, NGOs, and civil society have participated in the project. However, greater efforts are required to actually achieve involvement of different local and national actors.

Effects on the health system: Experiences in expansion of coverage through agreements with "community associations" or other providers has allowed local actors to participate in services delivery to neglected populations. Increased regulation also legitimizes the steering role of the institution.

TABLE 30. PERIODS IN THE PROCESSES OF CHANGE AND EFFECT ON HEALTH SYSTEM HONDURAS 1990-2005

Periods/ Implications of changes	1990-1994	1995-1999	2000-2005
Citizens' right to health	Right recognized in the Constitution of the Republic and different health plans	Right recognized in the Constitution of the Republic and different health plans National Reconstruction Plan	Poverty Reduction Strategy
Effect on steering role	Health Code (1991) defines the SS as steering entity	Steering role is strengthened by creation of 3 undersecretaries	Measurement of steering role begins
Separation of health system functions	Several actors play a role in delivery of services	Delivery of services by third parties in the SS is promoted	Creation of the departmental and metropolitan regions
Deconcentration and/or decentralization	Centralized system	Beginning of deconcentration process	Strengthening of deconcentration
Civil society participation	Strengthening of participation mechanisms	Socialization of participation by the municipalities with new management models	Implementation of participation by the municipalities with new management models. Increased social participation in SS services management
Effect on governance		Changes proposed in the reform process with decentralization at the intermediate and local levels achieved joint work with local governments. This improved sector governance by promoting greater participation	

Periods/ Implications of changes	1990-1994	1995-1999	2000-2005
Changes in care model			Introduction of changes in decentralization model
Changes in management model		Definition of new management models	Introduction of new results-based models
Access barriers to individual and collective health services	Geographical factors and rigidity of system	Partial reduction of barriers	Partial reduction of barriers by new models and quality management
Changes in quality of care	Definition of standards, indicators, and program standards	Creation of Bureau of Regulation	Introduction of health center accreditation process Quality assurance department is established
Changes in labor market and human resources for health	Enactment of physician employee law. Promotion of SS training for technical personnel	Masters degree in Public Health	

3.3 ANALYSIS OF ACTORS

The qualitative method was used to analyze the actors. Interviews of key health sector stakeholders were conducted based on the methodological guidelines for health system profiles. This led to a description of the current situation and the main actors in the health sector in terms of political dimension as well as their perception of the future with regard to sectoral reform initiatives.

Nineteen actors were initially identified. Nine actors were considered to be primary actors due to their action or decision-making capacity:

1. Presidency of the Republic
2. National Congress
3. Social Cabinet
4. Ministry of Finance (SEFIN)
5. Ministry of Health
6. National Health Council
7. Honduran Social Security Institute (IHSS)
8. International cooperation agencies and organizations
9. Banks (i.e., Inter-American Development Bank, World Bank)

The following actors were identified as secondary, since they do not have decision-making capacity in the health sector:

10. Association of municipalities of Honduras
11. Local governments
12. Political parties
13. Trade associations
14. Unions
15. Associations of sectoral workers
16. For-profit health service providers
17. Nonprofit health service providers (NGOs)

18. Community associations
19. Public universities and secondary schools

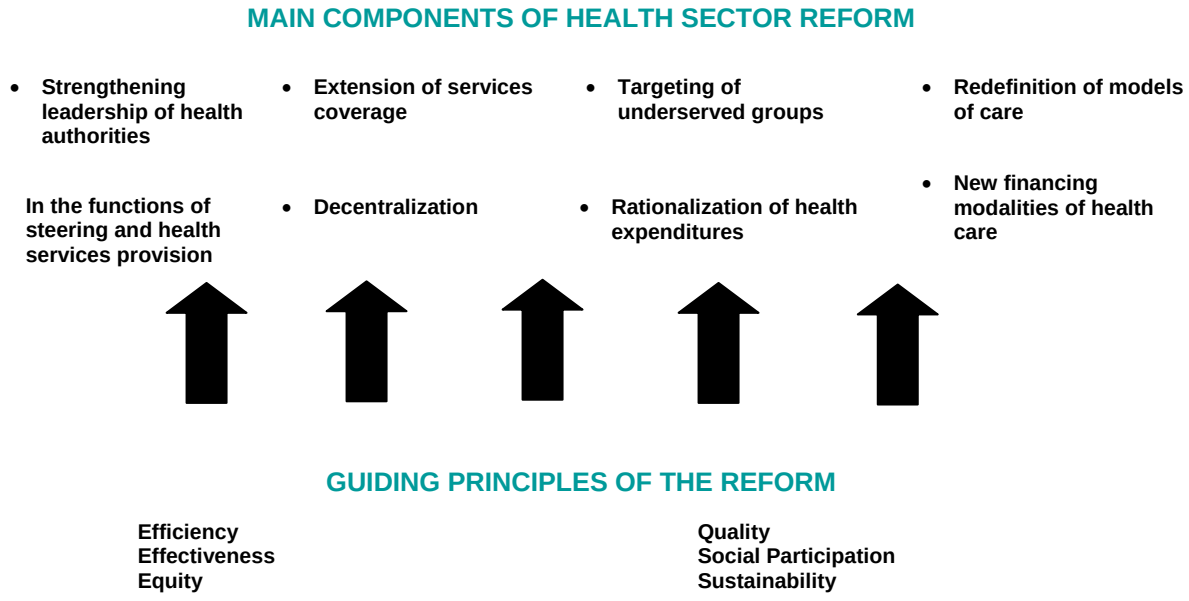
According to the results obtained, most of the actors identified are considered to be external actors. Therefore, decision-making to promote the health sector reform process is primarily in the institutional dimension of the State, particularly the Ministry of Health, the IHSS, and international cooperation. The right to veto is assigned to the executive and legislative branches.

The majority agreed that the processes of change and reform have led to greater social participation and seek to promote social control at the local level. They pointed out that the experiences must be evaluated in order to ensure that the different initiatives are compatible with the Honduran health system.

Health sector reform is considered to be a process that seeks to establish a pluralistic and integrated health system that focuses on equitable improvement in the health of the individuals, families, and communities; responds to the legitimate demands of the population; and is financially committed to the needs of the population.

The Ministry of Health, as NHA and regulatory entity for the sector, established the following main components of the reform in 2008:

FIGURE 10. MAIN COMPONENTS AND PRINCIPLES OF HEALTH SECTOR REFORM, HONDURAS, 2008

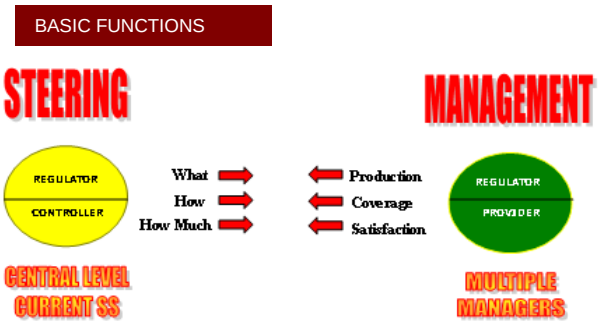


Source: Evaluation of SS Modernization Unit (UMSS), 2008.

As a regulatory entity, the Ministry of Health has defined a vision for the health system in which the population has increased life expectancy and quality of life; guaranteed access to a comprehensive, continuous, and universal system of services, especially for the most vulnerable groups; citizens, family, and the community promote practices that enable them to construct their health and development conditions; the population is satisfied with the respect, warmth, and promptness of care, as well as the conditions and safety of services offered by health workers and participates fully, with awareness, and in an organized manner, in planning, implementation, and evaluation of the services.

The main processes that seek to achieve concrete health system reform will be implemented in 2008. The most important process is the new model of health system operation and organization (Figure 11).

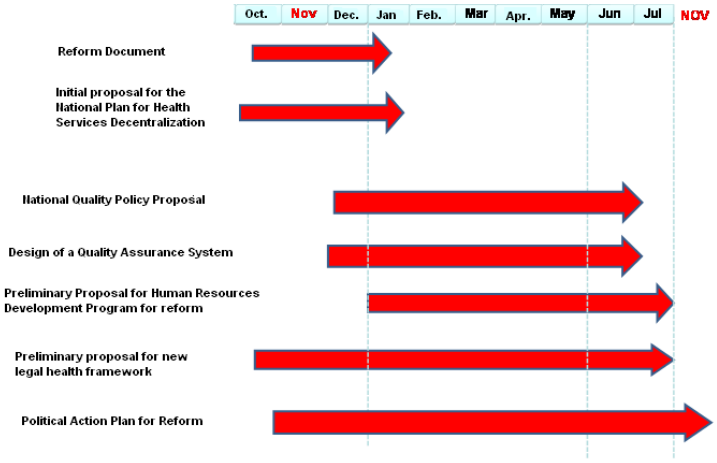
FIGURE 11. NEW MODEL OF HEALTH SYSTEM OPERATION AND ORGANIZATION, HONDURAS 2008



Source: UMSS evaluation, 2008.

In the progression to this vision, it has been decided that sectoral reform will be guided by construction of a pluralistic and integrated national health system that is duly regulated, includes public and non-public actors, coordinates and implements the response capacity of the different institutions through a new model of health system operation and organization, clearly establishing the roles and relationships between the actors with a regulation that defines all aspects of the system, and promoting the system in order to guarantee access to a basic set of health services defined with the criteria of equity, efficiency, quality, and sustainability, for all citizens. In this system, the what, how, how much, and who is responsible are clearly defined under the direction of the Ministry of Health as regulatory entity. Based on this, the periods and processes for implementation of the reform will begin in 2008 (Figure 12).

FIGURE 12. MAIN PROCESSES IN IMPLEMENTATION OF HEALTH SYSTEM REFORM HONDURAS 2008



Source: UMSS Evaluation, 2008.

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