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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

HONDURAS

PROJECT PAPER

PRIVATE SECTOR POPULATION II

AID/LAC/P-506

Project Number: 522-0369

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete)
Amendment Number:
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COUNTRY/ENTITY: HONDURAS

3. PROJECT NUMBER: 522-0369

4. BUREAU/OFFICE: LAC 05

5. PROJECT TITLE (maximum 40 characters): PRIVATE SECTOR POPULATION II

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 94

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 89 B. Quarter 2 C. Final FY 94

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 89 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	250	650	900	3,630	12,370	16,000
(Grant)	(250)	(650)	(900)	(3,630)	(12,370)	(16,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		375	375		7,100	7,100
Other Donor(s) IPPF				2,100		2,100
TOTALS	250	1,025	1,275	5,730	19,470	25,200

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PN	444	440		0	0	1,125	0	16,000	0
(2)									
(3)									
(4)									
TOTALS				0	0	1,125	0	16,000	0

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 430

11. SECONDARY PURPOSE CODE: 430

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	PVON	BNW				
B. Amount	13,700	16,000				

13. PROJECT PURPOSE (maximum 480 characters).

To contribute half of the increase in contraceptive prevalence (Percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50% in 1994.

14. SCHEDULED EVALUATIONS
Interim MM 06 YY 91 | MM YY | Final MM 06 YY 93

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☒ 000 ☐ 941 ☒ Local ☐ Other (Specify) CACM

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment)

17. APPROVED BY
Signature: John Sanbrailo
Title: John A. Sanbrailo, Mission Director
Date Signed: MM 06 DD 29 YY 89

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

Project Authorization

Name of Country: Honduras

Name of Project: Private Sector Population II

Number of Project: 522-0369

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Private Sector Population II Project for Honduras involving planned obligations not to exceed Sixteen Million United States Dollars ($16,000,000) in grant funds ("Grant") over a five and one half year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project ("Project"). The planned life of the Project is five years and six months from the date of the initial obligation.

2. The Project consists of technical, commodity and training assistance to Honduran private groups to support, strengthen and continue the process of extending family planning services with an emphasis on providing services and information to rural Hondurans. The Project includes as components community services and social marketing of contraceptives, medical/clinical programs, employee-based family planning services and new approaches through existing private groups, and an information, education and communications program.

3. The Project shall be implemented primarily through Cooperative Agreements with the Asociacion Hondurena de Planificacion de Familia (ASHONPLAFA) and Plan en Honduras. These agreements may be negotiated and executed by the A.I.D. officer to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority.

4. Source and Origin of Goods and Services

Commodities financed by A.I.D. under the Grant or Grants shall have their source and origin in the United States or in the Host Country or in other Central American Common Market Countries, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Host Country, countries which are members of the Central American Common Market or the United States (A.I.D. Geographic Code 000) as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Grant shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

John Sanbrailo

John A. Sanbrailo

6/29/89

Date

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PRIVATE SECTOR POPULATION II (522-0369)

TABLE OF CONTENTS

		Page
Part I.	SUMMARY AND RECOMMENDATIONS	1
	A. Statement of the Problem	1
	B. Summary Project Description	1
	C. Project Issues	2
	D. Recommendations	4
Part II.	BACKGROUND AND RATIONALE	
	A. Socioeconomic Setting	5
	B. Background and Achievements to Date	5
	C. The Problem	7
	D. Constraints to Increasing Contraceptive Prevalence	8
	1. Policy	8
	2. Social	8
	3. Institutional	9
	4. Financial	11
	5. Program Stage of Development	11
	E. Project Strategy	12
Part III.	PROGRAM FACTORS	14
	A. Relationship to Host Country Policy	14
	B. Mission Strategy and the Central American Initiative	14
	C. A.I.D. Policy	15
	D. Other Donors	16
Part IV.	PROJECT DESCRIPTION	17
	A. Project Goal and Purpose	17
	B. Beneficiaries and Expected Accomplishments	17
	C. Project Components	18
	1. ASHONPLAFA	18
	a. Community Services Program	19
	b. Social Marketing Program	22
	c. Medical/Clinical Program	27
	d. Information, Education, and Communication	31
	e. Training	33
	f. Monitoring and Evaluation	34
	g. Management and Administration	37

2. Technical Assistance 39
3. Private Voluntary Organizations and Other Groups 39
a. Background 39
b. Selecting the PVOs 39
c. Other Groups 41
d. Implementation Mechanism 41
e. Promotion 42
f. Training 42
g. Evaluation 43
4. Employee-Based Family Planning 43
D. Project Management and Technical Assistance 44
E. Project Inputs 44

Part V. FINANCIAL PLAN AND ANALYSIS 46
A. Summary Budget 46
B. Recurrent Costs 46

Part VI. IMPLEMENTATION ARRANGEMENTS 48
A. Selection of Implementing Agencies and Use of Cooperative Agreements 48
B. Implementation Schedule 48
C. Procurement Plan 48
D. Evaluation and Audit Plan 53

Part VII. PROJECT ANALYSES SUMMARIES 54
A. Technical Analysis 54
B. Social Soundness Analysis 57
C. Economic Analysis and Price Elasticities 59
D. Administrative Analysis 60
1. ASHONPLAFA 60
2. Plan en Honduras 61
3. Other Groups 61

Part VIII. ENVIRONMENTAL CONSIDERATIONS 62

Part IX. CONDITIONS AND COVENANTS 62

-d'

TABLES:

1. Contraceptive Prevalence of Married Women in Reproductive Age 6
2. Contraceptive Prevalence and Education of Mothers 8
3. Total Fertility Rate and Education of Mothers 8
4. Projected Temporary Method CYPs and VSC Procedures by program and calendar year 17
5. Couple Years of Protection in the CBD Program, by year 19
6. Projected CYPs in Community Services Program, by year 20
7. Projected CYPs in Social Marketing Program, by year 22
8. Projected Voluntary Surgical Contraceptive Procedures, by type of facility; projected CYPs provided as Temporary Methods; by year 28
9. PVOs, Beneficiaries, and Departments Served 40
10. Project Inputs Funded by Grant 45
11. Summary Project Costs by Component, Source, Currency Type, and Total 46
12. Beneficiary Profiles, by ASHONPLAFA Services Programs 58

ANNEXES:

A. PID Approval Action Memo
B. Logframe
C. Grantees Requests for Assistance
D. Detailed Budget
E. Project Analyses:
   1. Technical
   2. Social
   3. Economic
   4. Administrative
F. Private Voluntary Organizations Strategy
G. Environmental Threshold Decision
H. List of Acronyms
I. Organigrams of ASHONPLAFA and Plan en Honduras

UNATTACHED ANNEXES: (On file at USAID/Honduras)

A. Analysis of the Financial Situation and Cash Flow Projections, 1989-1994, of ASHONPLAFA
B. Financial Analysis Review (FARS) Memorandum on ASHONPLAFA, Project 522-0286
C. A Study of Cost Assessment, Cost Recovery, and Cost Effectiveness of ASHONPLAFA
D. Assessment of PVOs Interested in Incorporating Family Planning Services into Their Activities
E. Honduras: Private Sector Family Planning Assessment
F. Development of a Mass Media Strategy for ASHONPLAFA
G. Honduras CSM Program--SOMARC Debrief
H. Population Strategy Paper, USAID/Honduras
I. Administrative Analysis of Plan en Honduras

Part I. SUMMARY AND RECOMMENDATIONS

A. Statement of the Problem

Rapid population growth has a negative impact on both the health status of Hondurans and the prospects for social and economic development of the country. With the crude birth rate of 38 births per thousand and a crude death rate of under 10 per 1000, Honduras' population of 4,300,000 is growing at a rate of just under 3% per year. Women are bearing an average of 5.6 children over their lifetimes. With these population growth trends, Honduras finds it difficult to maintain the quality of life for its people.

Improved maternal and child health and increased child survival can result from family planning. However, many Honduran couples who wish to regulate their fertility do not have access to family planning services, especially in remote rural areas. In order to make services available using resources likely to be available, the quality and quantity of family planning services must be expanded while improving cost-effectiveness and cost recovery levels.

ASHONPLAFA, through its programs of Community Based Distribution, Social Marketing and Medical Clinical Services, provides a little over 58% of all family planning services in Honduras. The next largest coverage is provided by the MOH (17%) through its hospitals, clinics, rural health centers and posts. The Social Security Institute and various private sources provide the remainder. Total contraceptive prevalence was 41% in 1987, with prevalence in urban areas reaching 59% against the more difficult to reach rural areas where it was only 30%. All of the services provide approximately 231,000 Couple Years of Protection (CYP).[1]

B. Summary Project Description

The Sector Goal to which this Project will contribute is to reduce the Total Fertility Rate (the number of children a woman would have if, as she passed through her reproductive years, she had the fertility rates each age group is now experiencing) from 5.6 to 4.7. The Project Purpose is to contribute 50% of the increase in national contraceptive prevalence

[1] Couple year of protection is a measure which enables comparison and summation of family planning program output between different contraceptive methods and different individuals. For example, distributing 100 condoms supplies an average couple for one year, as does the distribution of 13 4-week cycles of oral contraceptives. Each case would be counted as one CYP distributed. Similarly, in terms of individuals participating in the program, it permits distributing 50 condoms to each of 2 couples to be counted as one CYP distributed. Some methods, including IUDs and VSC, when provided, contribute more than one CYP to program output, because the client is protected from pregnancy for more than one year.

(percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50% in 1994. The Project activities will contribute to a reduction in the fertility rate through expanded family planning services provided principally by the private sector.

In order to increase the availability and accessibility of voluntary family planning services in Honduras, support will be provided to three service delivery programs of ASHONPLAFA: Community Services, Social Marketing, and Medical/Clinical. Plan en Honduras and other private groups, will receive support to initiate delivery of family planning services, and/or to upgrade their referral relationship with ASHONPLAFA. ASHONPLAFA will conduct information, education, and communications activities which promote family planning services in general as well as its own program. Training will be conducted by ASHONPLAFA for its staff, the personnel of Plan en Honduras, and field promoters of the other private organizations included in the Project. In addition, monitoring and evaluation of ASHONPLAFA, Plan en Honduras and other private groups programs is included in the Project. In the case of ASHONPLAFA, the Project emphasizes actions to improve the Association's administration to achieve increased cost-recovery, improved efficiency, and regionalization of operations.

The Project will build on achievements made during the Private Sector Population I Program (522-0286). The cost of this new five and one-half year effort is $25.2 million with A.I.D. contributing $16.0 million in Grant funds. Five year Cooperative Agreements with ASHONPLAFA and Plan de Honduras will be used to implement the Project. Funding is included to finance buy-ins to centrally funded technical assistance projects to assist other Honduran PVOs which will participate in the Project.. Private sector organizations will provide $7.2 million in cash and in-kind contributions, and IPPF will donate $2.1 million during the planned five year Cooperative Agreement with ASHONPLAFA.

C. Project Issues

The following major issues arose in the course of the intensive Project review, and were analyzed and discussed at length by the Project Design Committee and Mission management. A summary of the resolution of each issue is provided below.

1. Budget

Concern that the Project is overbudgeted even at the PID approved level of $16 million was still evident during the intensive review period. However, the budget analysis carried out during the intensive review period showed that this level of resources is required in order to achieve Honduras' and USAID's population objectives during 1989-1994. The bulk of the grant funds, that is $12.6 million, is destined to support ASHONPLAFA's activities. Previously, ASHONPLAFA was the recipient of a $9.8 million grant covering the four year period 1985-1989. The relative proportion of grant funding proposed for the next five years to support expanded activities is slightly higher but not excessive in light of inflation and the higher costs involved in reaching new beneficiary target populations in remote rural areas.

2. Mortgage/Obligation Schedule

During the Action Plan review in Washington, an issue was raised on the growing overall mortgage on Mission funding. It was proposed that the Population Project be stretched out to six years and future obligations be straightlined at $2.7 million each year beginning in FY92 through FY95 after FY88-91 obligations of $6.2 million were made.

The Project Design Committee suggested a modified stretch out in order to avoid the need for significant project redesign and to minimize the negative impact on the cost benefit ratio of the Project if lower annual budget levels were mandated. By adding another six months to the PACD, additional funds could be obligated in early FY94 and enough time would remain in the implementation period to allow for the expenditure of the funds obligated. The Cooperative Agreements with ASHONPLAFA and Plan en Honduras will be for five years each. As was mentioned previously, buy-ins to centrally funded population projects will finance assistance activities to other PVOs which will run to the end of the PACD. The following obligation schedule was proposed.

	ASHONPLAFA	Other Groups	TA	TOTAL
FY89	800	175	150	1,125
FY90	2,810	285	885	3,980
FY91	2,650	365	905	3,920
FY92	3,180	275	170	3,625
FY93	1,750	0	150	1,900
FY94	1,400	0	50	1,450
	12,600	1,100	2,300	16,000

3. Financial Analysis

ASHONPLAFA is not expected to achieve overall self-sufficiency while it maintains its essential social development orientation. However, improvements in cost recovery and cost containment are possible and expected during this Project. Assertions are made in the Project Paper that significant increases in cost recovery will be achieved in social marketing and surgical contraceptive activities during the life of the Project. A question was raised regarding the basis for these assertions. Several audits and studies carried out by independent consultants were available to the design team and provided sufficient evidence that cost recovery levels can be expected to improve during the life of the Project. These documents include an audit by Price Waterhouse which projects a cashflow for ASHONPLAFA and a study undertaken by SOMARC of the social marketing component.

The Cooperative Agreement to be signed with ASHONPLAFA will specify performance levels expected to be obtained in cost recovery and cost containment for all components. Progress in lowering costs per unit of service provided and increasing income generated by services will be monitored closely throughout the life of the Project.

4. Expanding Participation of Other Private Groups

In the earliest stages of project development, Mission management indicated a strong desire that the participation of other Private Groups in providing family planning services be expanded both to increase coverage and to encourage cost effectiveness through friendly competition. The issue was raised whether or not the Project design accomplishes this objective.

During the intensive review period, PVOs were surveyed to determine which organizations had the interest and the potential to enter into agreements to provide family planning referrals or services in coordination with ASHONPLAFA. As a result, the project design incorporates a private group component to be funded over the five years of the project. In addition, these groups will be supported by the IEC efforts of ASHONPLAFA, and will receive training conducted by ASHONPLAFA staff.

D. Recommendations

The USAID/Honduras Project Committee has determined that the proposed activities are technically, administratively, economically, financially and socially sound. The specific analyses carried out during the intensive review indicated that all identified obstacles can be overcome. It is the Committee's judgment that the Project, as designed, can and will achieve its purpose.

The Project is in conformity with the Agency's policies on population and use of private sector organizations. It is also consistent with the USAID/Honduras Action Plan objectives of increasing contraceptive prevalence and improving child survival. The Project supports the Government of Honduras objective of decreasing the rate of population growth.

Part II. BACKGROUND AND RATIONALE

A. Socioeconomic Setting

Virtually all social and economic indicators show Honduras to be one of the least developed countries in the Western Hemisphere. Honduras has a large rural population (60%) living at or near subsistence level. Life expectancy is estimated at 62 years and although improvements have been made over the last three years, the infant mortality rate remains high at 60 per 1,000 live births in 1987. Most Hondurans do not complete more than a few years of primary grades as a result of a deficient educational system. Forty percent of adults are illiterate. Basic water and sanitation services are available to only one out of two Hondurans, approximately 75% of existing housing units are inadequate, and malnutrition affects nearly 40% of the population. These generally poor health conditions limit productivity, earning power and improvements in the quality of life for Hondurans.

A population growth rate of just under 3% in 1988 and a total fertility rate of 5.6 coupled with slow economic growth have made it difficult for Honduras to maintain the quality of life for the majority of its people much, less improve it. Honduras' per capita GDP was $740 in 1988. Real per capita GDP has declined or remained stagnant since 1980 due to high population growth rates and low economic growth rates. Growth in the labor force has outpaced real GDP growth thus causing unemployment to continue to rise to approximately 12% open unemployment.

Such statistics point to the severe poverty, weak human resource base, and the continuing need to invest large sums in social development and health programs in Honduras.

B. Background and Achievements to Date

Prior to 1970, there has been little perceived need for family planning and population programs. The MOH did not consider population a priority and religious, military and political opposition was strong. In the 1970s, however, the MOH began to offer family planning in a largely vertical service delivery structure. The program, funded by A.I.D., was discontinued in 1976, in large part due to political opposition to family planning activities. Services continued to be offered by a few government health facilities on their own. During this period, family planning services continued to be supplied by the private sector, of which ASHONPLAFA was the most prominent supplier.

In 1983, following the publication of a CPS conducted in 1981, official attitudes began to change and an improved climate for family planning developed. Family planning was established as a priority health program by the MOH. Additionally, the Social Security Institute (IHSS) expanded its services and continues to do so. Unfortunately, the MOH has experienced problems with implementation and as a result has not been able to significantly expand its coverage. Hence, the provision of family planning services continues to be largely in the private sector.

In June 1985 USAID/Honduras entered into an agreement entitled "Private Sector Population Program" (522-0286) with the Family Planning Association of Honduras (Spanish acronym - ASHONPLAFA) to support the latter's effort to improve and expand family planning information and services. The rationale supporting this program decision rested in large part on the well-documented evidence that there was both a large unmet demand for services and information and that the bulk of family planning services would continue to be most efficiently delivered by the private sector, of which ASHONPLAFA was the most important institution.

These family planning programs have supported significant change in the prevalence of contraception in Honduras, as indicated in the findings of surveys in 1981, 1984, and 1987, which are considered to be methodologically sound and accurate.

The 1987 National Epidemiology and Family Health Survey (NEFHS) indicated that contraceptive prevalence overall in Honduras has increased from 27% to 41% of married fertile age couples (including those in consensual unions) in the 1981-87 period. By any standard this is a remarkable achievement in the space of only 7 years. Urban contraceptive prevalence reached an impressive 59% by 1987 and in the two largest urban centers of Tegucigalpa and San Pedro Sula prevalence was 63.3%, very close to the levels found in the developed world. By contrast, contraceptive prevalence had increased in rural areas by 1987 to only 30% of fertile aged couples in union. Nevertheless, one must note that the percentage of increase in users in rural areas was larger than the percentage of increase in urban areas during the same period. This is shown in Table 1, below.

Table 1: Contraceptive Prevalence of Married Women of Reproductive Age

	Contraceptive Prevalence			% Increase from Previous Survey		
	Total	Urban	Rural	Total	Urban	Rural
1981	27%	48%	16%	-	-	-
1984	35%	51%	24%	30%	7%	49%
1987	41%	59%	30%	16%	17%	30%

Survey data for 1987 also show that women indicated an ideal average family size to be 3.2 children; urban women indicated 2.5 and rural women stated 3.5 as the ideal number of children. Over 90% of women surveyed had knowledge of at least one modern method of contraception, such as pills, sterilization, or the IUD. Among fecund women who were not contracepting at the time of the NEFHS 1987 survey, some 65% declared their intention to do so, using a modern method as their choice. These data support the contention that a large unmet demand for family planning services still exists and that much more can and should be done.

There is also evidence that ASHONPLAFA's efforts are those most responsible for the advances in contraceptive prevalence in Honduras. The 1987 survey indicated that 58% of all women using contraception used ASHONPLAFA as their

source of supply, up from 53% in 1984. The MOH was the source of supply for 17% of contracepting women in 1987, down from 19% in 1984. The IHSS served 1% in 1987, compared to 2% in 1984, and private sources served 21% of contracepting women in 1987, 26% in 1984. The efforts of the Ministry of Health have been impeded by a number of problems related to its re-entry into the family planning field in 1984/85 after a long absence. Clearly the expansion of ASHONPLAFA's service delivery systems, i.e. the Community Based Distribution program, Voluntary Surgical Contraceptive Services and the Contraceptive Social Marketing program, resulting in increased accessibility of contraceptives, has made the difference. Among providers of family planning services and information, ASHONPLAFA is now, and will continue to be the most prominent supplier.

C. The Problem

A major assumption upon which USAID/Honduras based its decision to support ASHONPLAFA in 1985 was that a vigorous family planning effort would positively impact on both the nation's health status and development prospects.

The most serious of the continuing problems is that with the crude birth rate of 38 births per thousand and a crude death rate of less than 10 per 1000, Honduras' population of 4,300,000 is growing by just under 3% per year. Since 1984, this population growth rate has more than offset Honduras' limited economic advances. One must realize, however, that the pace of modern contraceptive use has quickened only recently and that the effect of increased usage of family planning takes time to influence economic indicators.

While it is difficult to assess direct impact, the Infant Mortality Rate, the best available measure of the health status of the population, has dropped considerably in Honduras during the years that contraceptive prevalence has dramatically increased. Infants and children are at increased risk of dying at all ages if they are born less than 24 months following the birth of an older sibling. The infants at least risk are those whose mothers had an interval between pregnancies of two or more years. Infants born with less than 24 months after the last sibling have an IMR of 63.2 per thousand live births, whereas infants born after 24 months of the last live birth have an IMR of 39.8, according to data from surveys conducted in 1987.

Additionally, there is close correlation between high fertility (parity of the mother) and high infant mortality levels. Infants born to mothers with six or more live births are 82% more likely to die before completing one year than infants of mothers with only one live birth. Such evidence is apt to be supportive of couples' decisions to practice contraception and add to the better understanding of the economic advantages of smaller families.

A growing teenage pregnancy rate adds a new dimension to the problem. In Honduras, according to the 1987 National Epidemiology and Family Health Survey (NEFHS), teenage mothers have the highest mortality rates for all infant age groups, exhibiting infant mortality rates 83% higher than mothers 25-34 years of age. In addition, women who bear children when they are over 35 years old suffer from increased risks to themselves and their children.

D. Constraints to Increasing Contraceptive Prevalence

1. Policy

There are no major policy constraints to the delivery of family planning services in Honduras. The GOH development plan for 1987-1990 links demographic and development variables and identifies rapid population growth's adverse effect on development. The Ministry of Health has defined the norms and standards for proper service delivery which ASHONPLAFA follows, and which will be used by any other organization providing family planning services supported by this Project. As important, the GOH has not interfered with the private family planning association, which has operated for more than 25 years.

2. Social

a. Female Education

Education, particularly female education, is a strong predictor of whether a couple chooses to use family planning services. With only 60% literacy in Honduras, lack of female education is a constraint to accepting family planning usage. Recent survey information indicates that as female education increases, so does contraceptive prevalence. Education also affects the total fertility rate as women with higher education tend to have smaller families. Women with more education tend to want increased opportunities for their own children and thus limit their fertility. The specifics are shown in Tables 2 and 3 below.

Table 2: Contraceptive Prevalence and Education of Mothers

		EDUCATION			
	TOTAL	Less than 1 year	Primary 1-3 years	Primary 4-6 years	Secondary 7 years
USAGE	40.6%	23.7%	30.5%	45.8%	65.8%

Table 3: Total Fertility Rate and Education of Mothers

		EDUCATION			
	Total	Less than 1 year	Primary 1-3 years	Primary 4-6 years	Secondary 7 years
TFR	5.60	8.15	7.11	4.84	3.16

b. Religion

Religious opposition to family planning has always existed in Honduras, as it has elsewhere in Latin America. Recently, a pronatalist movement has begun to emerge and is challenging the existence of family planning programs in the country. Whether the pronatalist movement can capitalize on opposition to family planning by a minority of national

leaders is doubtful. Previously conducted studies on family planning attitudes indicated that only a very small proportion of women who do not wish to contracept cite religion as the reason. We see this as a minor problem at this stage, but with increased organization by the so-called pro-life groups, the problems could increase.

c. Male Involvement

Another social constraint to increased contraceptive prevalence is lack of male involvement in family fertility decisions. Attempts to involve men in family planning programs through increased education and information have not had satisfactory results. Evidence shows that like female education, male education is a strong predictor of whether a couple chooses to use family planning services.

d. Rural population

There are special constraints to working in the rural areas of Honduras, which will increase the difficulty of implementing this Project. Confidentiality is more difficult to maintain with the Community Services distributors than with clinic or social marketing programs. This will be somewhat mitigated by increasing the number of sources of supply in rural areas--both social marketing outlets and PVO services will operate in rural areas. Travel to clinics for VSC is difficult for some rural clients; consideration will be given to providing for transport, probably based on operations research studies to learn what is likely to be effective and efficient before instituting a strategy country-wide. There are inherent difficulties in selling contraceptives to the rural population which has much less cash than urban populations. A comprehensive pricing strategy for contraceptives will be developed and implemented as part of improved cost recovery by ASHONPLAFA. PVO pricing strategy will be set based in part on ASHONPLAFA strategy.

3. Institutional

Perhaps the greatest constraint to increasing contraceptive prevalence in Honduras is the dearth of organizations providing family planning services. There is only one private family planning organization with trained personnel, the ability to raise funds, significant beneficiary outreach, and a proven track record, that is, ASHONPLAFA. While other private groups have expressed interest in adding family planning to the other services they already offer their members or clients, none have solid experience nor immediate readiness to deliver family planning services. Technical assistance to be provided to other private groups as well as ASHONPLAFA will help overcome limitations in institutional outreach and organizational structure.

a. ASHONPLAFA

The primary implementing agency, ASHONPLAFA, will have to overcome some institutional constraints to effectively execute this Project. ASHONPLAFA is committed to carrying out the actions necessary to improve its operations.

Until 1985, ASHONPLAFA was a small organization accustomed to working with limited resources and under the tight control of its Executive Director. Up to the present, ASHONPLAFA has managed to deal successfully with expanded program levels without major changes in its organizational structure, managerial practices or staffing levels.

During the 1985-89 period some adjustments were made that improved ASHONPLAFA's operating efficiency. Two regional offices, in San Pedro Sula and Choluteca, have become operational. A third at La Ceiba will come on-stream in 1989. Two additional regional centers, at Santa Rosa de Copan and Juticalpa, are proceeding on schedule, and will be operational by November 1989. ASHONPLAFA is studying also the feasibility of limited service subcenters in additional smaller rural/urban locations. By granting these regional offices operational independence, ASHONPLAFA's ability to successfully implement the Project is greatly enhanced.

Recent developments in the managerial area bode well for the future. The Executive Director has named an assistant and centralized controls over Regional Offices have been loosened. Nevertheless, if ASHONPLAFA is to manage this Project successfully, additional adjustments need to be made in the Association's organizational structure, management attitudes and practices, and staffing levels. Expansion will be necessary in the IEC and CSP departments, and the Evaluation department should improve the internal training programs that it conducts. Consideration will be given to establishing a public relations office within the ASHONPLAFA central offices structure. It is essential that delegation of authority both from the Executive Director level to the line Departments and within the individual line Departments themselves become operational at the earliest possible moment. Cooperation between the Services Departments (CSP, MCP, SMP) and the Support Divisions (IEC, Evaluation, etc.) will be improved. Multi-year planning and the sense of cohesion and common purpose that this generates is a vital step for ASHONPLAFA to take early on. Additional staffing and staffing adjustments will be carried out.

b. PVOs and Other Groups

USAID sees few institutional constraints to the implementation of the PVO and Other Groups component of the Project, in large part because PVO family planning activities will be framed within ongoing programs. The PVO component will consist of two implementation mechanisms. The first will be executed through a Cooperative Agreement with Plan en Honduras which by itself has more than 16,000 families in its rolls. Plan en Honduras will develop a referral system and provide family planning services directly.

The second mechanism will be through a buy-in to a centrally funded project to manage the rest of the smaller PVOs which together have about 5,000 families. The centrally funded project would also handle the program for the National Union of Campesinos (UNC) a nationwide organization of about 250,000 members and their families. One such project which has already been involved in mobilizing the PVOs and the UNC is Enterprise and will be the prime

candidate to continue on with this work. Financing will be provided so that the centrally funded project could set up a local office with up to three individuals hired locally.

In order to add information, education and promotion of family planning to their activities, as well as services at a later date, the PVOs will need training for their personnel and other institutional support. ASHONPLAFA will be the principal source for this training and other agencies will be able to buy these services.

It is anticipated that the majority of potential acceptors will be referred to either the MOH or ASHONPLAFA to receive services, at least during the early years of the Project.

4. Financial

The principal financial constraint to the Project is that both ASHONPLAFA and the other private organizations are dependent on outside financing in order to provide family planning services, as is the public sector in Honduras. ASHONPLAFA, while very successful in providing services, has not focused attention on ways in which the organization might generate or raise funds.

To date, ASHONPLAFA's undue caution in experimenting with fundraising and lack of aggressiveness in increasing the funds generated from the services and supplies they sell has kept them almost totally dependent on USAID and IPPF support. Several measures are planned to increase cost recovery by ASHONPLAFA during the course of this Project, so that the subsidy per service unit now provided by A.I.D. and IPPF can be reduced. These include instituting a sliding fee scale for all services and supplies, instituting a comprehensive pricing strategy for contraceptives sold, and instituting the policy that all clients be expected to pay something for supplies and services. Clearly, occasional exceptions will need to be made for clients who are truly destitute.

In working with the other private organizations, cost recovery will be built into service delivery programs from the beginning, to reduce long-term dependency on external financing. An advantage that some of these groups will have is that they are involved with other programs and services, which have other sources of funding, so that the cost per unit of service may not be so high as with a single-purpose organization like ASHONPLAFA. At the same time, start-up costs will increase the unit cost of service.

5. Program Stage of Development

Another problem is the nature of the market from which increases in acceptors must largely be obtained. As statistics above show, expansion of family planning services in the 1980s has been very successful at penetrating the urban areas, with easier access to health facilities and commercial outlets and a more educated population. The challenge remains to obtain the same degree of penetration in rural areas where the population is dispersed

and communications and transportation between urban centers and rural outlets are more difficult. This task will be arduous, more costly, and taxing to the skills and energies of family planning providers.

Increasing program costs is yet another problem to be addressed. ASHONPLAFA has been very successful at increasing contraceptive prevalence among married fertile aged women and is currently the largest provider of these services in Honduras. However, in recent years the number of ASHONPLAFA users have grown slowly, unit costs have increased, and financial dependence on the Mission has deepened. The slowdown in growth at this stage of activities is not unusual. Family planning programs tend to "plateau" temporarily when the majority of easily reached users has been attained. A major effort is needed to expand high quality services while improving the cost-effectiveness of and cost-recovery from these services.

E. Project Strategy

A.I.D.'s strategy in this follow-on Project is based on the analysis presented in the foregoing sections and may be summarized as follows.

1. The bulk of the funding provided under this Project will support expanding ASHONPLAFA's on-going activities, because the private sector, predominately ASHONPLAFA, has proven to be the most efficient and effective deliverer of family planning services and information.

2. The Project will put emphasis on providing services and information to rural Honduras, while not neglecting urban areas. An increase in community service personnel, almost all of whom will be working in rural areas, is planned. Outreach to rural areas will also be improved by five regional ASHONPLAFA family planning centers offering temporary methods as well as voluntary surgical contraception (VSC). In addition to VSC being offered by the Regional Centers, these services will be provided in eight private clinics located in semirural areas. A vasectomy clinic will be established in Tegucigalpa in the first year, followed by San Pedro Sula in the second year of implementation.. The reorganized Social Marketing Program will supplement the above activities by improving the availability of temporary methods through commercial outlets in rural as well as urban areas.

3. The Project will support a selected number of Private Voluntary Organizations (PVOs), campesino organizations and the like, to further improve outreach to the rural population. These organizations are interested in adding family planning services to those they already provide. Through a Cooperative Agreement, the Project will support a birth spacing program of Plan en Honduras. Discussion will continue under the Project with the National Union of Campesinos (UNC) which reaches rural families totalling about 250,000 persons. The UNC is already has nationwide network to which simple family planning services could be added.

4. An increased emphasis on Information, Education and Communication activities will be supported by the Project. Survey data point the fact that many women would contracept if they have improved access to information on availability and use of modern methods.

5. Increased financial independence of ASHONPLAFA will be fostered by the Project. Efficiency will be increased, measured by decreased costs per couple year of protection for all contraceptive methods. Cost recovery will be improved: a sliding scale of fees, based on the client's means, will be instituted; a coherent pricing strategy for contraceptives will be implemented across programs and products; and all clients will pay for services and commodities received, even if only a token amount (the lowest rate on the sliding scale). The proportion of service delivery costs subsidized by A.I.D. is planned to decline over the course of this Project.

6. Both long and short term technical assistance will be provided to ASHONPLAFA and the other organizations to assist in improvements in management, evaluation, service delivery, and information, education, and communications, as well as training.

Part III. PROGRAM FACTORS

A. Relationship to Host Country Policy

This Project is consistent with the GOH Policy on Population as contained in the National Development Plan for 1987-1990, which is to decrease the rate of population growth by the provision of educational measures at the primary and secondary levels, by support to family planning programs of the Ministry of Health and the Social Security Institute, and by coordination with private sector organizations.

The National Development Plan also states that high population growth rates coupled with budget restrictions inevitably means limits will be placed on the institutional capacity to meet growing demand for social services.

The GOH National Health Strategy for 1986-1989 presents an even stronger position on population policy. It specifically mentions the adverse effect of rapid population growth on development and calls for family planning programs to reduce family size and the overall population growth rate.

A new population law is currently under consideration by a Commission of the Honduran Congress. The law supports family planning for health reasons and, if passed, would provide additional legal support for the activities of this Project.

B. Mission Strategy and the Central American Initiative

This Project is entirely consistent with the Mission's Population Strategy and the recommendations of the National Bilateral Commission on Central America.

USAID's strategy is to support Honduras in implementing its policy of reducing the crude birth rate by assisting in the strengthening and expansion of family planning services in both the private and public sectors to meet unmet demand.

This is based on a number of concepts.

-First, that reducing fertility by voluntary family planning use in Honduras will have a positive impact on both the nation's health status and economic development prospects.

-Second, that there is a strong desire for smaller family size among Honduran couples. According to the 1984 Contraceptive Prevalence Survey, women aged 15-24 have an average ideal family size of 2.5 children in urban areas and 3.5 children in rural areas. These family size ideals are quite different from the current Total Fertility Rate (TFR) of 3.9 in urban areas and 6.8 in rural areas.

-Third, that demand for fertility reduction can be met by increasing the availability of family planning information and services.

-Fourth, that neither the public nor the private sector has the means to adequately finance the needed expansion of family planning services without external resources.

-Fifth, although the GOH has received some criticism for developing a population policy, it will not reverse itself by taking a pronatalist

position. At worst, it will continue to permit family planning activities to exist.

-Sixth, in the foreseeable future, the bulk of family planning services will continue to be delivered by the private sector, especially ASHONFLAFA.

-Seventh, as Honduras is still predominantly a rural country, with the majority of nonusers residing in rural areas, the greatest potential impact on fertility will come from increased rural use of contraceptives. This does not mean that the Mission will neglect the efforts of other family planning providers, notably the Ministry of Health. To the contrary, in the Health Sector II Project with the MOH, there is a major ($3 million) child-spacing component, dedicated to increasing access of women to prenatal, birthing, post partum and family planning services and, particularly, to radically broadening attention, including subsequent family planning, to high risk pregnancies from 12% to 90% of such cases.

The Report of the President's National Bipartisan Commission on Central America recommends the continuation of population and family planning programs presently supported by A.I.D. on the grounds that rapid population growth has an adverse effect on development.

C. A.I.D. Policy

The design of this Project is entirely consistent with the Agency's policies.

The A.I.D. position on population is contained in three documents: the 1982 A.I.D. Policy Paper on Population Assistance, the 1983 A.I.D. Sector Strategy on Population, and the 1985 A.I.D. Administrator's Speech on Population.

The A.I.D. Policy Paper on Population states that population assistance is an "essential part of a cost-effective program of development assistance" on the grounds that it contributes to social and economic development and that it is critical to the health of mothers and children. The Population Paper goes on to say that the "underlying principles for U.S. assistance for family planning are voluntarism and informed choice." Finally, the Paper calls for the active strengthening and direct involvement of local institutions in population activities.

The 1983 A.I.D. Sector Strategy on Population calls for programs "to ensure the widespread availability of high quality voluntary family planning services through which couples who so wish can regulate their fertility." The strategy recommends that in the design of country-specific programs, the availability of private sector infrastructure, inter alia, be taken into consideration. Priority should be given to strengthening existing family planning delivery infrastructure, in both the private and public sectors, to address unmet needs. Emphasis should be placed on involving the private sector in the expansion of community based distribution and social marketing programs, as well as on fee-for-service and other cost-recovery activities.

D. Other Donors

In addition to the International Planned Parenthood Federation (IPPF) which provides about $400,000 per year to support portions of several activities at ASHONPLAFA, the United Nations Fund for Population Activities (UNFPA) is the only other major family planning donor to Honduras. UNFPA is providing $3.3 million in population assistance to the Honduran Government in the areas of the national population and housing census, maternal/child health and family planning, population education, and university level training for private and public sector officials in population and development. The national census project is an excellent example of donor coordination. The GOH counterpart contributions for local costs is met by using ESF generations and USAID is funding technical assistance from the US Bureau of Census.

The UNFPA-funded Maternal/Child Health and Family Planning Project with the Ministry of Health is oriented to helping the Government in the execution of its basic policies in maternal child health care and family planning. Because of the funding from other sources in this sector, the Project has focused on improving the administrative capabilities of central and local health centers. It also incorporates significant support for activities related to organization of women's groups.

Part IV. PROJECT DESCRIPTION

A. Project Goal and Purpose

The Sector Goal to which this Project will contribute is to reduce the current Total Fertility Rate (TFR) from 3.9 urban and 6.8 rural (national 5.6) to 3.0 urban and 5.8 rural (national 4.7). Achievement of this goal is based on the assumption that neither the Government of Honduras nor the U.S. Government will change its policies in support of family planning. The Project Purpose is to contribute 50% of the increase in national contraceptive prevalence from 41% in 1987 to 50% in 1994. To achieve this level of prevalence, 362,500 women will need to be practicing contraception with their partners in that year, up from the 1987 number of 231,250, a difference of 131,250. Of the total, 181,250 will receive services supported by this Project.

B. Beneficiaries and Expected Accomplishments

The central accomplishment of this Project will be to provide an expanded variety of family planning services, principally through the private sector, especially in rural areas, to an increased number of Honduran couples. These services will be subsidized by A.I.D. project funds, and therefore will be available to Hondurans who cannot pay for for-profit private services. The summary measure of this achievement will be the number of Couple Years of Protection (CYPs) provided with modern contraceptive methods, including Natural Family Planning. Until improvements in information systems are in place, the number of surgical contraception procedures will be the measure of that program; when the median CYP provided per procedure can be calculated, CYP will become the measure of achievements in the VSC program as well. Table 4, below, indicates the magnitude of these outputs expected.

Table 4: Projected Temporary Method CYPs and VSC Procedures*, by program and calendar year

	6 months 1989	1990	1991	1992	1993	6 months 1994
TEMPORARY METHOD CYPs						
CSP	24,950	53,400	56,600	59,400	61,800	32,150
SMP	11,561	29,125	29,423	32,603	35,766	19,299
MCP	5,378	11,079	11,413	11,755	12,108	6,357
PVOs/OG	0	0	0	5,000	8,000	4,500
TOTAL	41,889	93,604	97,436	108,758	117,674	62,306
PROCEDURES						
VSC	4,452	8,025	11,709	13,115	14,523	7,274

*Accomplishments are projected only for the duration of the ASHONPLAFA Cooperative Agreement.

The Project beneficiaries will be Honduran couples in which the woman is between 15 and 44 years of age. Although women in the age group 20 to 29 are

experiencing the highest fertility, the Project will target all couples with fertile age women, since very young (15 to 19) and very old (40 to 44 years) women (reproductively speaking) experience the greatest risk to their health with pregnancies. The indirect beneficiaries will be children born to women who avoid high risk births; that is, births which are too closely spaced (less than 2 years apart); births to women too young (under 20) or too old (35 or older); or births to women who already have three or more children.

Those beneficiaries to be reached by the other PVOs and other groups, who will make referrals to ASHONPLAFA services, has been estimated as follows. The total number of families reached by the participating PVOs live in remote villages and is estimated at 23,800 families . (A family is a nucleus of at least one parent with any number of children. In rural areas there is a large number of single mothers who may not be married or in union but are sexually active.) Using an average of seven children per family, the total number of children in the 23,800 families is 166,600. Out of these, 16,194 are in the 15-19 age bracket, and about one-half are female (8,097). This number of 15-19 year olds together with the 23,800 women that the PVOs work with brings the total population that is at risk to 31,897.

According to the latest Contraceptive Prevalence Survey, in 1987 30% of rural women in union of child bearing age used some form of contraception. Thus, 9,570 women could be using some form of contraception. However, because many of the areas where these PVOs work are remote and not serviced by either MOH or ASHONPLAFA, this figure could be significantly lower. Hence, using figures above, the total target population for receiving information and promotional services from the 8 PVOs would be 22,328 persons of child bearing age.

The National Union of Campesinos (UNC) has a national membership of 245,000 family members throughout the country and therefore represents 36,730 women of child bearing age, using the same calculation method as for the PVOs.

There are outputs established for each project component, which are detailed in the program description and the Logical Framework.

C. Project Components

This Project has four main components: family planning service delivery and support programs of ASHONPLAFA, technical assistance to ASHONPLAFA and other private family planning groups, family planning promotion by PVOs (with some services likely in the latter years of the Project), and family planning services provided by private industry to employees and dependents. Budgets and specific expense items described in each component are illustrative, and will be finalized during negotiations with recipients of funding.

1. ASHONPLAFA

In order to increase the availability and accessibility of voluntary family planning services in Honduras, support will be provided to three service delivery programs of ASHONPLAFA: Community Services, Social Marketing, and

Medical/Clinical. ASHONPLAFA will conduct information, education, and communications activities which promote family planning services in general as well as their own program. Training will be conducted by ASHONPLAFA for their staff and the personnel of the other private organizations included in the Project. In addition, monitoring and evaluation of ASHONPLAFA and other private groups programs, to facilitate improved efficiency of service delivery, is included in the Project. Management and administration changes will be supported at ASHONPLAFA to improve performance, including cost recovery. Technical assistance will be provided to ASHONPLAFA and other private family planning providers to increase and improve provision of services. Other private groups will receive support to upgrade their referral relationship with ASHONPLAFA, and possibly, in the later years of the Project, to provide services directly.

a. Community Services Program (CSP)

The ASHONPLAFA Community Based Distribution (CBD) program has sold contraceptives (condoms, vaginal foaming tablets, and pills) to couples in their community, using a network of 1,424 volunteer distributors throughout the country. The distributors retain a portion of the sale price of contraceptives they sell. Promoters supervise and also re-supply distributors during visits to their communities, obtaining supplies from regional warehouses. They are in turn supervised by Supervisors. Both promoters and supervisors are salaried employees of ASHONPLAFA.

In order to make the program's name reflect the work it does, and to improve its image in the community, ASHONPLAFA has renamed the Programa de Distribucion Comunitaria as the Programa de Servicio Comunitario or Community Services Program (CSP).

This program serves the largest percentage of contraceptive users in Honduras, especially in rural areas where 60% of Hondurans live. From 1982 to 1988 the program increased by 50% the number of Couple Years of Protection (CYPs) it sold, but in recent years the rate of increase has slowed. (See Table 5, below.) As mentioned earlier, urban prevalence is almost twice that of rural contraceptive prevalence, thus the slowing of the increase in the CSP is due to early penetration of the easier urban market. At present, about half of the 50,000 users served by this ASHONPLAFA program live in rural areas.

Table 5: Couple Years of Protection in the CBD Program, by year

Year	1982	1983	1984	1985	1986	1987	1988
CYPs	33,347	39,625	40,666	42,895	42,814	45,999	46,203
% Change	-	19 %	14%	5.0%	-0.19%	7.44%	7.06%

Under this Project, ASHONPLAFA proposes to increase the number of users served through the CSP program, measured by CYPs delivered, starting with a projected user population of approximately 49,000 in June 1989, reaching a total of 64,300 by 1994, this latter figure being for the full year. The expansion will focus on underserved rural areas in Lempira, Gracias a Dios, Copan, Ocotepeque, Islas de la Bahia, Intibuca, and La Paz.

Table 6: Projected CYPs in Community Services Program, by year

	6 months 1989	1990	1991	1992	1993	6 months 1994
	24,950	53,400	56,600	59,400	61,800	32,150
Percent increase from previous year		7%	6%	5%	4%	4%

This Project component is budgeted at approximately $3.2 million from A.I.D., and $1.1 million from other sources, including sales of contraceptives, for a total of $4.3 million during 5 years.

Through sales of contraceptives, the CSP was able to generate 35% of their direct operating costs 1988, including the value of donated contraceptives. Several factors will contribute to raising this to an estimated 50% by the end of the Project. With the information system being developed on unit costs, described below in section C.1.f., "Monitoring and Evaluation," program managers will have timely information available to permit better cost control measures. In addition, the CSP distributors will be selling SMP products, thus serving as additional outlets for the SMP. (This is described in more detail Section IV. C. 1. b., "Social Marketing Program," below.) Finally, prices of all CSP products were raised, and, as sales increase, revenues should increase.

1) Strategy

The planned increase in CYPs will require both the establishment of 310 new distribution points, and increased sales by the 1450 volunteer distributors projected to be in place at the end of the previous Project, increasing the average number of CYP provided from about 36 per year to about 40 per year. This implies an increase of two CSP promoters if supervision levels are kept at the June 1988 average of 65 distribution points per promoter. At least one new supervisor will be required, as well, thus ensuring one supervisor per regional center.

An incentives scheme to encourage high levels of efficient service delivery, as yet to be worked out in detail, will be based on participation by distributors, promoters and supervisors, will offer both monetary rewards and other methods of recognition and will be judged on both a quarterly and annual schedule. The scheme will be designed not to create a method preference among service personnel, which could reduce freedom of choice for clients.

The CSP department will reinforce efforts to improve promoter performance and effectiveness through quarterly meetings at the regional level which will provide refresher training as well as problem-solving discussion opportunities. The program will hold an annual national meeting of distributors, promoters, supervisors, and Department heads for purposes of performance recognition and goal achievement reinforcement for the following year.

Since many of these new distribution points will be in rural areas with limited access by public transportation, ASHONPLAFA will investigate alternate transportation options to provide supervision by promoters, which might include: 1) use of ASHONPLAFA owned vehicles; 2) use of motorcycles where terrain permits; and 3) periodic contracts with taxi cooperatives. If the pilot project with motorcycles proves cost-effective, additional motorcycles will be purchased during the life of the project.

2) Products

The program will experiment with expanding range of products available at the distribution posts, adding oral rehydration salts and additional contraceptive products, including SMP products. Consideration will be given to adding progestin-only oral contraceptives, available through A.I.D., to the program, to provide an additional option for lactating mothers and women over 35.

In addition, CSP promoters will distribute SMP products to SMP distribution points outside the Mandofer network. This is described below in the Social Marketing Program section.

3) Pricing Structure

There have been several observations relevant to pricing of CSP products during the intensive review of this Project. First, in rural areas, many people have very little cash, and therefore any cash price is an impediment to some potential program users. Second, the same product should be sold for the same price in all ASHONPLAFA program outlets--pharmacies and other Mandofer outlets being considered non-ASHONPLAFA outlets. And third, if large price differentials exist between two brands of the same type contraceptive, the public is likely to perceive the lower-priced one as "bad" and the higher-priced one "good." All of this points to the need for a coherent, agency-wide, pricing structure for commodities. This is discussed further in the section below on Management and Administration of ASHONPLAFA.

4) Promotion

The CSP program will receive support in mass media communications from ASHONPLAFA's Information, Education and Communication (IEC) Division as part of the association's overall communication strategy. ASHONPLAFA will increase production of printed materials for use in promotional work. To further facilitate promotional work, each regional center will be equipped either with one projector and set of films for each five promoters, or with the equivalent video equipment and video cassettes.

5) Training

The new distributors will be trained by the Department of Evaluation and Training. The new promoters and supervisor will be oriented to ASHONPLAFA by the Department of Evaluation, but will be trained on the job. Continuing education of distributors, promoters, and supervisors will include familiarization with Natural Family Planning, enabling them to refer clients to service facilities with NFP teachers.

b. Social Marketing Program (SMP)

The Social Marketing Program utilizes marketing techniques to promote the family planning, and to sell contraceptives at commercial retail outlets at lower-than commercial prices. The overall objective of the SMP program is to promote the use of contraception and to make contraceptives more accessible to consumers with low levels of economic resources. The specific objectives for the SMP program are: to increase the number of CYPs provided by SMP products by 67% from the current level of 23,122 to a projected 38,598 for the entire year of 1994, and to achieve program self sufficiency by 1994.

It is anticipated that the SMP will contribute to the provision of CYP in ASHONPLAFA's program as shown below. (These figures are based on the assumption that new subsidized contraceptive products will be available to the SMP program.)

Table 7: Projected CYPs in Social Marketing Program, by year

	6 mos. 1989	1990	1991	1992	1993	6 mos. 1994
CYPs	11,561	29,125	29,423	32,603	35,766	19,299

This Project will provide funds for promotion and contraceptives from A.I.D., totalling $636 thousand, and will also receive income from sales of contraceptives and other donors in the amount of $1.5 million, for a total component cost of $2.1 million. Training for pharmacists and their aides, as well as for CSP personnel, is planned and is discussed below. The Social Marketing for Change Project, SOMARC, will continue to provide ASHONPLAFA technical assistance required for this program during the life of the Project. The Mission will buy-in to the SOMARC Project in the amount of $197,000 for such services.

It is anticipated that this component of the Project will cover its operating costs in the fifth year of the Cooperative Agreement with ASHONPLAFA, exclusive of training and technical assistance. If commercial or IPPF products are included, the program can be 100% self-sufficient, recovering even the cost of the commodities. If commercial products, with their higher profit margin, are not included, then it is projected that the program can be recover all costs except the cost of the donated contraceptives.

1) Distribution Networks

The SMP distribution network includes the 2,000 pharmacies throughout Honduras, which are located primarily in urban areas, and will include the ASHONPLAFA CSP nationwide network of distributors which includes more than 1,400 distributors. In addition to the above arrangement, in areas where there are no pharmacies or other points of sale handled by the wholesale distributor, ASHONPLAFA's CSP promoters will distribute SMP products to the SMP distribution network, while at the same time supervising and supplying CSP distribution points. The ASHONPLAFA CSP promoters will add SMP products (Perla and Norminest oral contraceptives and Guardian condoms) to the other contraceptives they already sell. Programming and training plans were developed for CSP promoters in the first quarter of CY 1989. The CSP distribution network with SMP products will be tested and debugged before a nationwide implementation of the system is attempted. The commercial and CSP distribution networks are complimentary in terms of the geographic locations that they serve. The CSP network tends to reach more rural couples with lower cash income.

2) Implementation Strategy

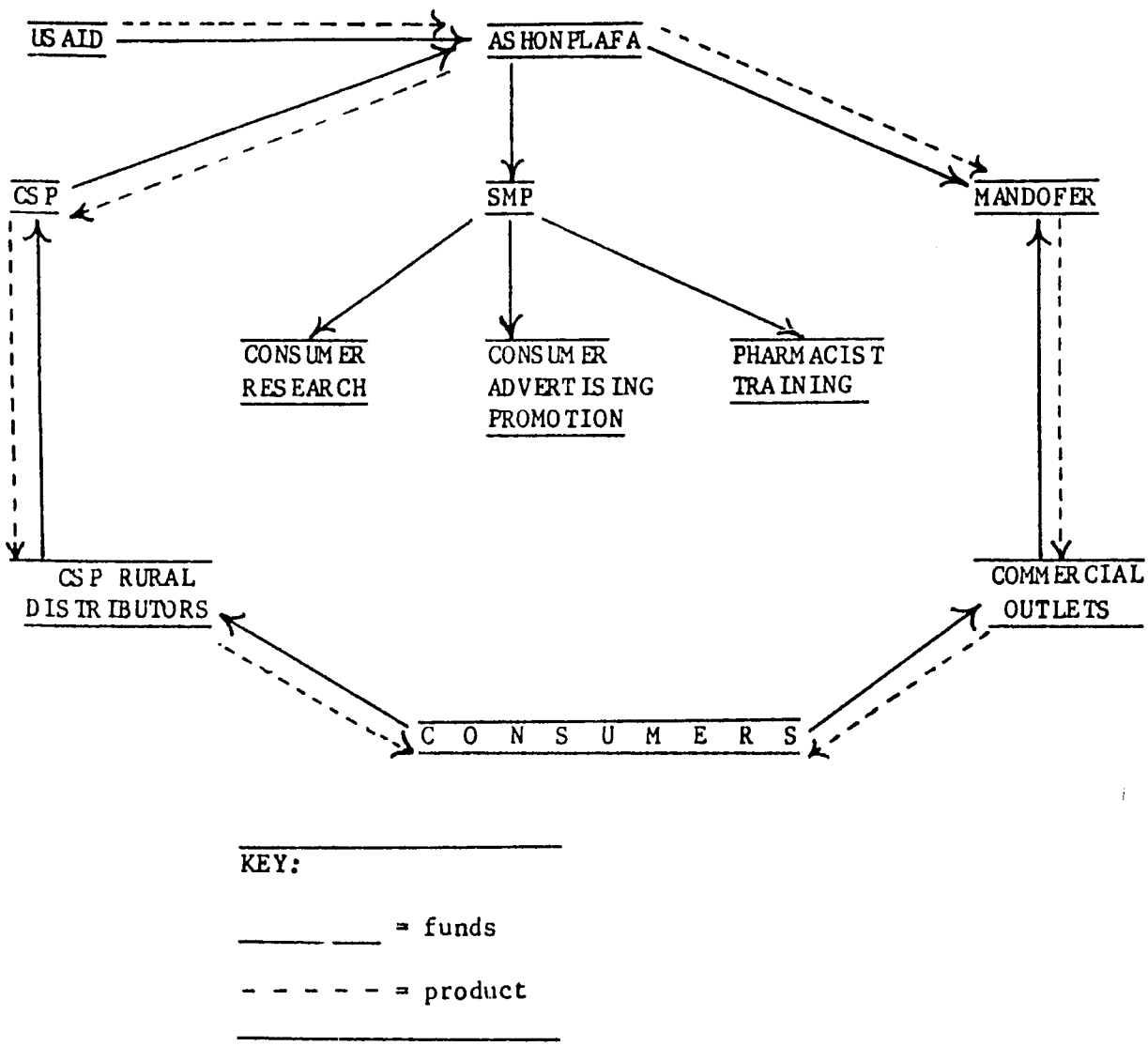
The SMP has been operating since 1984. Drogueria Nobel, a commercial distributor owned by ASHONPLAFA, was the implementing agency until December, 1988. It was responsible for the distribution of all SMP products to pharmacies throughout Honduras, as well as for all marketing activities including development and execution of the marketing plan, and supervising all advertising, promotional, and research activities. While Drogueria Nobel was successful in penetrating the market with contraceptives, it was unable to make significant improvements in reducing the cost per couple year protection (CYP) or increasing its level of self sufficiency, despite large inputs of funding. Therefore, another mode for implementation of the SMP was selected.

After in-depth analysis by SOMARC consultants it was determined that the distribution of ASHONPLAFA's contraceptives, obtained from A.I.D. and IFFP, would be effectively and efficiently carried out by an independent, established, commercial wholesale drug distributor. Of all the commercial drug distribution companies in Honduras, MANDOFER, S.A. proved to be the largest in terms of outlets served, as well as the most interested. ASHONPLAFA entered into a contractual agreement with MANDOFER in early 1989 and products began immediately to flow though its system. Although the pipeline was half-empty, sales have increased over 1988 levels by 30% in the early months of 1989.

Concomitant with contracting MANDOFER, ASHONPLAFA created a Social Marketing Department within its organization, which is responsible for monitoring the MANDOFER contract, coordinating advertising campaigns, supervising repackaging, maintaining adequate stocks and sales records, and planning, executing, and controlling marketing strategies. A highly competent manager was selected from a list of qualified candidates obtained by advertising. Within three months, he collected 70% (over $40,000) of accounts receivable that Drogueria Nobel had written off as uncollectible. He expects to recover 15% more of these outstanding receivables.

The figure which follows this section illustrates the flow of contraceptives and funds among the different organizations participating in the Project.

Figure 1: ASHONPLAFA SMP Program Flow of Funds and Product



3) Products

The current products include two oral contraceptives, Perla (Noriday) and Norminest, and Guardian condoms. While Drogueria Nobel planned to introduce SANA brand vaginal tablets in 1989, this strategy will be re-evaluated by the new management team on the basis of SANA's potential contribution to prevalence, and to the overall cost recovery of the SMP program and and analysis of the socio-cultural obstacles to foaming tablet use. All of these contraceptives are to be donated to the program by A.I.D.

IPPF contraceptive products may be added in the near future to the SMP, as mentioned above.

In addition, ASHONPLAFA is considering the possibility of including commercial products in the SMP product line. While these would have to be purchased, the price to the public would include a higher markup than on the donated products currently being sold, so that the program would make a profit on the commercial products. Both Schering and Wyeth have expressed interest in introducing lower priced versions of their low dose products and would be willing to collaborate with ASHONPLAFA in return for marketing support. Similar collaborative efforts are functioning successfully throughout Latin America, most notably in the Dominican Republic, Ecuador, Peru, and Brazil. Consideration will be given to introducing progestin-only oral contraceptives to this program, since they represent a new market segment, lactating women and older women, who should not use combined orals.

Careful market research will be needed to determine whether this increase in brands of combined low-dose oral contraceptives will increase contraceptive prevalence and increase financial independence of this program, and perhaps ASHONPLAFA. This will be contracted for and supervised by the Evaluation Department, and is budgeted as part of Monitoring and Evaluation.

4) Pricing Structure

Currently, all ASHONPLAFA SMP products fall within the generally accepted social marketing price parameter of 1% to 2% of the minimum wage. The minimum wage in Honduras is currently L.200.00 per month. The relationship between the cost for a month's worth of contraceptive protection and the minimum wage follows.

SMP BRAND	Price to Public	Cost per Month	% of min wage
Perla(Noriday)	L.1.50	L.1.50	0.75%
Norminest	L.2.00	L.2.00	1.00%
Guardian	L.0.42	L.3.36*	1.70%

*Note: The cost per month for Guardian is based on the assumption that 100 per year and 8 per month constitute a CYP.

Based on these prices the current price structure is as follows:

SMP BRAND	Price to Public	Pharmacy Margin	SMP Dist Margin	ASHONPLAFA Revenue
Perla	L1.50	.30	.28	.92
Norminest	2.00	.40	.38	1.22
Guardian	1.25*	.25	.24	.76

*box of three condoms

Although the new management team considered implementing an increase in prices in 1989, it is not feasible at this time because the price is already imprinted on the packages and such an increase would affect the CSP. A reduced price of contraceptives in rural areas has also been suggest by some analysts, and faces the same problems. The prices are printed on the packaging to prevent retailers from over-charging for these products. A coherent pricing policy for all ASHONPLAFA contraceptive products, across programs, will be instituted during this Project, based on operations and market research. This is described further in the Monitoring and Evaluation section of this paper.

The price to the public will be the same for pharmacy sales and sales through the CSP. For example the range of prices for SMP oral contraceptives distributed through the CSP program is from L 1.50 to L 2.00. The pricing structure for the SMP products sold by the CSP follows.

SMP BRAND	Price to Public	CSP Dist. Margin	CSP Margin	SMP Revenue
Perla	L1.50	.60	.18	.72
Norminest	2.00	.60	.38	1.02
Guardian	1.25*	.30	.19	.76

*box of three condoms

5) Promotion

The SMP will contract for promotional activities, which will continue to focus on mass media. The contractor will also be responsible for the development of point of purchase materials.

Regarding oral contraceptives, PERLA will continue to be supported with television and radio advertising as well as continuing to receive promotional support at the point of purchase. NORMINEST advertising will receive a limited promotional back-up since it will be discontinued by 1990. In addition to this, ASHONPLAFA intends to add a second new low dose product to its SMP line. Once the new low dose product or a progestin-only pill is introduced, SMP advertising dollars will be used to support the new brand(s).

The Honduran Ministry of Health's AIDS campaign has created an opportunity for the SMP program to become more aggressive with condom advertising. The MOH campaign recommends through mass media the use of condoms for AIDS prevention. Until now, the SMP program has been unable to use the word condom on mass media, however, the MOH AIDS campaign indicates that it may now be possible. Furthermore, the SMP program will explore the possibility of advertising condoms on television. While condoms make a limited contribution to CYPs, since they are a product used by males, condom advertising can be an effective vehicle for involving men in family planning.

6) Training

Training, to be conducted by the Evaluation department of ASHONPLAFA and budgeted there, is planned for CSP promoters to enable them to provide SMP products to their distributors, and also to distribute SMP products to additional commercial outlets in areas not served by the commercial distributor.

Pharmacist training, to be conducted by the IEC department of ASHONPLAFA and budgeted there, is a element that will be reintroduced into the Honduras SMP program. This marketing technique has been extremely successful in other Latin American countries. For example, in Ecuador, pharmacist training programs over the last six months have generated a 50% increase in average monthly sales of the SMP product.

c. Medical/Clinical Program

This program of ASHONPLAFA provides temporary contraceptives and voluntary surgical contraception (VSC) in clinic settings. Its objective is to make VSC available to Hondurans at a reasonable cost, to provide temporary methods which require clinical services (such as IUDs), to offer clinical backup for temporary method users with problems, and to provide an additional outlet for temporary supply methods (pills, condoms, foaming tablets) for those who prefer such a source.

Medical/Clinical services, particularly voluntary surgical contraception, have not increased greatly during the course of the previous Project, reaching a level of 10,442 CYPs of temporary methods and 3,315 VSC procedures in ASHONPLAFA clinics during 1988, with two of its centers having operated for all 12 months and a third, the Choluteca center, operated for 10 months. The remaining three centers will open in 1989. Private physicians provided 3,311 procedures, and the HMI performed 664 procedures, for a total of 7,290 procedures supported by ASHONPLAFA in 1988.

During this Project, it is expected that this program will support services as indicated in the table below. When all six centers are operational, 8,208 procedures will be performed each year if procedures are increased to six each day at each center, from the three which was initially the standard. This assumes contracting for four physician hours at each center and offering services on 228 nonholidays. If volume is increased to eight procedures per day (less than three procedures per hour for three surgical hours), 10,944

procedures could be done per year with no increase in personnel and only minimal cost increases for supplies.

Table 8: Projected Voluntary Surgical Contraceptive Procedures, by type of facility; projected MCP/CYPs as Temporary Methods by year

	(4 AHPF clinics operating)		(6 AHPF clinics operating)			
	6 mos. 1989	1990	1991	1992	1993	6 mos. 1994
VSC facility						
AHPF clinics	2,280	4,560	8,208	9,576	10,944	5,472
Private clinics	1,423	2,733	2,733	2,733	2,733	1,358
Hosp. Mat-Inf.	349	732	768	806	846	444
Total VSC Procedures	4,452	8,025	11,709	13,115	14,523	7,274
MCP/CYPs Temporary	5,378	11,079	11,413	11,755	12,108	6,357

The total budget for this project component is $5.2 million over the 5 year Cooperative Agreement, with A.I.D. contributing $4.4 million, and ASHONPLAFA collecting $770 thousand from other sources, including cost recovery from program users. The costs to A.I.D. under this component include personnel, per diem for supervisory travel, equipment and repairs, medical supplies and medicines, VSC promotion, and reimbursement to private physicians. The oral contraceptives used in this program are those supplied by IPPF.

1) Sites

ASHONPLAFA will have six regional family planning centers, all of which will be operational by the end of 1989. These were purchased or constructed during the previous Project, and are located in Tegucigalpa, San Pedro Sula, Choluteca, Sta. Rosa del Copan, La Ceiba, and Juticalpa.

ASHONPLAFA has raised the possibility of opening centers in four additional sites with its own funds: Danli, La Esperanza, Comayagua, and Santa Barbara. Such centers will only be opened if they offer VSC services, and they should only offer VSC services if they can be provided at a lower total cost than the private clinic program. Essentially, this means that ASHONPLAFA would have to be certain that their volume could be built to a break-even level within a reasonable amount of time.

2) Strategy

Services are provided by physicians and nurses, and clients pay for services and supplies received. Under the previous Project, ASHONPLAFA contracted for four physician hours per day for each of its surgical centers. On the average, two of these hours are spent in surgery, and the other two in dealing with patient's problems on temporary methods and in supervising the temporary methods clinic.

VSC services funded under this project component are also delivered at the Hospital Materno-Infantil, where three ASHONPLAFA nurses work in the operating

room. The private clinic program will continue in communities where ASHONPLAFA does not have centers. ASHONPLAFA will finance between 2,500 and 3,000 procedures per year with payments of L 120 per procedure to trained private physicians. ASHONPLAFA staff who supervise these physicians will also encourage them to provide temporary methods as part of their practice. This will relieve the burden on subsidized services of clients able to pay for private services.

ASHONPLAFA will explore the feasibility of arranging transportation for women in remote rural areas to its regional centers as a way of assuring equal access to all services, including VSC.

A number of efforts will be made during this Project to increase efficiency in operations of the Medical/Clinical program. For example, ASHONPLAFA's medical director believes that three hours, instead of two, (of the four that physicians are contracted for daily) could be spent in surgery without impairment of the supervisory functions, thereby gaining productivity without paying for additional hours. This can be studied as part of the operations research to be funded under the Monitoring and Evaluation component of the Cooperative Agreement with ASHONPLAFA. Patient Flow Analysis, a study methodology originated by the Centers for Disease Control in Atlanta, is another technique which could be used to improve clinic service delivery by identifying the bottlenecks which cause inefficiency.

The new Project will make better use of the existing clinic facilities by testing a Men's Clinic during afternoon hours (hours when the clinics are currently unused). The Men's Clinic concept will begin on a pilot basis at the Tegucigalpa clinic where vasectomy services will be offered, along with treatment of sexually transmitted diseases in men. If successful after a pilot period, Men's Clinics will be established at other centers. Tulane University, which assisted in the development of the operations research protocol for this activity, will provide the technical assistance required to carry out the study, funded by AVSC using ST/POP central funds.

3) Methods offered

Under this program, temporary contraceptive methods, including pills (supplied by IPPF: Microgynon, Neogynon, and Ovral), condoms, vaginal foaming tablets, and IUDs, as well as Voluntary Surgical Contraception for both males and females are offered.

Georgetown University will provide technical assistance to ASHONPLAFA to develop and carry out a strategy to introduce modern methods of Natural Family Planning (NFP) to the CSP and MCP. This will start with familiarizing all staff members who are in contact with clients with these methods. ASHONPLAFA training staff from each region will be trained to train NFP teachers, and then conduct teacher training in the regions. A limited number of NFP teachers will be trained to work in clinics, and CSP personnel will include information about the availability of this service in their contacts with clients. NFP service statistics will be collected in such a way that pregnancy and continuation rates can be compared to other methods.

Consideration will be given to increasing the knowledge and skills of ASHONPLAFA personnel in promoting and supporting breastfeeding, and especially appropriate introduction of contraceptives for lactating women. A local consultant with experience in lactation promotion and management programs can be used by ASHONPLAFA to assist in the design of these training programs. In this way, breastfeeding can contribute the maximum to child spacing, and contraception can help Honduran women continue to breastfeed for the health of their children.

Related to breastfeeding is the need to consider the introduction of a progestin-only method to ASHONPLAFA's program. These are especially appropriate for women over 35 or who are breastfeeding, since breastfeeding can be prematurely discontinued due to a new pregnancy, and the volume of breastmilk is reduced by combined oral contraceptives. Currently, AID/W can supply progestin-only oral contraceptives; some of the contraceptives for this Project may be of this type.

4) Cost Recovery

This program, like other clinical programs of family planning service delivery, is the most expensive per temporary method CYP delivered. (During this Project, ASHONPLAFA will improve its management information system so as to be able to cost out VSC costs per CYP.) Cost recovery in the surgical program during the previous Project has not been notable. For procedures done through August 1988 in the Tegucigalpa clinic, the average fee paid by patients was just over 8 lempiras. Although an estimate of 15 lempiras per procedure was given in San Pedro Sula for an introductory period, only a minimum effort at cost recovery is being made in Choluteca (an average of 1 Lempira per patient to date).

Greater efforts at cost recovery will be required under the new Project. A sliding fee scale will be established and gradually phased in so that fees collected on average increase substantially. All clients will be expected to pay although provision will be made for a very low minimum level of payment for the truly destitute, so that no one is barred from receiving services or supplies due to inability to pay. The portion of voluntary surgical contraception costs subsidized by A.I.D. will therefore decrease over the course of the Cooperative Agreement with ASHONPLAFA from the current level of about $58 per procedure, by annual amounts to be negotiated as part of the Cooperative Agreement.

5) Promotion

VSC promoters are located in Tegucigalpa (4), San Pedro Sula (3), and one each in Danli, Siguatepeque, El Progreso, Sta. Barbara, Choluteca, Tela, La Ceiba, Comayagua, Sta. Rosa, and Juticalpa. They promote the idea of family planning among the population most at risk and refer potential acceptors to the nearest facility. The voluntary nature of accepting VSC is strongly emphasized. To date, these have been promoters only of VSC; consideration is being given to training these workers also to promote temporary methods.

There are currently two VSC supervisors at San Pedro Sula and Tegucigalpa who plan, organize, coordinate, and evaluate the work of the promoters. If necessary, to assure that quality standards are maintained in the VSC program at all of the regional centers, a VSC supervisor may be added to the staff at the San Pedro Sula clinic to oversee the surgical program in the northwest region. VSC promoters and supervisors work in the IEC Department.

In addition to the VSC promoters described above, efforts to increase demand and VSC service volume will be made through the use of the communications program described below. All the sources of VSC (MOH, IHSS, and ASHONPLAFA) will be promoted at the same time to mitigate possible criticism of ASHONPLAFA.

6) Training

Training will be provided to enable the VSC promoters to promote temporary methods and programs of ASHONPLAFA, and all clinic personnel will be familiarized with vasectomy, Natural Family Planning, and breastfeeding promotion. At least one NFP teacher per clinic location will be trained. This training will be conducted by the Evaluation department, which handles training for ASHONPLAFA staff.

7) Technical Assistance

The Association for Voluntary Surgical Contraception (AVSC) will provide periodic supervisory visits to the Honduran program to assure the quality and voluntarism of the program. This will be centrally funded, at no direct cost to this program. Technical assistance funded under this Project relating to training, NFP introduction, and management and administrative improvements will also help ASHONPLAFA to improve the medical/clinical program.

d. Information, Education, and Communications

The new Project will emphasize an integrated communication strategy to increase the knowledge of the target groups of the advantages of family planning and to promote methods, SMP brands, and points of access (CSP distributors, SMP outlets, and clinics) of ASHONPLAFA and, indirectly, other service providers. The concept of family planning as contributing to maternal and child health and to increased child survival has not been emphasized nor skillfully used as an important reason for use of contraception. In the minds of many, this notion is a far more compelling and positive reason for planning one's family size than the idea of "restricting" or "reducing" the number of children one desires to have. The spacing of births, rather than the prevention of births is a powerful argument especially if both the risks of closely spaced births and the advantages of same are explained to fertile aged couples. For example, some of the themes that could be highlighted are that the recommended period between birth is at least two years: closely spaced births can cause maternal depletion resulting in premature births and/or low birth weight infants. Short intervals may interrupt breastfeeding for the earlier child, or create competition among siblings for parental attention and care. New messages regarding vasectomy, breastfeeding to maximize the birth

interval, and family planning to preserve breastfeeding, possibly including progestin-only pills, as well as the availability of Natural Family Planning counselling will be added. Technical assistance will be contracted from Johns Hopkins University and its sub-contractor, CREA (Centro Regional de Audio Visuales), an A.I.D. funded production center in Guatemala to work with ASHONPLAFA's communications personnel and participating private groups in designing the communications strategy and materials to carry it out.

This component is budgeted at $2.3 million total, with A.I.D. contributing $1.1 million over the 5 year Cooperative Agreement including funds for personnel, travel, educational materials, and publicity. It will be overseen by the IEC Department of ASHONPLAFA, which also conducts training for persons and groups not employed by the Association.

The feasibility of the use of a professional advertising firm to carry out the communications strategy is under intensive study by ASHONPLAFA. If such a move proves to be advantageous, it is envisaged that the ASHONPLAFA IEC director, working with a small internal committee, will serve as the liaison between the Association and the advertising firm to assure the appropriateness of the communications campaign.

Mass media can be used to reinforce the work of the various units within the institution, and to complement use of each different medium. Various formats will be used both in radio and TV, all to mutually reinforce each other, and working toward positioning ASHONPLAFA as an important national institution. The strategy also contemplates introducing a musical theme and a slogan that would become, together with the logo, the institutional trademark. Radio will be the principal medium, and the range will include spots, testimonials, talk shows and a "Dear Abby" type advice program to which listeners may address questions about sexual issues and family planning. The latter programming will target young adult audiences.

ASHONPLAFA's communications unit will be strengthened through observational trips and technical assistance, and production quality will be improved by exposing the staff to Central and South American centers with extensive experience in social marketing. Since the media production capabilities in Honduras are limited at best, the Project will engage the technical assistance of CREA. Technical personnel from CREA will visit ASHONPLAFA, meet with the different PVOs and be engaged for the design and production of the promotional materials.

The IEC unit will continue to print materials for use in the various programs of the association. New materials will be required for Natural Family Planning methods, promotion of appropriate breastfeeding and family planning during lactation, and progestin-only methods (if introduced). Materials will be sold at cost to the other private groups participating in this Project.

ASHONPLAFA will consider establishing a Public Relations (PR) office that would be the spokesperson for the Association. Among the duties of this office would be to publish information regarding the importance of family

planning, including data linking lowered infant mortality rates with avoidance of high risk births. Funds will be available for working with journalists and other opinion leaders regarding population and health issues which can be ameliorated through the provision of family planning services. These will include attendance at seminars either organized by ASHONPLAFA or by other agencies in the region. The PR office would be responsible for dealing with the press when the Association is under attack in the media.

e. Training

Training for service delivery and for other support elements, such as management and IEC, will be conducted as part of this Project. There is no separate Training Department at ASHONPLAFA; two departments have responsibility for training. The Evaluation Department conducts training of ASHONPLAFA employees, and the IEC Department conducts training of other persons and groups, as an extension of its outreach work to the general public.

Training is budgeted at $657,000 as part of the ASHONPLAFA Cooperative Agreement, and will cover expenses for activities described below. Other sources will contribute $143,000 for training activities, for a total of $800,000 over the course of the 5 year Cooperative Agreement.

At this time, training plans in the Evaluation Department are based on detailed analyses of strengths and needs for training of each employee. Competency-based training courses were designed and carried out to increase job-related skills. While this approach may be warranted for senior staff at the regional and central levels, a more general plan, focusing on the broad-based needs of personnel for service delivery and essential support activities, such as IEC and evaluation, is needed. Such a plan could form the basis for competency-based continuing education for service delivery and support staff in technical topics, such as new contraceptive methods, and in new administrative procedures, such as use of the computer for routine service statistics. During the course of this Project, the Evaluation Department will work toward such an approach.

Training needed from the Evaluation department for ASHONPLAFA employees as part of this Project will include training the 310 new distributors for the community services program, and providing orientation for the 2 new promoters and the new supervisor for that program. (The training for their jobs for these two latter categories will be on-the-job.) For the Social Marketing Program, the CSP promoters who will serve as distributors of SMP products to distributors will be trained in this new duty. The VSC promoters need to be trained to promote all methods offered at ASHONPLAFA, not just VSC.

Addition of NFP methods and promotion of appropriate breastfeeding/ contraceptive behaviors in ASHONPLAFA programs will require training for all personnel. All personnel with client contact will need enough information to make NFP referrals, and a few NFP teachers will need to be trained per regional center. All service delivery personnel will need to be trained to

promote appropriate breastfeeding and contraception for new mothers to maximize the birth interval and to prolong breastfeeding. As mentioned above, the use of a local lactation consultant, will assist ASHONPLAFA to develop this training.

Consideration will be given to preparing the staff of the regional centers to provide orientation to the staff of the Ministry of Health's rural health facilities to make them better referral sources for the VSC program.

Training will be needed for regional and central staff in data entry, and report generation from the MIS, and managers will need to be trained to request and to use these reports for program management and strategic planning.

The IEC Department will provide training as part of this Project for a variety of persons who are not employed by ASHONPLAFA. This includes the personnel of the other PVOs and other private groups who will provide referrals, and perhaps services at a later time, as part of this Project. This will be provided at cost to those organizations by ASHONPLAFA, using the course outlines and materials developed by the Evaluation Department for training of ASHONPLAFA staff.

Pharmacists and their assistants will be trained for their roles in the SMP, as discussed in the SMP section above. As part of the regionalization effort, volunteer groups, called Cuerpos de Apollo, who will support the work of ASHONPLAFA in the local communities will need orientation and training for their activities, which will be conducted by the IEC Department.

In addition to the above, the IEC Department will continue providing training as it has under the previous Project to the service delivery personnel of the Ministry of Health in contraceptive technology, and to the Ministry of Education Normal Schools, and other outside groups, such as community leaders.

f. Monitoring and Evaluation

Three major means will be used to monitor and evaluate program activities and performance of ASHONPLAFA during the course of this Project. First, a management information system will be used, for routine reporting and to enable special analysis as needed. Second, operations research will be used to investigate potential improvements in service delivery or support services. Third, national surveys will be undertaken, for which ASHONPLAFA will administer the local costs, which will measure purpose-level achievements of the entire Project.

This project component is budgeted at $619,000, which will cover costs of personnel, and local costs for operations research and two nationwide surveys. ASHONPLAFA will receive $506,000 from other sources for this program, for a total of $1.1 million over the course of the Cooperative Agreement.

ASHONPLAFA's consultants routinely comment in their reports about the absence of adequate program and budget data with which to understand the functioning and performance of various components of the program. One of the major deficiencies is the lack of a clear responsibility for data collection and analysis, as well as the inability to tie program data to cost data.

To assist ASHONPLAFA in correcting some of these deficiencies, the Enterprise Project, under a buy-in from the previous Project, provided assistance to ASHONPLAFA in developing a management information system (MIS). Enterprise set up a Local Area Network (LAN) computer system and provided technical assistance and training to ASHONPLAFA both in use of the computer hardware and the development of the information system. The development of the information system is in process. The major elements of the system are an updated accounting system and a program data system.

The accounting system allows program managers and regional directors detailed information by department, region, and funding source regarding expenditures, income generated, and current balances. Another feature is that information will be generated indicating when a certain budget line item has been overspent, enabling the accounting department to follow through with cost reduction actions or budget changes.

In the service departments and the regions, the new program data system will track program performance against targets and provide ASHONPLAFA managers with timely information for decision making. Each department is identifying functional descriptions and institutional objectives to include in their information system. Specifically to be tracked are CYPs provided for all service programs, and the number of VSC procedures per clinic. (As the data system improves, it will be possible to determine the median number of CYPs provided per VSC procedure, so that CYPs can be calculated for that part of the program as well.) Program output information will also be collected for other program elements, such as training and IEC, but the methodology to be used by ASHONPLAFA needs further development.

A very important advantage the new accounting and program data systems will provide ASHONPLAFA is the ability to tie program data and accounting information. For example, expenditures by promoter by region could be tracked, to enable identification and perhaps study of particularly successful or problematic portions of the program.

Under the new Project, a system for entry and analysis of program data gathered on users, methods, CYP, etc., will be developed. The first step will be an analysis of needs, after which selection of hardware and software can be made. Program data entry could be undertaken at the regional center level by the regional secretary, both to expedite the process and to reinforce the responsibility and importance of regional staff in meeting association goals. Data could be transferred to ASHONPLAFA headquarters by floppy diskette. Program data files will be accessible by other database software programs (e.g., dBase III) so that special analyses can be undertaken as needed without

additional data entry or reentry. If this were the design, purchase of regional computer hardware, and additional software modules would be needed (e.g., Accounts Receivable, Accounts Payable, Inventory Control).

Regional personnel and central office personnel will be trained in data entry and output, and managers will be trained in utilization of data for programmatic decisions, as well as long range planning. Consideration will be given to adding a second MIS staff person to assist in the management of the system.

Further technical assistance in MIS, on inventory management, as well as in the use of computers for budgeting and cost containment will be required in this Project to ensure that the Evaluation Department can provide the basic statistics and analysis for the program as a whole. This will include help to the staff to simplify the data system (forms used, data collected, etc.). Technical assistance will be provided on a frequent, regular schedule initially, and less frequently during the remainder of the Project to insure that the system is operational and any adjustments required are made.

ASHONPLAFA program managers and regional directors, as well as senior managers, will use program and financial data to track program performance and costs indicators on at least a quarterly basis; some program managers may choose to keep track on a weekly or monthly basis. In addition, information can be used by individual promoters in the CSP, for example, to understand the performance of the distributors working for them. Quarterly reports will compare achievement against program targets for the period and cumulatively for the year, and will be available by program as well as by region. These reports will be provided to USAID to enable the Mission to track Project outputs. This will be particularly important since the Cooperative Agreement will specify individual service program expectations in improving cost recovery and efficiency in service delivery. ASHONPLAFA will also continue to collect and report national VSC statistics, which will enable measurement of its role in the national effort.

At least two operations research projects will be undertaken each year. The first operations research activity, to start July 1989, will be to test the male clinic at the Tegucigalpa center. Vasectomy and treatment for male problems will be provided at this clinic. Tulane University, which helped in the development of the protocol, will provide the technical assistance funded with AVSC central funds. Depending on the results, this clinic might be replicated in San Pedro Sula or other regional centers. Examples of other studies meriting investigation are the cost-effectiveness of various transportation options (motorcycles, ASHONPLAFA vehicles, contracts with taxi cooperatives) to mobilize CSP promoters in their supervisory and promotional functions; changes in distributor and promoter productivity due to introducing a performance recognition system; the efficiency and effectiveness of supervision of temporary methods clinics by nurses instead of physicians; the effect on each program of converting promoters from single purpose (CSP or VSC) to multipurpose; the feasibility of introducing progestin-only pills; or price elasticity of contraceptive commodities.

A buy-in to the new ST/POP LAC Operations Research Project will provide the technical assistance required for design, implementation, and evaluation of the operations research components of the Project, with recommendations on whether and how to incorporate the improvement.

The Evaluation Department will also collaborate with the Ministry of Health in conducting the 1990-91 and 1993-94 Contraceptive Prevalence Surveys and interim Rapid Surveys at the regional level. These are described in Part IV., D. Evaluation and Audit Plan.

g. Management and Administration

ASHONPLAFA has achieved substantial gains in providing services and information during the preceding project period without materially reorganizing the management and administrative structure with which it had operated for over twenty years, although additional administrative personnel have been hired. An organigram of ASHONPLAFA is attached as Annex I.

This component is budgeted at $1.9 million from A.I.D., and includes funds for central and regional administrative personnel and other costs. Other sources will provide $3.6 million to ASHONPLAFA for administration during this period, for a total of $5.6 million. Technical assistance for management and administration will be provided by the PSC Population Advisor and the PSC Project Liaison Officer. Their functions are described in more detail in Part IV., D. Project Management.

Steps towards improving the efficiency of the administrative areas of the Association have been taken. ASHONPLAFA has begun the automation of its Administrative Department by installing a number of accounting software modules which will allow it to provide financial and other information in a more timely, complete, and detailed fashion than has been possible previously.

An additional step recently taken towards increased efficiency has been the naming of a Deputy to the Executive Director, who will coordinate the activities of the individual Departments and supervise the Regional Directors. A special priority area will be closer cooperation and support by the Evaluation and IEC Departments to the Services Divisions - CSP, SMP, and MCP. Additional personnel at middle management levels will be required in several of the Departments.

Finally, increased delegation of authority from the Executive Director to the Regional and Departmental levels and within the Departments themselves will take place.

Regionalization is proceeding in both physical and operational terms. A network of regional family planning centers was begun under the previous Private Sector Population Project: centers in Tegucigalpa, San Pedro Sula, and Choluteca are in operation; construction in La Ceiba is completed; the Santa Rosa remodeling is in process; and construction for the Juticalpa center

has begun. The Santa Rosa Center will be ready in August 1989 and Juticalpa will be completed in November 1989. These regional clinics and centers will manage the CSP and MCP programs in their respective areas.

Some steps toward decentralization and delegation of authority have been taken. For example, regional center directors have discretionary budget authority of up to L10,000. They have responsibility for program supervision, vehicle use, recommending hiring and firing of regional center staff, and the granting of leave and vacations. Complete program and budget planning is now done by the Choluteca and San Pedro Sula regional centers.

Under this Project, the strategy is to continue with regionalization. Steps toward greater delegation will be taken so that regionalization will become fully implemented. The Tegucigalpa region will be "regionalized" last, so as to not interrupt current operations. Regional directors will be delegated authority for operational implementation at the regional level, based on approved guidelines and norms developed at the central level, on such subjects a s hiring, firing, promotion, and re-assignment of personnel. Regional directors will have increased levels of discretionary budget authority. They will have increased responsibility for initiating cost-savings and cost-recovery measures, particularly in the CSP program. Regional directors will be expected to exercise both leadership and supervisory roles, including team building and motivation of regional staff, and will receive bonuses based on program achievement and cost-effectiveness of their regional operations.

Similar to the efforts to regionalize service delivery, the role and functions of the central departments and personnel will need management attention during the course of this Project, including their relationships and relative functions in central operations, and roles in regional service delivery. For example, it might be possible to increase the role of the director of the MCP to medical director for the agency as a whole, hiring a separate director for the day-to-day management of the service delivery in the MCP. In some cases, functions and budget, such as the VSC promoters, have been lodged in a department other than that which logically could direct the efforts. Consideration also needs to be given to consolidating some functions, such as training, into a separate department.

Challenges in administration which must be undertaken during the course of this Project will include developing and implementing a sliding fee scale, coherent pricing of all commodities, across programs and products, and collection of fees from virtually all clients. Discussion has taken place regarding installing an incentive scheme to improve efficiency of service delivery. Any such scheme must be neutral with respect to promotion of different contraceptive methods, so that voluntary choice for clients is not distorted. It should be based on impartial information, available to all staff, so that fairness can be assured. One possibility would be a scheme which rewarded staff for the CYPs delivered at the least cost for each method, so that there would be an award for orals, for condoms, etc. These could be within service programs, or across them. The funds for an incentives scheme are currently budgeted in the CSP, which is illustrative. Some of these

issues could be explored using the operations research portion of the Project, providing guidance to leadership in selecting between different ways of accomplishing these objectives.

2. Technical Assistance

Technical assistance will be provided to ASHONPLAFA and other groups by a variety of sources. These will be budgeted as part of the Cooperative Agreement with ASHONPLAFA, but procurement will be made by USAID, principally through PSCs, buy-ins to Central projects, and IQCs. ASHONPLAFA or the receiving organization will approve the timing and scope of work for each consultancy. Description of technical assistance is included in each of the project components, and listed in the procurement plan and the Project budget.

3. Private Voluntary Organizations and Other Groups

a. Background

In 1988 the Mission conducted a survey of PVOs working in the health area in Honduras. The data collected showed that PVOs played an important role in the delivery of health services to a large part of the rural population not serviced by other entities. This stimulated Mission interest in using the existing PVO infrastructure to help meet some of the unmet demand for family planning. Concomitantly, a number of PVOs had already expressed interest in adding family planning to the scope of services they were offering to rural populations. Use of PVOs to deliver family planning services and information has proven both effective and efficient in expanding contraceptive usage in rural areas in other population programs in Latin America. This service delivery mode complements efforts by family planning associations and host country governments to increase contraceptive prevalence.

The objective of this project component is to reduce the obstacles to use family planning by rural Hondurans by improving knowledge about family planning methods and service availability, and to increase contraceptive usage by these groups, through promotional activities carried out by the participating PVOs.

b. Selecting the PVOs

Technical assistance was obtained from the Enterprise Program to identify those PVOs that offer services to rural populations and have the necessary infrastructure to add family planning services to their existing portfolios of social and medical services. ASHONPLAFA had essentially the only PVO offering family planning services in the country. There was little knowledge regarding which PVOs could be tapped in the effort to increase contraceptive prevalence in Honduras.

In identifying the PVOs special attention was paid to achieve the largest possible rural coverage, particularly in areas with no MOH facilities. Some 26 PVOs were identified by the inventory. Of those interviewed, a group of

about twenty expressed serious interest in incorporating family planning programs into their existing programs.

To engage in in-depth discussions of the social and medical benefits of child spacing, a four-day workshop was held in February, 1989, to bring together the interested PVOs and the Mission to identify how the Mission could support the groups and what the PVOs could offer on the service side. Twenty organizations were invited and 14 attended.

Another workshop was held for two and one half days in early April 1989, which was attended by eight of the fourteen PVOs that had attended the February session. All of the steps needed to complete a proposal for A.I.D. consideration were covered, and so were the important content concepts as to what each one of them would offer to their target populations.

This last group of participants represents a natural selection of PVOs after a careful and well thought out process. All have requested assistance in providing family planning information and referrals for services to their beneficiaries, have other established projects in rural areas, and have relationships with Ministry of Health regional personnel. Some already have working relationships with ASHONPLAFA and are already providing other child survival interventions (vaccination, ORT, growth monitoring, breastfeeding, etc.). The Mission is satisfied that this methodology has identified those PVOs that are most apt to successfully execute this part of the Project. These PVOs are listed below, including the number of beneficiaries expected and the geographical locations where each operates.

Table 9: PVOs, Beneficiaries, and Departments Served

Name of PVO	Number of Beneficiaries	Departments where services are offered
PLAN en Honduras (S.P.S.) PLAN en Honduras (Teguc.)	16,000 families national total	Fco. Morazan, Comayagua, El Paraiso, Olancho, Intibuca, La Paz, Copan, Sta. Barbara
Save the Children	3,000 families	Fco. Morazan, Intibuca, Choluteca
Horizontes de Amistad	700 single mothers	Costés
Meals for Millions	700 families	Olancho
Association of Evangelical Churches in Honduras (AIEH)	400 families	Sta. Barbara, Yoro
Hermandad de Honduras	1,000 families	Ocotepeque
Organization for the Development of Women (ODEF) Entrepreneurs	300 single mothers	Yoro, Costés, Sta. Barbara

c. Other Groups

Two other organizations which are not PVOs, the National Peasants Union (UNC, and its affiliate, the Cooperativa Agrícola Regional Proyecto de Mecanización Agrícola La Concepción (CARPROMACOL), have shown potential for participating in the Project. The leadership of the UNC has expressed great interest in receiving assistance from A.I.D., and considering that it has a large national constituency, together with CARPROMACOL, it merited individualized attention. After the initial February workshop, one meeting was held between the UNC leadership and the Mission staff. During this meeting, the UNC particularly focussed on developing child spacing programs to offer to their constituency (245,000 members nationwide) and requested assistance in developing a program to detect and prevent high reproductive risk. Both the UNC and CARPROMACOL will require considerably more support than the PVOs in order to participate in the Project, given that they do not have developed health care systems for their affiliated members.

d. Implementation Mechanism

To facilitate managerial, financial and administrative tasks, a buy-in arrangement will be made with a centrally funded project contractor to coordinate sub-projects with the remaining PVOs and other groups. The contractor would make sub-agreements and coordinate technical assistance needed by the PVOs to implement the Project. Local staff would be hired to supervise the program, which would consist of a supervisor, an administrative assistant/accountant, and secretarial support.

Proposals for sub-agreements would be submitted by the PVOs to the contractor. These would be reviewed by a committee composed of the contractor, one representative from ASHONPLAFA, and one from USAID. Approval by a majority of those present and voting would decide. All of the PVOs understand the mechanism which will be used to handle the administrative and financial activities of this Project. No reservations have been expressed about this issue.

During the April workshop all of the PVOs present designed draft proposals. Final budgets were not included since that step was left for each organization to work out and then to present with its final proposal.

Standards against which sub-agreements will be judged will be developed by the contractor and A.I.D. In general, however, the main considerations would be the degree of extra access to family planning in underserved rural areas each proposal would provide, and the capability of the organization to deliver information promoting family planning, or actual services.

Plan en Honduras will have its own Cooperative Agreement with USAID. Plan en Honduras (hereafter referred to simply as PLAN) is affiliated with Foster Parents International headquartered in Warwick, Rhode Island. The Rhode Island headquarters has approved in principle PLAN's proposal to participate in this Project with a five year birth spacing promotion effort. PLAN is a registered USPVO with AID/W. Further information regarding the administration and management of PLAN is found in Part VII., D. Administrative Analysis.

e. Promotion

In addition to the direct promotion of family planning to be done by the PVOs and other groups, the IEC efforts of ASHONPLAFA funded under this Project will reinforce the same messages. The PVOs will be able to purchase, at cost from ASHONPLAFA, generic radio programming (which allows PVOs to add their own identifying logo) and pamphlets which they can hand out.

f. Training

All of the PVOs identified have indicated a need to train their personnel in family planning methods and family planning promotion, with particular attention in how to deal with certain cultural behavior (machismo, reluctance by the male population to become involved in what is perceived as a "women's problem", and negative religious attitudes).

To maximize the use of existing resources and a wide national infrastructure, ASHONPLAFA, with its extensive experience in family planning and a proven track record in providing training in both permanent and temporary methods to the MOH and other PVOs, is the logical and most capable institution to provide training to the PVOs, purchased by them at cost. The instruction would be training of trainers (TOT) and directed at supervisor/promoter personnel of the PVOs. These persons would, in turn, train other workers. Four of the PVOs have developed plans which indicate that 20 supervisory and 153 promoter personnel will need to be trained. They would train in turn some 1144 others-midwives, volunteers, teachers, local primary health care providers, etc.

A training manual expressly for the PVOs will be developed by ASHONPLAFA and will include the following subjects:

* Detection and prevention of reproductive risk;
* Family planning methods (they should include natural family planning, breast feeding, and any valid indigenous practices);
* Responsible parenthood;
* Sexually transmitted diseases;
* AIDS;
* Adolescent pregnancies;
* How to address: religious opposition; cultural patterns (emphasis on machismo)
* Male involvement.

ASHONPLAFA will also produce audio visuals to accompany the training covering the different subjects indicated above. Copies will be made available for the PVOs. (The PVOs have expressed a need for audio visual equipment and energy generators for use in non-electrified rural areas.) As part of the effort to attract the male partner in the couple, efforts should be made to train staff who can communicate more freely with male members in the community.

g. Evaluation

The bottom line for evaluation of family planning programs is the increase in the couple years of protection (CYP) provided as a result of project activities. Since the PVOs and other groups will not be providing services, (at least in the early years of the Project) they will not generate CYPs directly. However, the number of referrals made will be recorded and reported in Quarterly reports. ASHONPLAFA will report the number of clients referred by PVOs, so that the effectiveness of the referral system can be evaluated. We would expect that 90% of the acceptors motivated by the PVO program would obtain services from ASHONPLAFA outlets, while only 10% would use MOH facilities. Private groups will also track costs to make referrals, and later to provide services.

4. Employee-Based Family Planning

Efforts have already begun in Honduras to encourage private industries to include family planning in the health services that they offer to employees and dependents. The advantage to the employer is that the services can be purchased at a lower price than maternity and delivery services, and employee absenteeism from the work place will be greatly reduced.

The ST/POP project, Technical Information on Population for the Private Sector (TIPPS), surveyed three major companies on the North Coast and their employees to collect data on knowledge, attitudes and usage of family planning services as well as information on company expenditures for providing maternity benefits. A cost benefit analysis will be presented to the management of these industries in order to explain the long term benefit of providing family planning to their employees. Currently employees go to the Social Security Hospital but may lose up to a day in work waiting to be seen by a doctor. Therefore, while all acceptors in such programs are not new to family planning, they often were receiving subsidized, public sector services, and can be switched to this self-financing, private program as a source of supply, thus alleviating the burden on subsidized services. Service statistics from this program will identify new users of family planning and those switching from another service delivery mechanism. TIPPS will identify a provider to sell maternal child health services to these employers.

TIPPS is planning a second survey for the employees of Tela Railroad Company (a subsidiary of United Brands) and Textiles Rio Lindo, a textile mill located in Tegucigalpa with approximately 1200 employees.

Start-up costs for the family planning services will be provided under this Project, using a buy-in to the TIPPS Project. Preliminary estimates are that 50% of these costs will be recovered during the first year of project implementation. It is estimated that by the end of five years, no project support would be needed, since the clinics will be self-sustaining.

D. Project Management and Technical Assistance

A.I.D. Project management responsibilities will rest with the Office of Human Resources Development's Division of Health and Population. The Health and Population Development Officer will provide general technical and administrative oversight. The Project will be managed by the Mission's Population Development Officer, with assistance from a locally contracted PSC Population Advisor and a project-funded PSC Project Liaison Officer. The Population Development Officer will monitor progress, and work with ASHONPLAFA and PLAN to identify and resolve problems in project implementation. As part of their work, these individuals will visit regional installations of ASHONPLAFA and the PVOs from time to time for routine project monitoring and to facilitate problem resolution.

The Population Liaison Officer will assist ASHONPLAFA in establishing scopes of work, scheduling and monitoring the population technical assistance to the program. An important aspect of this work will be to assist ASHONPLAFA to use technical assistance to the best effect: to guide and direct their own efforts. The Population Liaison Officer will also facilitate the regionalization process, providing assistance to the regions in the development of action plans and budgets and other areas indicated, and will serve as liaison between the USAID-provided TA and ASHONPLAFA.

The Population Advisor will coordinate population efforts among the USAID supported institutions working in population and assist in medical family planning matters. In addition, she will coordinate and monitor the work of private groups and the employee-based family planning service component.

Both the Population Liaison Officer and the Population Advisor will be procured using Personal Services Contracts.

Short term technical assistance for this Project will be procured through buy-ins to centrally awarded Cooperative Agreements or indefinite quantity contracts work orders. These are listed in the procurement plan. The Population Officer will have overall responsibility for writing scopes of work for the technical assistance, in coordination with ASHONPLAFA or the recipient organization, and scheduling of visits.

E. Project Inputs

To achieve the desired outputs, the Project will finance a mix of technical assistance, commodities, local costs (including in-country training), and evaluations and audits.

A combination of long-term and short-term technical expertise will be provided under the Project through Personal Services Contracts, use of IQCs, and buy-ins to A.I.D. centrally funded projects. Inputs include purchase of contraceptives, and procurement of a limited amount of commodities, mainly audiovisual equipment. Local costs for ASHONPLAFA, PVOs supported by the centrally funded contractor and the employee-based services will be provided. Other project costs will include audit and evaluation for the entire Project.

Table 10: Project Inputs Funded by Grant
(U.S. $1000's)

Type of Input	
Technical Assistance	2,300
Contraceptives	1,110
Other Commodities	554
Local Support Costs	12,036
TOTAL	16,000

Part V. FINANCIAL PLAN AND ANALYSIS

A. Summary Budget

The total cost of the Project is estimated at $25.2 million with A.I.D. providing $16 million in grant funding and the private organizations and other donors contributing a total of $9.2 million in cash and in-kind support. The foreign exchange costs are less than 25% of the total grant funding and all dollar procurement associated with technical assistance, commodities, audit, and evaluation will be paid to suppliers/participants by the Mission. Financing of other project costs will follow the standard A.I.D. procedures for direct payment and reimbursement.

A detailed year-by-year budget is found in Annex D. Summary Project costs are estimated as follows.

Table 11: Summary Project Costs by Component, Source, Currency Type, and Total (U.S.$ millions)

COMPONENT	L/C	A.I.D. DLS	TOTAL	INCOME/ DONORS	TOTAL
ASHONPLAFA:					
Community Services	2.38	0.84	3.22	1.13	4.35
Social Marketing	0.31	0.33	0.64	1.51	2.15
Medical/Clinical	4.39	0.06	4.45	0.77	5.22
IEC	1.09	0.01	1.10	1.21	2.31
Training	0.66	0.00	0.66	0.14	0.80
Monitoring/Evaluation	0.60	0.02	0.62	0.50	1.12
Administration	1.85	0.06	1.91	3.64	5.55
Technical Assistance	0.00	2.30	2.30	0.00	2.30
Other Private Groups	1.10	0.00	1.10	0.28	1.38
TOTAL	12.40	3.60	16.00	9.20	25.20

B. Recurrent Costs

Complete assumption of recurrent costs by the implementing organizations by the end of the Project is not feasible given the nature of the services provided and the limited potential for full cost recovery. If contraceptive prevalence is to be increased to 60% (the replacement rate), external financing for family planning services will be needed at least to the year 2000.

An analysis of ASHONPLAFA's financial situation and cash flow projections for 1989-1994 was carried out by Price Waterhouse at the request of the Mission. The analysis confirmed that ASHONPLAFA's future is closely tied to continued A.I.D. support. Price Waterhouse recommended that ASHONPLAFA

reorganize its structure to allow for more efficient operations and the rational allocation of resources. They further recommended that sales and pricing policies be established to better control collections and improve income generation. ASHONPLAFA should study options for diversifying medical clinical services to make full use of underutilized physical plant. Finally, the analyst pointed out the need for ASHONPLAFA to broaden its donor base and to gradually change from an exclusive social welfare orientation to a cost conscious, market-oriented approach to providing family planning services.

Though the Mission recognizes that donor support to family planning efforts will need to continue beyond the life of this Project, language in the Cooperative Agreement to be signed with ASHONPLAFA will require specific performance levels in cost recovery and cost reductions to be reviewed on an annual basis. Use of the results of operations research under the Project will assure that efforts toward improved cost recovery will become institutional.

Part VI. IMPLEMENTATION ARRANGEMENTS

A. Selection of Implementing Agencies and Use of Cooperative Agreements

ASHONPLAFA was selected as the primary implementing agency because it is the leader in providing family planning services to Honduras. Its Community Based Distribution Program and the Commercial Social Marketing program account for 60% of the oral contraceptive market in the country. ASHONPLAFA's surgical contraception program is also quite extensive and accounts for more than 70% of voluntary sterilizations. The Mission has determined that ASHONPLAFA has the administrative capabilities and financial responsibility necessary to manage and implement the activities to be funded by A.I.D. ASHONPLAFA was registered as a local PVO by the Mission in March 1987. This registration is being updated to submit to A.I.D. Washington for approval of permanent registration.

A Cooperative Agreement will be signed for this Project with ASHONPLAFA which will have overall responsibility for the project activities with substantial involvement of USAID. The relationship between USAID and ASHONPLAFA will be one of collaboration and joint participation, particularly in monitoring activities and review of management processes to be carried out during the life of the Project.

A Cooperative Agreement will be negotiated with Plan early in the Project.

B. Implementation Schedule

A detailed schedule for the first year of project implementation follows which indicates activities which will continue through the life of the Project.

C. Procurement Plan

A procurement plan follows, indicating services and commodities to be procured, probable sources, and contracting procedures and responsibilities. Contraceptives will be purchased through the existing A.I.D./W purchasing mechanism. Other commodities will total approximately $200,000. All dollar purchases and contracting of services will be undertaken by A.I.D. The implementing organizations will be responsible for all local currency procurements following their own procurement policies and practices and in conformance with A.I.D. requirements.

The source and origin of all materials, equipment and services purchased with foreign exchange will have their source and origin in the United States or the Central American Common Market countries.

The Mission intends to comply with the requirements of the Gray Amendment to the maximum extent possible. However, since all technical assistance will be obtained through the use of Personal Services Contracts, buy-ins to centrally funded projects, and work orders under Indefinite Quantity Contracts, the opportunities for use of minority or small businesses will depend on previously competed contracts.

IMPLEMENTATION PLAN

PROJECT ACTIVITY ID

a) START UP
b) Contraceptive Social Marketing (CSM)
c) Information, Education, Communication (IEC)
d) Regionalization (Reg)
e) Community Services - community Based Distribution (CBD)
f) Community Services - Voluntary Surgical Contraception (VSC)
g) Evaluation (EVAL)
h) Administration (ADM)
i) All Activities (ALL)

Major Implementation Actions	Project Activity Identification	Responsible Party or Parties	Initiate Action	Complete Action
Negotiate and Sign CA with ASHONPLAFA	Start up	AID/ASH	May 1989J	June 1989
Issue Proj. Implementation Letter PIL No. 1 to ASHONPLAFA	Start up	AID	May 1989	June 1989
Contract Signed for L/T USPSC Advisor	Start up	AID/ASH	May 1989	June 1989
Contract Signed for L/T LHPSC Advisor	Start up	AID/ASH	May 1989	June 1989
Plan for S/T Technical Assistance during first year of Implementation Prepared and Completed	ALL	ASH	June 1989	June 1989
Technical Assistance from SOMARC for Social Marketing Program - PIO/T and Contract	CSM	AID	June 1989	July 1989
Sign Cooperative Agreement with PLAN	Start up	AID/PLAN	Aug 1989	Aug 1989
Construction of La Ceiba Regional Center Completed and Staffed	REG	ASH	In progress	June 1989
Construction of Sta. Rosa Center Completed and Staffed	REG	ASH	In progress	Aug 1989
Construction of Juticalpa Center Completed, Staffed and Equipped	REG	ASH	In progress	Nov 1989
Establish 310 new Distribution Posts	CBD	ASH	July 1989	Dec 1991

Major Implementation Actions	Project Activity Identification	Responsible Party or Parties	Initiate Action	Complete Action
Train new Distributors	CBD	ASH	July 1989	June 1994
Hire and Train 2 Promotors	CBD	ASH	July 1989	June 1991
Hire and Train 1 Supervisors	CBD	ASH	July 1989	June 1991
Procurement of A/V Material	CBD	ASH/AID	July 1989	Dec 1989
Medical Equipment procured at various stages of the Project. Procurement begins shortly after first obligation	VSC	AID/ASH	June/July 1989	Dec 1993
VSC and Lab equipment for Sta. Rosa	VSC	AID/ASH	June/July 1989	Jan 1990
Pilot Men's Clinic - Tegucigalpa	VSC	ASH	June 1989	LOP
Establish Incentive System	CBD	ASH	Sept 1989	Oct 1989
Evaluation of Men's Clinic	VSC/EVAL	ASH	Oct 1990	Dec 1990
Preparation of Communication Strategy (T.A. needed)	IEC	AID/ASH	July/Aug 1989	Sept 1989
Press and Radio Programming for CY 1989-90	IEC	ASH	July 1989	LOP
T.V. Programming for CY 1989-90	IEC	ASH	Oct 1989	LOP
Training Modules for Specific Groups T.A. needed	IEC	ASH	Nov 1989	LOP
Seminar for Jounalists, Opinion Leaders, Decision Makers, Commerce and Industry	IEC	ASH	Oct 1989	Oct 1989
Training/Observation Trips abroad for ASH IEC personnel 1st stage	IEC	AID/ASH	Sept 1989	LOP

Major Implementation Actions	Project Activity Identification	Responsible Party or Parties	Initiate Action	Complete Action
Production of Printed Materials	IEC	ASH	July 1989	LOP
Research on habits, behavior patterns, size and location of potential FP users	IEC/EVAL/ CBD/VSC	ASH	July 1989	Jan 1990
Research - Adolescent Behavior	IEC/EVAL/ CBD/VSC	ASH	July 1989	Jan 1990
Plan for IEC penetration of areas of traditionally low FP usage	IEC	ASH	Oct 1989	———
Contract w/Ad Agency signed	IEC/CSM	ASH	In progress	June 1989
Order lo-dose contraceptives for new product marketing	CSM	AID/ASH	May 1989	Nov 1989
Preparations for marketing new lo-dose produ ts - focus groups for name and packaging selection, promotion campaign, etc.	CSM	ASH	June 1989	Nov 1989
Perla/Guardian/Norminest advertising campaigns begun	CSM	ASH	July 1989	LOP
Training of Pharmacy Personnel	CSM/IEC	ASH	Aug 1989	LOP
Launch new lo-dose products	CSM	ASH	Jan 1989	LOP

PROCUREMENT PLAN

SERVICES	DURATION (MONTHS)	SOURCE CODE	PROBABLE SOURCE	CONTRACTING MODE/ PROCEDURES	PROCUREMENT/CONTRACTING RESPONSIBILITY
A. TECHNICAL ASSISTANCE					
1. LONG-TERM					
Population Liaison	18 months	000	Belcher	AID Direct/PSC	A.I.D.
Population Advisor	36 months	935	Miranda	AID Direct/PSC	A.I.D.
2. SHORT-TERM					
Social Marketing Spec.	8 months	000	SOMARC	AID/Buy-in	A.I.D.
VSC Specialist	8 months	000	AVSC	AID Central	A.I.D.
Communications Strategy	2 months	000	PCS	AID/Buy-in	A.I.D.
IEC Mats. Production	6 months	935	CREA	AID/Buy-in	A.I.D.
Training Specialist	6 months	000	PAC contractor	AID/Buy-in	A.I.D.
NFP Training Spec.	2 months	000	Georgetown	AID/Buy-in	A.I.D.
BF Promotion Spec.	2 months	935	Canahuati	PSC	A.I.D.
Ops. Research Spec.	1 month	000	Tulane(AVSC)	AID Central (AVSC)	A.I.D.
Ops. Research Spec.	15 months	000	LAC OR Contract	AID/Buy-in	A.I.D.
Survey Costs	N/A	935	FHI	AID/Buy-in	A.I.D.
Mgmt. Info. Systems	10 months	000	Enterprise	AID/Buy-in	A.I.D.

COMMODITIES	MUMBER OF UNITS	PROBABLE SOURCE	PROCUREMENT RESPONSIBILITY
B. COMMODITIES			
1. Audio Visual Equipment for Regional Centers (TV or Projectors, etc.)	18 sets	000	A.I.D.
2. Medical Equipment Vol. Surg. Contraception Laboratory	Various	000	A.I.D.
3. Contraceptives			
Condoms (Pieces)	5,272,344	000	A.I.D.
Pills (Cycles)	5,357,249	000	A.I.D.
VFT (Pieces)	347,763	000	A.I.D.

D. Evaluation and Audit Plan

This Project will be evaluated in a number of ways. First, routine quarterly reports from grantees and trip and technical reports from technical consultants will be read and analyzed by the Population Development Officer, the Population Liaison Officer, the Population Advisor, and/or the Finance Officer concerned with this Project. In addition, these individuals will visit field sites of the Project as part of their oversight responsibilities, and will assess progress and identify problems and potential solutions during such visits.

Annual audits will be performed of each Cooperative Agreement awarded as part of this Project, by an independent auditor acceptable to A.I.D. and the Cooperating Agency. The agreements this Project will buy into for technical assistance are audited regularly.

A mid-term evaluation will be conducted at the end of the second year of the Project, focusing on outputs to date, and needed adjustments in project design and planned outputs for the rest of the Project in order to achieve the project purpose and contribute to the sector goal. Possible shifts of resources between ASHONPLAFA and other groups will be considered at that time. This will follow the first of the two contraceptive prevalence surveys to be funded as part of this Project, so that if purpose level achievements are lagging, it will be possible to suggest remedies.

The Evaluation Department of ASHONPLAFA will collaborate with the Ministry of Health in conducting the 1990-91 and 1993-94 Contraceptive Prevalence Surveys and interim Rapid Surveys at the regional level. Technical assistance for these surveys will be provided by Family Health International. The two contraceptive surveys will take national random sample of women between the ages of 15 to 44. The 1990-91 survey will include a subsample of men to identify male participation in family fertility decisions. Consideration will be given to including a few questions relating to other child survival technologies, perhaps using questions developed by the Demographic and Health Surveys Project. These two surveys will measure project impact at the purpose level.

An evaluation will be undertaken during the end of the fourth year of the project to assist in the design of any follow-on efforts. It will focus more on the means to achieve the project purpose and the sector goal, the role of ASHONPLAFA and other project participants, and the outlook for private sector family planning in Honduras.

PART VII. PROJECT ANALYSES SUMMARIES

A. Technical Analysis

The Private Sector Population II Project composed of a three service delivery components and four support components within ASHONPLAFA, plus referrals and services to be provided by PVOs and other private groups, conforms to technically accepted methods of family planning implementation and as such was found to be technically sound. The following recommendations were made to USAID for consideration in designing this project.

1. Community Services Program

The Community Services Program of ASHONPLAFA is well designed to increase use of contraceptives, and is one of the best CBD programs in Latin America.

ASHONPLAFA should present A.I.D. with a detailed plan of how the Community Services Program will improve the performance of the distribution posts, over the current average of 36 users per post, and increase the number of distribution posts without a major increase in the number of promoters or costs. Operations research studies should be undertaken to improve services, but not used to delay introduction of important changes into the program.

A transportation option that should be considered is to allow promoters to purchase the vehicles that are assigned to them. This will vastly reduce the costs of maintenance, the life of the car is extended, and trying to control the use of the car during nonworking hours is eliminated. This option may be evaluated by an operations research study.

Any incentive program using cash awards should be initiated for promoters only. Distributors should be given performance recognition with certificates of recognition and social events that highlight the volunteers accomplishments.

The variety of products offered in the Community Services Program should be increased, however care should be taken to avoid differences in prices of the same contraceptives such that users feel some products are good while others are bad. Again, operations research may be useful regarding this question.

2. Social Marketing Program

The Social Marketing Program as described is technically feasible, will be cost effective, and is similar to experiences in other countries.

ASHONPLAFA should adopt a pricing policy so that the same product is sold at the same price under different ASHONPLAFA programs, even if SMP products are sold at a different price in the pharmacies.

3. Medical/Clinical Program

The Medical/Clinical Program described meets accepted medical standards for voluntary surgical contraception. In addition, the inclusion of the

Association for Voluntary Surgical Contraception to provide technical assistance will insure that the high quality of the services under this program will be maintained.

The increase in the number of procedures per day per clinic from the traditional three cases per day should be done gradually. It is not realistic to plan to increase to 8 cases per day immediately.

Costs estimated for the program at $70 per procedure appears to be high, given that other Latin American countries are reporting costs of $35 per procedure. Actual costs should be determined.

A policy of charging fees to the users of the VSC program should be instituted, with the condition that no patient be rejected for lack of ability to pay.

Provision of free transportation to clients must be approached with caution; it is possible to create a situation in which clients expect free transport to the clinic and will not make efforts on their own to come.

Project staff should exercise stricter supervision on private clinics subsidized by ASHONPLAFA surgical program in order to have the clinics provide temporary family planning methods.

All ASHONPLAFA promoters should promote all methods and refer clients to all ASHONPLAFA programs according to the client's choice and the recommended methods for the clients. Promoters should be properly trained for appropriate referrals.

Natural Family Planning should be introduced gradually, since it is normally a very expensive service to provide, due to the high number of visits per client needed to learn the method.

4. Information, Education, and Communication

The demand for services has to be differentiated from the felt need as expressed in recent surveys. Both A.I.D. and ASHONPLAFA should insure that a national campaign of information and education is established to promote family planning services, thus creating demand.

As part of the planning of activities under this Project ASHONPLAFA should submit to A.I.D. an IEC project for the duration of the Cooperative Agreement. The report on Information, Communication and Education presented by Ana Klenicki should serve as a useful instrument in the preparation of the project.

Although mass media IEC is important, person-to-person communication must not be neglected.

The IEC Department should maintain its promotional activities but commercial advertising agencies should be used for the Social Marketing Program. In addition, the IEC departments should be strengthened with observation visits and technical assistance to design the communications strategy.

ASHONPLAFA should consider utilizing the IEC materials already developed by neighboring FPAs, to save time and money in their development.

ASHONPLAFA should have a special office or officer in charge of the public relations of the Association vis a vis other organizations and the public, to improve the image created by the current attitude of isolation.

Contact with journalists might be an interesting field to explore in Honduras. Although Colombia had a rather negative experience with journalists, in that they were more interested in trips, congresses, and meetings than in promoting family planning services. This is an avenue that Honduras should attempt.

5. Monitoring and Evaluation

Reports from previous consultants such as Dr. Gabriel Ojeda and the Overall Program Evaluation from the IPPF mission must be carefully reviewed, all the recommendations studied, and a clearly defined plan for reforms and improvements of the Evaluation Department made. For this purpose, immediate action should be taken by the Executive Technical Council of ASHONPLAFA. The Association should request technical assistance from IPPF for the reorganization of the Evaluation Department, particularly in the field of service statistics and adapt it to the new electronic equipment now available to ASHONPLAFA. IPPF/WHR has a well known and recognized capability and experience in these fields and, with their technical input, the new information and data system will be compatible with information of the other federated associations.

6. Technical Assistance

The position of Project Liaison Officer has created controversy, since USAID considers it necessary and ASHONPLAFA considers it an imposition. ASHONPLAFA also argues that having a resident advisor will not enable them to develop the management, administrative and programmatic capacities required under the Cooperative Agreement.

There should be a formal request for TA from ASHONPLAFA before it is provided. ASHONPLAFA should specify the objective, the dates, duration, and the institution or persons who will provide the TA.

7. PVOs and Other Groups

ASHONPLAFA role in this component should be amply discussed between the involved institutions to clearly establish how much time of its personnel the Association is willing to divert to these activities, concurrent with the tremendous pressure generated by the new Agreement with A.I.D.

USAID should pay special attention to the private groups with which it is going to work in this Project, to avoid the experience of other countries

where a "demographic explosion" of private groups has occurred. Quite often the private groups were not broad-based, formal organizations but rather individuals with no infrastructure for the delivery of counseling and services in Family Planning and primary health care.

B. Social Soundness Analysis

Conclusions drawn from the social soundness analysis confirm that the Project design is in fundamental compliance with the major features of Honduran culture and traditions. After a quarter of a century of family planning leadership of ASHONPLAFA, the association is regarded as a genuine Honduran initiative led by a Honduran institution. The proposed Project is, moreover, in strict conformity with the stated policy of the GOH. The social analysts warns, however, that a number of sociocultural and policy problems do exist and need to be examined and addressed in project design.

The analysis found that the degree of acceptability of Project components has varied in the past with the socioeconomic condition of targeted populations and will, most likely, continue to do so in the future. Specifically, those most and best served by the Project are urban dwellers, and among rural beneficiaries by those with the most years of formal education. One reason for a low level of acceptability is the difficulty of the program in providing confidentiality for acceptors. Some data available on rural household incomes suggest that the ASHONPLAFA pricing schedules for rural families are beyond the financial means of rural women, many of whom receive only in-kind support from their spouses but not cash.

1. Major Assumptions

The analyst examined the assumptions on which the Mission bases its strategy for this Project and found that those related to family planning's positive effect on the health status of mothers and children and economic development and the need for external financing are correct. His review also showed that indeed Honduran couples desire smaller families and there is an unmet demand for family planning services. The project design assumes that the demand can be met by increasing the availability of family planning information and services. As previously mentioned, the issue of privacy and confidentiality could cause couples to hesitate to obtain the services they want and need. In this respect, the social analyst found that the inclusion of healthcare-providing private groups in the project design is exceptionally significant since these organizations can succeed in assisting many women with information and services on family planning in a context that does not identify them as family planning clients.

Further examining the validity of the Mission's assumption that the GOH will not reverse its support family planning policies, the analyst found that while the government's de jure policy record is an impressive one, its de facto commitment to implementing its policies is weak. At worst, and most probable, the GOH will continue to permit family planning activities to exist without significant support for the growth of those services within the public health system. This, of course, makes all the more important private sector delivery of services to Honduran couples who want them.

While the USAID decision to develop closer working relations with private organizations is an important one, given the preeminent of ASHONPLAFA in the field, it is appropriate to continue to deliver the larger share of funding to the Association. If the use of other private groups proves successful, then the PVO aspect of the Project could develop into a highly desirable competitive situation in which performance would determine the distribution of A.I.D. family planning resources.

Finally, the assumption that the greatest potential impact for reduced fertility will come from the increased use of contraceptives in rural areas was supported by the analysis.

2. Beneficiaries

The target group identified in the Project Paper is all women in union between the ages of 15 and 44 years of age. Men also are direct beneficiaries as users of condoms and acceptors of voluntary surgical contraception. The most important indirect beneficiaries are the children of mothers whose fewer and better spaced pregnancies will result in her improved physical health and improved health and chances of survival for the children themselves.

There are three basic demographic characteristics which ASHONPLAFA uses to characterize its beneficiaries. These are age, number of children, and years enrolled in formal education. The profile of the women in the couples who are beneficiaries of project activities is as follows.

Table 12: Beneficiary Profiles, by ASHONPLAFA Service Programs

Program	Median Age	Median Living Children	Median Education of Woman
CSP	25-29	2	primary graduated
SMP	N/A	N/A	N/A
MSP/Temp	25-29	2	secondary incomplete
MSP/VSC	30-34	4	primary incomplete

3. Sociocultural Feasibility

One of the most important concerns is the difficulty in reaching the poorest households in rural Honduras. Rural isolation is a major reason why access to the poorest sector of the population is so difficult. Coupled to the almost total absence of formal education, the task of enabling the rural poor to use family planning services is a challenge. The project design includes an increased number of promoters, distribution points, and transportation options for promoters. This will facilitate the reaching and training of volunteers during the dry seasons if proper maintenance of the motorcycles can be assured. Purchase of other vehicles is being considered for use in the rainy season.

ASHONPLAFA may have to review its pricing strategy to adjust to the realities of low rural cash incomes in order to permit the poorest sectors access to contraceptive products; this is of course in conflict with the idea that all prices within ASHONPLAFA should be the same for the same product, and will be considered as part of the management decisions setting a ration pricing policy agency-wide.

The need to assure confidentiality for the acceptor, especially in rural areas, can be met by improved selection and training of the CSP distributors. This in turn will require that in-service training of CSP promoters in client confidentiality so that they understand and can articulate its importance to the volunteer distributors. The positive role of private groups in this regard has already been discussed.

Finally, in reviewing whether religious opposition to family planning might be a serious constraint to project implementation, the analysis showed that criticism of religious groups towards family planning and ASHONPLAFA is less significant than generally believed by major donors.

C. Economic Analysis and Price Elasticities

The economic analysis confirms that the Internal Rate of Return (IRR) of the Project is sufficiently high to justify the investment of A.I.D. resources in expanding contraceptive prevalence. Standard methods of analysis were used in the economic analysis. Birth, health, consumption and education expenditures per person were calculated and multiplied by the estimated number of births and persons avoided in order to obtain a figure for total expenditures avoided.

The costs of the proposed Population Project were forecast and compared to the economic benefits which would be realized. Even with the net present values of costs and benefits of the Project discounted at a 12% rate, the benefits are about 2.5 times the costs. The IRR indicates that the Project would not be economically justified only if the discount rate reached a value of more than 31%. Thus, the social profitability of the Project is proven and the analysis supports a decision to implement the Project.

The consultant carried out an analysis of the price elasticities of various contraceptives in order to provide some guidelines for pricing policies. In summary, the results showed that price increases of 10% for condoms would reduce demand by only 2% whereas a similar price increase for two types of oral contraceptives would reduce utilization by as much as 20% to 30%. Further research in the topic of price elasticities and the efficiency of various contraceptive methods was recommended, and is planned as part of the operations research program.

D. Administrative Analysis

1. ASHONPLAFA

The administrative analysis assessed ASHONPLAFA's capabilities to execute the Project as designed. In addition, a financial review carried out by the Mission's Financial Analysis and Review Section (FARS) examined ASHONPLAFA's financial controls and disbursement procedures. Both reports give assurance of ASHONPLAFA's demonstrated ability to meet the basic implementation and reporting responsibilities and tasks assigned to it.

ASHONPLAFA was established in 1963 as a non-profit organization to promote family planning in Honduras. It is an affiliate of the International Planned Parenthood Federation (IPPF) and receives part of its operating funds from that organization. Other funding sources are member contributions and Association dues, income from sales of contraceptives and fees from services, and grants from United Brands, World Neighbors, Packard Foundation, and two ST/POP central projects, Enterprise and operations research. During the five-year Cooperative Agreement, ASHONPLAFA expects income from all sources to be about $21.5 million. ASHONPLAFA has been a recipient of A.I.D. funding since 1977. A large-scale Project was signed with ASHONPLAFA in 1985, significantly increasing levels of activities.

The governing body of ASHONPLAFA is the General Assembly from which a Board of Directors is selected. The Executive Director reports to the Board on a regular basis. Line functions are distributed among seven separate Departments: Administration, Evaluation, Personnel, Medical Services, Information Education and Communications, Community Services, and Social Marketing. ASHONPLAFA has two regional offices and three more soon to open, plus the Tegucigalpa facilities. An organigram is included as Annex I.

ASHONPLAFA employs 158 persons in a variety of functions to meet its needs for service delivery and support functions, 58 in the Central office and 101 in regional service delivery programs (of which 33 are in Tegucigalpa and 36 in San Pedro Sula). Among programs, 31 work on CSP, 3 on SMP, 40 in MCP, and 27 in the IEC department (including the VSC promoters, and training for persons outside ASHONPLAFA). Six persons work in evaluation and training, and 51 in administration, personnel, or senior management. All of ASHONPLAFA's senior staff and much of the second tier staff have many years of experience working in the organization. Staff turnover is not a problem. Some additional staff will be needed both for headquarters and the regional offices in order to implement the new program.

Service outlets include 1424 CSP distribution posts, to which 310 will be added during this Project, 910 Mandofer SMP outlets, to which an undetermined number will be added during this Project, and 6 regional clinics, which will achieve full use during this Project.

Up to the present, ASHONPLAFA has managed to deal successfully with expanded program levels without major changes in its organizational structure,

managerial practices or staffing levels. Nevertheless, if ASHONPLAFA is to manage this Project successfully, changes in organization and practices will have to take place. The analyst cited the need for a real continuing and workable pattern of delegation of authority, decentralized systems, increased communication and cooperation among Departments, redirection of the Evaluation Department, expansion of the IEC and Community Services Departments, and the establishment of a Public Relations Office.

The administrative analyst concluded that if the changes and adjustments suggested above are carried out, ASHONPLAFA has the basic management capabilities and organizational experience to successfully implement the Project. Technical assistance will be provided in the areas identified where organizational or procedural adjustments will improve ASHONPLAFA's performance in Project implementation.

ASHONPLAFA has a proven track record in financial management. The latest FARS report concludes that ASHONPLAFA's accounting systems, fiscal controls, and disbursement mechanisms assure the correct use of A.I.D. funds. Having found that ASHONPLAFA's long years of experience in handling A.I.D. funds has produced well developed systems, FARS had no major recommendations to make regarding ASHONPLAFA's financial management.

2. Plan en Honduras

PLAN operates in Honduras under the terms of Agreement No. 876 signed with the Ministry of Public Health in June 1976 and subsequently ratified in January 1977. It is non-sectarian and non-political and emphasizes the importance of the family and the community in all its programs. Its projects include potable water systems, school construction, nutrition education, agriculture, health, and community development. PLAN is mainly financed through contribution from Foster Parents, but all of its projects stress financial self-sufficiency—an important point in a Project that emphasizes cost recovery and cost efficiency.

In addition to the above, PLAN has demonstrated its ability and experience in working in close coordination with the MOH in support of existing programs in child survival, potable water and sanitation, as well as working harmoniously with other national PVOs. It has managed an AID Project in the past and therefore is familiar with AID procedures and documentation. It has a well functioning administration and infrastructure and substantial ability to plan, execute and evaluate projects.

PLAN has 105 employees of which 18 serve in administrative positions, five in program resources, 75 as field promoters, and seven as regional coordinators. The highest authority is the Country Director who is also the Director of the Tegucigalpa office and reports only to the International headquarters. PLAN's management describes its organization as essentially a field operation and sees little to recommend tight control by central office authority in the implementation of projects once they have been approved by the Director.

Taken together with PLAN's proven track record in Honduras, an analysis of PLAN's management practices revealed that they so clearly parallel AID project requirements that there is little doubt as to the capacity of PLAN to plan and execute the activities proposed for it under this Project.

3. Other Groups

These organizations have no health infrastructure, per se. On the other hand, the UNC has two training centers and six regional offices, they offer their members assistance in areas such as: cooperatives promotion and organization; cooperative-political education; legal and technical assistance in production and economic managerial training; development and implementation of educational and productive programs. It should not be an insurmountable obstacle to add family planning to this already existing infrastructure.

PART VIII. ENVIRONMENTAL CONSIDERATIONS

Under Section 216.2(c)(viii) of Chapter 22 of the Code of Federal Regulations, programs involving nutrition, health care or population and family planning services except to the extent those designed to include activities directly affecting the environment, are categorically excluded from the applicability of A.I.D. environmental procedures. An Initial Environmental Examination is not required and the Recommended Environmental Threshold Decision confirmed the categorical exclusion.

PART IX. CONDITIONS AND COVENANTS

The Mission has determined that the appropriate mechanism for funding the ASHONPLAFA and the Plan en Honduras activities is through Cooperative Agreements (CA). The Conditions and Covenants of the CA will provide for extensive programmatic oversight on the part of A.I.D. Periodic review of program implementation will include use of annual incremental funding to review the Grantee's progress under the Project thus linking satisfactory performance to continued funding decisions. ASHONPLAFA will be required to submit periodic progress reports and annual work plans for A.I.D. approval before proceeding with Project implementation. The results of joint monitoring, frequent consultations, and formal independent evaluations and audits will further facilitate the Mission's substantial involvement in Project implementation and oversight.

ANNEX A

ACTION MEMORANDUM FOR THE ACTING MISSION DIRECTOR

THRU: Peter Kranstover, Acting Director, O/DF

FROM: Margaret Kromhout, DF

SUBJECT: Approval of the Private Sector Population Program II (522-0369) PID Equivalent

DATE: January 4, 1989

ACTION REQUESTED: This is to request your approval of the subject PID equivalent and your authorization to proceed with development of the Project Paper.

BACKGROUND: In a memorandum dated July 8, 1988, the Agency's Procurement Executive stated his opinion that, for the purposes of a grant to a NGO, there needs to be a programmatic authorization (PP equivalent) and the obligating document (the OPG or OPCA). He further stated that "a PID equivalent is not necessary from our point of view, but we have no objection to it". However, given the size of the proposed project ($16 million in DA funds), the Mission decided that a PID equivalent document should be prepared for the project, though abbreviated in its format. On December 9, 1988, the Mission reviewed the Private Sector Population Program II PID equivalent. The following decisions and conclusions were reached during the review which was based on the issues paper prepared to serve as the agenda for the meeting (Attachment 1).

1. Compliance with Policy Guidelines

Because the PID made no mention of natural family planning (NFP) methods, the question was raised whether the project will comply with the legislative requirement that NFP be included in A.I.D. supported population activities. Several options for making NFP methods available to the beneficiary population were discussed at the review. The review committee decided that all policy requirements should be examined in detail during the intensive review period. Further, a description of the mechanisms for making NFP available will be included in the Project Paper.

2. Target Group

The project attempts to target the entire Honduran population of reproductive age, both male and female. The issue of whether it would be more cost effective to narrow the target group was discussed in the review. For example, should male surgical contraceptive services be dropped and resources concentrated on providing services to females in the 20 to 30 years age group? The Project Officer pointed out the desirability of encouraging the participation of men in family planning decisions and providing the broadest range of services as possible. Nevertheless, some activities under the Project will be centered on more narrowly defined subgroups. The definition of the general target group and the rationale

for targeting certain components to subgroups is now included in the PID. In the course of project implementation, decisions to suspend or add services or products will be based on operations research which will be carried out under the project.

3. Institutional Structure

During the Action Plan exercise, the Mission Director indicated a preference to involve other PVOs in providing family planning services. An illustrative list of PVOs surveyed in the preliminary design stage of this project will be included in the PP, and institutional analyses will be carried out for those organizations which have the highest potential for participating in the project.

To correct an omission in the PID, a brief explanation of the role of the GOH, especially the Ministry of Health, is now included.

4. Services, Products, Delivery Systems

Several technical issues in design were reviewed this section. The question of whether ASHONPLAFA should aim to increase the user base per distribution point, rather than the number of distribution points was discussed. It was concluded that efforts on both fronts will probably be needed. Concern was expressed over ASHONPLAFA's plans to raise prices for CBD products since the degree of price elasticity for those products has not been studied. Use of incentive programs and conversion of single purpose promoters to multipurpose promoters were two other design features that were discussed in the review. The review committee concluded that all these issues should be addressed during the intensive review period of project design.

5. Self-Sufficiency and Financial Management Capabilities

It was recognized that not all family planning activities can be expected to be self-sufficient. The PP will set targets for self-sufficiency determined by the final design of each component. For components not expected to achieve full cost recovery, the goal will be to cover an increasing percentage of operating costs. The PP will demonstrate how the amount of subsidy needed by implementing organizations will be reduced and how they will move toward greater efficiency.

The Mission has a recent evaluation, an independent audit, and other reports on ASHONPLAFA that all point favorably to the Association's technical competence and financial responsibility. Early in January 1989, the FARS division will have completed its review of ASHONPLAFA. The financial analyst reported that no serious deficiencies have been detected during the course of his review. It was decided that the design team will evaluate prior Mission studies and assessments, consolidate the findings of those documents, and draw conclusions for the institutional analysis section of the PP.

6. Project Budget and Obligation Method

The estimated total budget is over $25 million with $16 million coming from DA grant funds. The budget will be closely scrutinized, adjusted and refined during the intensive review period. DA funding from the Population fund are expected to be readily available.

A separate issue to be investigated during the budget review and final project design is whether it is legal and appropriate to pay ASHONPLAFA overhead versus operating costs and how the decision will impact on institutional objectives.

The review committee concluded that the use of a Cooperative Agreement is appropriate and a noncompetitive award could be justified. An ad hoc delegation of authority will be required from A.I.D./W for the Mission to sign the Cooperative Agreement due to its size. It was also decided that the PP should provide specific information on what constitutes the Mission's "substantial participation" in the project.

7. Other Issues, Concerns, Clarifications

A question was raised as to why a five year PACD was proposed. The Project Officer replied that A.I.D. was committed to population activities over the long term. Further, the duration of the project in no way limits our involvement which will certainly extend beyond the year 2000. The five year horizon represents a convenient time to measure progress and evaluate the impact of our interventions. Nevertheless, the design team will examine the timeframe for implementation and recommend an appropriate PACD.

Regionalization was presented in the PID as a project component. The review committee concluded that regionalization is a goal, as are self-sufficiency and increasing cost recovery. The design committee was instructed to include these goals in the PID as part of a strategy statement. In addition, a general description of the project and its main components have been added to the introductory section of the PID so that readers unfamiliar with family planning activities in general, and the specific experience with ASHONPLAFA, will better understand the concepts and mechanisms contained in the PID.

The review committee suggested that a short section on design strategy be included in the PID. The design team will include expert consultants contracted under an IQC and funded with PD&S which is available for population projects.

AUTHORITY:

In State 207299 dated June 29, 1988 on the review of the Honduras FY 1989-90 Action Plan, the Mission was authorized to review, approve and authorize the Private Sector Population Program II during FY 1989. It was noted in the same cable that M/SER clearance will be needed to delegate authority to the Mission to sign the two proposed cooperative agreements, one of which would be with ASHONPLAFA.

RECOMMENDATION: All the major issues were satisfactorily addressed in the project review and you should sign the PID facesheet.

APPROVE _____

DISAPPROVE _____

DATE 1/6/89

2656C 37-40

Action Memorandum to approve Private Sector Population II Project PID

Drafted: DF:MK-Mnout

Cleared: HRD:ASiegel
HRD:RHaladay 1/3/89
HRD:HReynolds
DF:PKranstover 1-4-89
ADMD:ESzepesy 1/5/89
CONT:RZelaya

ANNEX B

Life of Project
From FY89 to FY94

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK MATRIX

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOAL	MEASUREMENT OF GOAL ACHIEVEMENT		
Reduce the National Total Fertility Rate (TFR)	Reduce TFR from 5.6 to 4.7 - Reduce TFR for rural women from 6.9 to 5.8. - Reduce TFR among urban women from 3.8 to 3.0	Data from Contraceptive Prevalence Surveys (CPs) of 1991-2 and 1993-94	GOH will continue its pro-family planning stance. USG will continue support of family planning programs in its foreign assistance program.
PURPOSE	CONDITIONS INDICATING PURPOSE HAS BEEN REACHED		AFFECTING GOAL - PURPOSE LINKAGE
Contribute 50% of the increase in modern contraceptive use.	- Of couples in union, 40% in rural areas and 65% in urban areas are using a modern contraceptive, of which 50% will be doing so as a result of this program.	Data from the CYPs of 1991-2 and 1993-4.	- That other national groups, private and public continue to provide contraceptive services at the same ratio as a present. - That all groups providing contraceptive services continue to receive adequate funding for their programs. - ASHONPLAFA's present good image continues. - IPPF will continue to provide funding and contraceptives.

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OUTPUTS	MAGNITUDE OF OUTPUTS End of Project Status		
A. Community Services			
1. ASHONPLAFA services expanded, especially in rural areas.	1-1 Increase family planning service distributors by 310 posts, 295 of which are in rural areas.	ASHONPLAFA Quarterly Reports	IEC activities will motivate additional potential acceptance to use FP services.
2. Private Voluntary Organizations referring 90% of potential acceptors to nearest ASHONPLAFA service delivery post.	2-1 64-65,000 active users in 1994 1-2 Eight PVOs, all in rural areas, making referral of potential acceptors to MOH, ASHONPLAFA or other service providers.	Supervisor Reports Reports from PVO's	
B. Social Marketing Program reorganized and coverage increased.	1. Contract plan between ASHONPLAFA and Drogueria MANDOFER implemented. 2. Distribution network supplying 90% of pharmacies and other authorized prescription drug point-of-sales outlets. 3. Program providing 40,000 CYP in 1994. 4. 100% of operating costs (excluding product cost) being defrayed by program income.	Narrative Reports Quarterly Sales Reports from MANDOFER Sales Reports Financial Reports	College of Chemistry and Pharmaceuticals does not oppose importation of contraceptives by ASHONPLAFA. Present legislation continues with favor program activities.
C. Medical/Clinical Services			
1. Service Availability increased through the addition of three regional centers. 2. Private clinics and GOH hospitasl continue providing services at the same proportional levels.	ASHONPLAFA and private clinics providing 39-40,000 female VSC, 500 vasectomies and 12,00 acceptors of temporary methods. 81,589 citological examinations and 59,000 other laboratory examinations done.	Statistical Reports Supervisory Reporting Clinical Reports	Availability of funds Availability of a wide range of reversible methos to offer. Continued support of the medical school and the OB/GYN society. Continue support by Regional Health Directors of the MOH.

70

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
D. Information Education, Communication (IEC)			
1. Expansion and intensification of the Information and Education Programs.	1. 50 % of all educational efforts directed at rural target population.	IEC Division Reports	Church and other opposition groups are unsuccessful in discouraging use of modern FP.
	1-2 50 % of promotional efforts directed at rural target populations.	IEC Division Reports	Present atmosphere of acceptance of modern FP methods among the general public continues.
	1-3 25% of promotional activities directed at men to increase acceptance of male methods (condoms and vasectomies).	IEC Division Reports	
	1-4 Strategy for adolescents developed and in operation by 3rd year of project.	Written strategy completed	
2. Institutional Strategy for Communications established	2-1 Strategy defining and coordinating actions needed for communication activities supporting the service delivery division implemented.	Existance of Strategy Document	
	2-2 Advertising agency producing radio and TV spots, maintaining bellboards, developing newspaper advertising and press releases.	Observation and Reports	Attitude of media towards FP continues to be favorable.
E. Training			
Institutional Training	1. Training manual completed and in use. 2. Orientation for 310 new distributors. 3. Orientation for all distributors on CPS/SMP link-up.	Training Records	
	4. Two new promotors and 1 new supervisor trained formally and on the job. 5. Pharmacists' employees training program established. 6. Training provided to personnel of 8 PVO's. 7. Refresher training for all ASHONPLAFA personnel.	Supervision Reports	

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
F. Monitoring and Evaluation			
1. Management Information	1-1 MIS producing information for informed decision making on a timely basis. 1-2 System totally computarized.	Statistical Reports	
2. Operation Research Programs	2-1 OR aimed at improving a more efficient and effective internal work system. 2-2 Management decisions taken on basis of information generated by OR.	Observation Observation	
3. Program Evaluation	1. Evaluation directed at measuring institutional improvements in relation to stated program goals.	Evaluation Results	

INPUTS	LEVEL OF EFFORT (Budget)	MEANS OF VERIFICATION	ASSUMPTIONS
Activity	AID		
Technical Assistance	$ 1,900,000	Financial Reports	Timely Availability of AID funding
Contraceptives	$ 1,110,000	Obligation Documents	AID Funding
Other Commodities	$ 554,000	Annual Budget and Expenditures Reports	Income generations and other donor contributions total $9,100,000 over LOP.
Local Support Costs	$12,436,000		

10

ANNEX C

06-10

ASOCIACION HONDUREÑA DE PLANIFICACION DE FAMILIA

Tegucigalpa, F.M., 1 de junio de 1989

RECEIVED
USAID/HONDURAS
C&R UNIT
1 JUN 89 16 11

W/att

OFFICE	ACTION	INFO
MD		1
DMD		1
PLA		
EXO		1
EXC/P		
EXO/D		
EXO/PER		
DP		1
DF		
CONT		1
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FHU.J		
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DUE [illegible]		
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ATTACH		
INITIALS		

Señor
JOHN A. SANBRAILO
Director, Misión AID/HONDURAS
Presente

Estimado señor Sanbrailo:

Tengo el agrado de dirigirme a usted, con el propósito de solicitar formalmente la suscripción de un nuevo convenio entre esta Asociación y la Misión USAID, con el objetivo de llevar a cabo en nuestro país actividades educativas, informativas y asistenciales en Planificación Familiar, durante el período Julio de 1989 - Junio de 1994, de acuerdo a los componentes que se enuncian en el documento adjunto.

Es importante señalar, que tanto el convenio como la donación para ejecutarla, deberán considerar todos los rubros que nosotros planeamos en el presupuesto, en vista de que el fiel cumplimiento de las obligaciones financieras, operacionales y legales, es fundamental para el logro de los objetivos de los programas y de los fines institucionales.

Solicitamos se reconozca el pago de prestaciones laborales que corresponden al convenio No. 522-0286 que finalizará el 20 de Junio próximo: así como la reserva de fondos en el próximo convenio cuya suscripción estamos solicitando, con el fin de liquidar la obligación patronal de ASHONPLAFA con sus empleados a la terminación de ambos convenios.

Esperamos contar nuevamente con el apoyo de la Misión, para lograr nuestro empeño de contribuir al bienestar de la familia hondureña.

Cordialmente,

ALEJANDRO FLORES AGUILAR
Director Ejecutivo

DE-141/89

cc: Sr. Thomas Park

OFFICIAL FILE COPY

Calle Principal, Colonia Alameda — Apartado Postal 625
Teléfonos: 32-3225; 32-6449; 32-3959
Tegucigalpa, D. C., Honduras, C. A.
CABLE: ASHONPLAFA TELEX: 1395 APLAFAM
Oficina Regional: San Pedro Sula, Apartado Postal 829, Tel. 52-3072
Oficina Regional: Choluteca, Barrio Los Graneros, Tel. 82-0648

PLAN EN HONDURAS

(FOSTER PARENTS PLAN INTERNATIONAL)
DESARROLLO INTEGRADO - FAMILIA Y COMUNIDAD

Apartado Postal 41-C
Tegucigalpa, D. C.
Honduras, C. A.
Cable: "FOSTACHILD"
TEL. 32-4424

Tegucigalpa D.C. 16 de junio de 1989.

Sr. Francisco Zamora.
Oficial de Población
U.S. AID. Tegucigalpa D.C.

Estimado Sr. Zamora:

Por medio de la presente quisiera expresarle que es nuestra intención someter ante Ustedes una propuesta para obtener aproximadamente la cantidad de U.S. $ 320,000.00 que serían destinados a un proyecto de Espaciamiento de Embarazos y Promoción de los métodos de Planificación Familiar, en todas las comunidades donde nosostros trabajamos, este proyecto tendrá una duración de cinco años. La propuesta la estaremos enviando cuando nosotros recibamos la aprobación por escrito de nuestra oficina Internacional, ya que hemos sostenido conversaciones telefónicas con ellos y en pricipio están de acuerdo en que sometamos esta propuesta.

Aprovechando la oportunidad para saludarle y desearle muchos éxitos en sus actividades, me es grato suscribirme de Usted,

Atentemente,

Hubert Van Havel
Director Ejecutivo.

PLAN EN HONDURAS - DIRECCION -

CC: Dr. Raúl Gómez.
Arch.

14

ANNEX D.

PRIVATE SECTOR POPULATION II
522-0369

I. COMMUNITY SERVICES PROGRAM

		1989	1990	1991	1992	1993	1994	TOTAL
Personnel	L	92,199	193,618	203,298	213,464	224,136	117,673	1,044,388
Fringe Benefits	L	31,347	65,830	69,121	72,578	76,206	40,009	355,091
Per Diem	L	38,060	76,119	78,403	80,756	83,177	42,836	399,351
Contraceptives	D	67,208	143,826	152,454	160,075	166,478	86,570	776,611
Maintenance	L	28,505	35,254	33,505	46,860	34,451	10,300	188,875
Equipment	D	24,295	39,442	0	0	0	0	63,737
Promotion	L	3,306	28,384	31,106	23,758	23,889	0	110,443
Office Supplies	L	13,382	25,283	26,793	27,124	28,974	17,485	139,041
Customs Services	L	600	1,200	1,200	1,200	1,300	700	6,200
Incentives	L	11,162	23,439	24,611	28,191	30,834	16,188	134,425
Other Costs	L	375	750	800	800	800	400	3,925
AID Costs CSP		310,439	633,145	621,291	654,806	670,245	332,161	3,222,087
Income/Other Donors		123,831	231,100	234,564	214,503	220,750	104,299	1,129,047
Total Costs CSP		434,270	864,245	855,855	869,309	890,995	436,460	4,351,134

II. SOCIAL MARKETING

		1989	1990	1991	1992	1993	1994	Total
Contraceptives	D	40,368	47,772	93,304	99,416	52,870	0	333,730
Prom. & Advertising	L	132,706	77,132	73,189	19,602	0	0	302,629
AID Costs SMP		173,074	124,904	166,493	119,018	52,870	0	636,359
Income/Other Donors		92,467	291,406	303,423	338,759	330,183	154,171	1,510,409
Total Costs SMP		265,541	416,310	469,916	457,777	383,053	154,171	2,146,768

III. MEDICAL/CLINICAL PROGRAM

		1989	1990	1991	1992	1993	1994	Total
Personnel	L	179,114	376,240	394,947	414,694	435,428	228,590	2,029,013
Fringe Benefits	L	60,899	127,921	134,281	140,995	148,046	77,724	689,866
Per Diem	L	9,865	20,485	21,271	22,064	22,915	11,900	108,500
Equipment	D	9,600	4,800	0	9,000	0	0	23,400
Private Clinics	L	98,633	190,300	190,335	190,370	190,410	39,025	899,073
Office Supplies	L	4,754	9,101	9,433	9,726	9,608	6,820	49,442
Medicines	L	17,728	37,232	39,094	41,046	43,098	22,627	200,825
Medical Supplies	L	20,361	40,326	42,343	44,460	46,681	24,508	218,679
Maint. & Repairs	L	924	21,847	1,941	2,038	22,139	1,123	50,012
Promotor Meetings	L	2,617	5,491	5,765	6,053	6,356	3,337	29,619
Transp. Promotors	L	14,468	29,805	30,703	31,625	32,576	16,778	155,955
AID Costs MCP		418,963	863,548	870,113	912,071	957,257	432,431	4,454,383
Income/Other Donors		75,320	141,536	147,387	155,403	163,108	87,099	769,853
Total MCP		494,283	1,005,084	1,017,500	1,067,474	1,120,365	519,530	5,224,236

IV. INFORMATION, EDUCATION, AND COMMUNICATIONS

		1989	1990	1991	1992	1993	1994	Total
Personnel	L	10,350	21,735	22,822	23,963	25,161	13,210	117,240
Fringe Benefits	L	3,519	7,390	7,759	8,147	8,555	4,491	39,861
PerDiem	L	11,760	18,320	9,394	9,676	9,966	5,133	64,249
Mail & Communic.	L	1,410	2,905	2,994	3082	3,175	1,636	15,202
Office Supplies	L	965	1,200	1,236	1,273	1,311	675	6,660
Equip Manten.	L	3,500	2,300	2,369	2,440	2,514	1,294	14,417
A/V Equipment	D	1,158	3,460	309	318	328	169	5,742
Promo. & Adver.	L	55,000	113,300	116,699	120,200	123,806	63,760	592,765
Educ. Materials	L	23,000	47,380	48,801	50,265	51,773	26,663	247,882
A.I.D. Costs IEC		110,662	217,990	212,383	219,364	226,589	117,031	1,104,018
Income/Other Donors		99,019	202,259	207,940	222,769	229,254	245,371	1,206,612
Total Costs IEC		209,681	420,249	420,323	442,133	455,843	362,402	2,310,630

V. TRAINING

		1989	1990	1991	1992	1993	1994	Total
Personnel	L	13,472	28,291	29,706	31,191	32,751	17,194	152,605
Fringe Benefits	L	4,580	9,619	10,100	10,605	11,135	5,846	51,885
Per Diem	L	13,405	24,625	25,483	26,539	27,780	18,168	136,000
Trng. All Scv. Divs.	L	16,195	26,461	73,862	77,337	30,563	19,777	244,195
Educational Mats.	L	1,377	4,938	5,110	5,365	5,702	3,698	26,190
Equipment	D	500	0	679	713	758	492	3,142
Vehicle Maint.	L	675	1,265	1,310	1,375	1,462	948	7,035
Off. Supl./ Comms.	L	1,008	1,018	1,050	1,107	1,174	1,166	6,523
Other Costs	L	2,695	5,375	5,561	5,840	6,209	4,026	29,706
								0
A.I.D. Costs Trng.		53,907	101,592	152,861	160,072	117,534	71,315	657,281
Income/Other Donors		5,750	20,501	27,189	34,287	36,181	18,901	142,809
Total Costs Training		59,657	122,093	180,050	194,359	153,715	90,216	800,090

VI. MONITORING AND EVALUATION

		1989	1990	1991	1992	1993	1994	Total
Personnel	L	3,836	7,980	8,379	8,798	9,238	4,850	43,081
Fringe Benefits	L	1,304	2,713	2,849	2,991	3,141	1,649	14,647
Per Diem	L	13,793	37,315	27,669	39,960	23,846	15,474	164,057
Equipment	D	749	5,500	4,078	5,890	4,399	2,281	22,897
Vehicle Maint.	L	3,715	2,642	1,959	2,829	2,113	1,096	14,354
Off. Supl./Comm.	L	1,487	4,623	3,428	4,951	3,699	1,916	20,104
Data Process.	L	400	1,547	1,147	1,657	1,237	642	6,630
Evaluations	L	14,680	129,453	21,839	31,540	123,557	12,214	333,283
A.I.D. Costs Mon/Eval		39,964	191,773	71,348	98,616	177,230	40,122	619,953
Income/Other Donors		38,474	93,185	88,284	111,514	114,350	60,160	505,967
Total Costs Mon/Eval		78,438	284,958	159,632	210,130	291,580	100,282	1,125,020

		1989	1990	1991	1992	1993	1994	Total
Personnel	L	99,603	209,166	219,624	230,606	242,137	127,122	1,128,258
Fringe Benefits	L	33,865	71,116	74,672	78,406	82,327	43,221	383,607
Per Diem	L	2,758	5,516	5,792	6,081	6,385	3,352	29,884
Audit	L	0	4,200	0	0	0	0	4,200
Equipment	D	0	30,000	30,000	0	0	0	60,000
Mail/Communications	L	8,598	13,676	14,360	15,078	15,832	8,312	75,856
Spare Parts	L	0	0	300	315	331	174	1,120
Professional Fees	L	1,200	2,500	1,300	2,400	2,500	1,200	11,100
Printing	L	300	600	630	662	695	365	3,252
Janitor Services	L	2,100	4,200	4,200	4,410	4,631	2,431	21,972
Maintenance/Gen'l	L	6,472	14,473	14,571	15,335	16,031	8,282	75,164
Data Proc.	L	16,238	14,779	5,145	2,613	5,591	2,796	47,162
Office Supplies	L	1,125	2,250	2,363	2,481	2,605	1,367	12,191
Prom./Publicity	L	1,030	1,030	1,030	1,030	1,030	515	5,665
Insurance	L	0	5,150	5,600	5,700	6,000	0	22,450
Miscelaneous	L	737	1,300	1,365	1,433	1,505	790	7,130
Public Services	L	1,400	2,800	3,102	2,987	2,887	1,602	14,778
Transportation	L	250	600	600	600	650	330	3,030
A.I.D. Costs Mgt/Adm		175,676	383,356	384,654	370,137	391,137	201,859	1,906,819
Income/Other Donors		313,625	702,235	674,900	758,140	729,669	468,190	3,646,759
Total Costs Mgt/Adm		489,301	1,085,591	1,059,554	1,128,277	1,120,806	670,049	5,553,578
Total A.I.D. Costs		1,282,680	2,516,306	2,479,143	2,534,084	2,592,868	1,194,919	12,600,000
Total Other Donors		748,486	1,682,222	1,683,687	1,835,376	1,823,495	1,138,191	8,911,457
GRAND TOTAL		2,031,166	4,198,528	4,162,830	4,369,460	4,416,363	2,333,110	21,511,457

VIII. TECHNICAL ASSISTANCE

		1989	1990	1991	1992	1993	1994	Total
Pop Advisor	D	18,500	36,500	38,500	40,500	42,000	21,500	197,500
Pop Liaison	D	68,000	108,000	112,000	114,000	116,000	70,000	586,000
Oper. Research	D	4,000	30,000	25,000	20,000	15,000	5,000	99,000
SOMARC	D	30,000	60,000	35,000	40,000	20,000	10,000	195,000
PVO/OTHER GROUPS	D	0	150,000	150,000	100,000	0	0	400,000
Info/Educ/Comm	D	5,000	20,000	10,000	7,500	6,000	0	48,500
Mgt. Info. Systems	D	25,000	20,000	10,000	10,000	10,000	0	75,000
FHI Survey	D	0	55,000	28,000	8,000	55,000	5,000	151,000
Nat. FP G'town U.	D	0	23,000	0	0	0	0	23,000
Training Spec.	D	0	16,000	14,000	10,000	8,000	5,000	53,000
VSC Specialist	D	0	5,000	5,000	4,000	4,000	0	18,000
Comm. Strategy	D	0	20,000	10,000	0	0	0	30,000
Brst Fdng Prom Spc	D	5,000	5,000	5,000	4,000	3,000	2,000	24,000
Evaluation	D	0	0	175,000	0	175,000	0	350,000
Audit	L		10,000	10,000	10,000	10,000	10,000	50,000
A.I.D. Cost TA		153,500	558,500	627,500	368,000	464,000	128,500	2,300,000
A.I.D./AHPF Coop Agr		1,282,680	2,516,306	2,479,143	2,534,084	2,592,868	1,194,919	12,600,000
AHPF Inc/Other Donor		748,486	1,682,222	1,683,687	1,835,376	1,823,495	1,138,191	8,911,457
AHPF PROGRAM TOTAL		2,184,666	4,757,028	4,790,330	4,737,460	4,880,363	2,461,610	23,811,457

IX. PVO/OTHER GROUPS

		1989	1990	1991	1992	1993	1994	Total
Prog. Costs/PLAN	L	70,000	82,500	102,500	110,000	115,000	70,000	550,000
Pro Csts/Other PVO	L	70,000	82,500	102,500	110,000	115,000	70,000	550,000
A.I.D. Cost PVO/OG		140,000	165,000	205,000	220,000	230,000	140,000	1,100,000
PVO/OG Counterpart		35,000	41,250	51,250	55,000	57,500	35,000	275,000
Total PVO/OGs		175,000	206,250	256,250	275,000	287,500	175,000	1,375,000
A.I.D. GRAND TOTAL		1,576,180	3,239,806	3,311,643	3,122,084	3,286,868	1,463,419	16,000,000
COUNTERPART		783,486	1,723,472	1,734,937	1,890,376	1,880,995	1,173,191	9,186,457
PROJECT TOTAL		2,359,666	4,963,278	5,046,580	5,012,460	5,167,863	2,636,610	25,186,457

X. FOREIGN EXCHANGE/LOCAL CURRENCY ANALYSIS

	1989	1990	1991	1992	1993	1994	Total
FOREIGN EXCHANGE							
CSP	91,503	183,268	152,454	160,075	166,478	86,570	840,348
SMP	40,368	47,772	93,304	99,416	52,870	0	333,730
MCP	9,600	24,800	0	9,000	20,000	0	63,400
IE & C	1,158	3,460	309	318	328	169	5,742
TRAINING	500	0	679	713	758	492	3,142
MONIT & EVAL.	749	5,500	4,078	5,890	4,399	2,281	22,897
ADMINISTRATION	0	30,000	30,000	0	0	0	60,000
TECH. ASST.	153,500	558,500	627,500	368,000	464,000	128,500	2,300,000
TOTAL FX	297,378	853,300	908,324	643,412	708,833	218,012	3,629,259
LOCAL CURRENCY							
CSP	218,936	449,877	468,837	494,731	503,767	245,411	2,381,559
SMP	132,706	77,132	73,189	19,602	0	0	302,629
MCP	409,358	838,747	870,291	903,072	937,262	432,433	4,391,163
IE & C	109,504	214,530	212,073	219,046	226,260	116,862	1,098,275
TRAINING	53,407	101,591	152,185	159,358	116,778	70,821	654,140
MONIT. & EVAL.	39,215	186,273	67,270	92,726	172,831	37,841	596,156
ADMINISTRATION	175,676	353,356	354,654	370,137	391,137	201,859	1,846,819
TECH. ASST.	0	0	0	0	0	0	0
PVO/OTHER GRPS.	140,000	165,000	205,000	220,000	230,000	140,000	1,100,000
TOTAL L/C	1,278,802	2,386,506	2,403,499	2,478,672	2,578,035	1,245,227	12,370,741
TOTAL PROJECT	1,576,180	3,239,806	3,311,823	3,122,084	3,286,868	1,463,239	16,000,000

ANNEX E.1

COOPERATIVE AGREEMENT USAID/HONDURAS - ASHONPLAFA

PHASE I I

COMMENTS AND RECOMMENDATIONS

Gonzalo Echeverry, M.D.
Consultant
March, 1989

I INTRODUCTION

This report has been prepared following the order of the draft of the Project Paper for the Cooperative Agreement between the USAID Mission in Honduras and the Asociación Hondureña de Planificación Familiar, ASHONPLAFA. Some additional observations and recommendations on subjects not contemplated in the Project Paper, are inserted in the report or placed at its end.

The author acknowledges the full cooperation offered by the two involved institutions, as well as the kind attentions received from the personnel of both entities.

II PERCEIVED PROBLEMS

FAMILY PLANNING DEMAND

I agree with the seven suppositions adopted in the draft, and find them true, but I have to comment on the statement of the final sentence that "the areas of focus should be on the supply side of the equation", in the sense that nobody can be sure that there is in Honduras a strong demand of family planning services. When visiting different points of delivery of family planning services, urban or rural, clinical or community based, and finding those places almost empty; when all kind of efforts are made to increase the number of acceptors in the current family planning programs; when the prevalence of use of contraceptives is still under one half of the target population, one must conclude that there is not an actual strong demand for the services of FP. It is different to think in terms of an existent need or "felt need" -as it was said back in the 60s- for family planning in the hondurean population, that does not materialize itself in actual demand because of lack of information about the existence of FP, defined as how many children the couple wants to have, and when, provided that there is no impairment in the health of the mother or of the already existing children.

So, the focus will not be only in the supply side of the equation but both in the supply and demand sides, in terms of converting the felt need into actual demand. The fact that 60% of women in fertile age and in union wanted to space future children or limit them (National Epidemiology and Health Survey, Honduras, 1987) does not confirm that there is a "continuing unmet demand" for FP, but shows a "continuing unmet need" that can be converted into actual demand by an

adequate IEC activity, which is something different.

It is important to remember that the continuation rates in contraceptives depends on the amount of information received by the user, not only for VSC but for all methods. I finally quote the words of Dr. Jaquin Nuñez, Medical Director of the FPA: "Bring me the patients to the clinics, and I will take care of them".

#1 Recommendation: Both AID and the Family Planning Association should give due attention to the establishment of a nationwide IEC campaign to promote family planning and create actual demand. As a part of the planning for its activities under the new agreement, the FPA should submit to AID a detailed IEC project for the duration of the cooperative agreement. The report on IEC by Ana R. Klenicki (Dec. 1988) could be a very interesting instrument for the preparation of the proposal.

TABLE 2. CONTRACEPTIVE PREVALENCE

Just a short comment on the difference in the percentage of increase in prevalence from previous surveys: 49% between 1981-1984, and only 30% between 1984-1987, that may be explained by the facto that the lower the prevalence, the easier the recruiting of users for a program, provided there is a good IEC campaign.

PRIVATE DOCTORS

In regard to the physicians who provide VSC services in their private clinics and do not have temporal contraceptives available for women who for some reason do not have VSC, the case has been discussed with the Head of the Clinical Dept. of the FPA.

#2 Recommendation: A closer supervision of the private clinics that perform VSC under contract with the FPA should be made, to ensure that a good provision of temporary contraceptives is available and offered to the users who don't have sterilization.

REFERENCE OF USERS FROM CBD PROGRAMS TO AQV

The anecdotal information about some clients of the community services who, after 35 years of age are not referred to VSC and are kept in the CSP under orals, was discussed as well with the head of the CSP DEpt. The discussion and related recommendation are presented in page recommendation #18.

TABLE 4 - PROJECTION OF COUPLE YEARS OF PROTECTION (CYP) AND VSC PROCEDURES

#3 Minor recommendations:

-81'

a). Please, make clear that the column for 1994 corresponds only to the firs half of the year, make the necessary adjustments, fill the blanks in the line for "clinics" and revise the whole table jointly with the FPA;
b). I don't see the reasons to include the projections for the PVOs and Employee-based family planning in the agreement with ASHONPLAFA, since they are having their own Cooperative Agreement;
c). When referring to the Community Services Program, use a constant acronym, CSP, in stead of CSD or, in Spanish, PSC;
d). In the paragraph that follows Table 4, after mentioning "new approaches through PVOs, community doctors, and employee-based FP services, it should be stated that these are not FPA programs but are part of a separate agreement.

LIAISON OFFICER FOR THE PROJECT

"ASHONPLAFA's Executive Director will appoint a Deputy Director..... who will act as a counterpart to the USAID Project Liaison Officer (PLO)".
a). The Deputy Director has been already appointed and taken office, and her responsibilities are not to be the counterpart of the PLO of USAID, but a support to the Executive Director and a liaison element with AID if the FPA considers it appropriate;
b). The position of a Liaison Officer of AID within ASHONPLAFA has generated plenty of controversy. USAID considers it necessary to provide the APF with technical assistance, so that complete programs and budget planning is done at central and regional levels. The FPA thinks that under the new Cooperative Agreement a liaison officer will not be necessary. Obviously, it is accepted that USAID has full right to have the necessary personnel for the follow-up of the project, as well as for offering technical assistance whenever requested by the FPA. but this should be an internal officer in AID offices and not a resident AID advisor inside the FPA premises. Once again, ASHONPLAFA accepts that AID has the right to have that position, and that it can be useful for the accomplishment of the agreement, but they argue that if there must be a permanent observer of AID inside the Association, they will never have the opportunity to develop their own managerial and programmatic capabilities, which is one of the main objectives of the present Cooperative Agreement.

#4 Recommendation: To settle the issue of a permanent advisor of AID in the FPA, the two parties should meet and after a friendly discussion, come to an agreement on this point, based on the liberty of AID of having the officer for the project, who will work from his office in AID quarters, and in the usefulness and convenience of an officer for liaison and technical assistance upon request from the FPA.

SV

III COMMUNITY SERVICES PROGRAM (CSP)

UNITS OF PERFORMANCE

"....ASHONPLAFA proposes to increase the users (CYP)..."

#5 Recommendation: That all along this Cooperative Agreement and in all documents, projections, statistics or any activities related to it, the unit "Couple Years of protection" (CYP) be exclusively used by USAID or ASHONPLAFA, in order to avoid confusion or misunderstandings. It is understood that there are cases in which it will be necessary to refer to VSC or IUD methods by number of procedures rather than by CYPs.

TABLE 5 In the column for 1984, the actual percentage of change is 2.6% and not 14%

TABLE 6

#6 Recommendation: To discuss and agree with the FPA the most real and viable projections of program performance for the years 1989-1994, since the figures have been changed three times in one week.

INCREASE OF CSP

Regarding to the mechanisms to face the projected increase in the performance of CSP, the document considers the establishment of new distribution posts over the already existing ones, assuming a current average of 36 users per post, with the corresponding increase in the number of promoters. However, to increase the number of distribution posts it is not essential to increase the number of promoters in the same proportion: many of the existent promoters can open new posts if the CSP adopts the policy of leaving the old and well established posts work by themselves or, at least, with much less activity of the promoter, so that the latter will have the time to explore new areas and open new posts.

On the other hand, the increase in the number of users can be achieved not only with more distributors and promoters, but by improving the average of the current posts, as well. It is understood that the two mentioned mechanisms can work together in a parallel way and do not exclude each other, as it is the intention of the FPA.

#7 Recommendation: ASHONPLAFA will submit to AID a detailed plan to improve the performance of the distribution posts of the CSP, over the current average of 36 users per post.

TRANSPORTATION OF CSP PERSONNEL

As to the transportation options to provide supervision by promoters, i. e. FPA four wheel drive vehicles, motorcycles and/or contracts with local taxi cooperatives, I have some experience with the first two but, due to the extremely ample variations in each country or in each region of the same country, I do not feel sure to particularly recommend one of them. However, I can inform that in regard to 4 wheel drive vehicles and motorcycles, it proved far better to sell them to the promoters in favorable conditions of price and terms of payment, and contract with them the transportation on a basis of an agreed rate per kilometer according to pre-determined travel schedules. This substantially reduces the costs for maintenance, prolongs the life of the vehicles and eliminates the problem of the control of the use of the vehicles for personal activities or in non-work time. It is important to point out that ASHONPLAFA is in the way of initiating two Operation Researches on this subject.

INCENTIVES

As any institution, the FPA may have a personnel policy that contemplates incentives or any types of performance recognition for its employees. As a matter of fact, the FPA currently has a plan for incentivation of the CSP personnel at all levels, and it is intended to improve their motivation. There is also an incentive plan for the voluntary distributors. In this regard, the CSP must be particularly cautious not to give the idea that the program is "buying" the conscience or the good will of the volunteers. Preferably, the recognition can be made in the form of certificates, distinctions, medals, parties, or modest gifts, rather than in money. Naturally, incentives of any kind should be never considered for users.

VARIETY OF METHODS AND PRODUCTS OFFERED

"the range of products available at the distribution posts will be increased." This is an already existing plan n the FPA to increase the range of products offered in the CSP, through two different ways: a) distribution and sale of the contraceptives of the Social Marketing Program, and b) addition of new health products of popular use and demand, that will be purchased with the revenues of the current CSP. I think this will be a good innovation in CSP for improving the confidence an interrelationship between the users and the FPA.

#8 Recommendation: That the CSP includes new items for distribution in its posts, provided that if different brands of the same contraceptive are sold, all of them should have the same price to avoid confusion in the public regarding to whether the program is offering "good" and "bad" products or methods.

QUESTIONS FROM THE CONSULTANT's SCOPE OF WORK

a). The design of the CSP in ASHONPLAFA is fully consistent with the existing body of knowledge regarding the use of community distribution networks for increasing contraceptive average. Even more, is one of the top CBD programs in Latin America. Obviously, as considered above, improvements can and should be made.

b). The Operation Research proposed for increasing CYPs and lowering costs are worth the inclusion in the project, as long as they are not taken as a pretext for delaying the initiation of positive changes in the program;

c). The question about incentives has been answered right above.

IV CONTRACEPTIVE SOCIAL MARKETING (CSM)

PRICES POLICY

I have already recommended for CSP the policy of equal prices for different brands of same contraceptive; in the same order of thinking, I find inconvenient to have different prices for the same article in different points of delivery of the FPA: in other words a given article should have the same price either in a CSP distribution post of ASHONPLAFA or in a clinic of the FPA, whether in urban or rural areas, not to create the idea of internal competition of prices. It is different when the same contraceptive is sold by a pharmacist through the CSM program, since the pharmacy is not owned by the FPA, there is no internal competition, and CSM is a commercial activity oriented to keep contraceptives at low prices and to generate some income for the FPA and, therefore, the prices in CSM are more subject to the alternatives of the market than the internal prices in the FP programs of the FPA.

#9 Recommendation: To establish a policy of equal prices for equal products within the family planning programs of ASHONPLAFA.

COST-EFFECTIVENESS OF CSM

Under the new structure, it is expected and expectable that CSM will cover operating costs in its fifth year of operations. It is different from the case of Drogueria Nobel since the latter was always very far from self-sufficiency for two reasons: a) DN was intended to be a nationwide organization for the distribution of four to six products in competition with other Droguerias that distribute over 600

products each; b) the over-generous amounts of money put in Drogueria Nobel that made self-sufficiency even more remote.

URBAN - RURAL CSM?

Although the paragraph stating that CSM was basically oriented to urban low-class couples that can afford the purchase of CSM contraceptives, was deleted from the Project paper Draft, it is yet important to insist that the character of urban or rural is not an indicator of economic status of people and that there can be poorer people in the cities than in the countryside, hence the need for CSP distributors in urban marginal areas, even in the case that some overlapping of the two programs could eventually occur.

#10 Recommendation: To reword paragraphs 3 to 5 of the section F (Social Marketing) of the draft of the project paper so that they have a more clear meaning.

QUESTIONS FROM THE CONSULTANT's SCOPE OF WORK

Although I have no expertisse in Social Marketing, the experience in the management and observation of FP programs has shown me that the answers to the questions raised in the scope of work about CSM programs of ASHONPLAFA regarding to 1) technical feasibility of a model with commercial and CBD distributors; 2) cost-effectiveness of the model, and 3) experiences in other countries, should be answered in a positive sense. As for question No. 1, the only important observation is that CSP distribution posts should be just additional outlets for CSM, that CSP will not be the administrator of CSM, and that none of the two programs will be a branch or a part of the other. Collaboration but not interdependence.

For more details, please see the SOMARC report of December/88 on the CSM program of ASHONPLAFA, by Santiago Plata and Juan Manuel Urrutia.

V CLINICAL SERVICES

On clinical services, the project draft deals only with Voluntary Surgical Contraception; for better understanding, the projections and targets of the project should be made for all methods delivered by the Medical-Clinical Dept., although no funded by AID.

The first paragraph of the draft is not clear in regard to the time when six clinics of the FPA will be operational. Is

it before the current (first) stage of the project ends (June 1989) or before the end of the second stage (June 1994)? Or when?

TABLE 6, VSC PROJECTIONS

Different opinions were found about the figures in Table 6, and it must be defined whether the projections include private clinics under contract with ASHONPLAFA, Government Hospitals supported by the FPA in their programs of VSC (AID doesn't want to include them in the present project because financial support is being given to the MOH), or not.

#11 Recommendation: To discuss and agree with Dr. Joaquin Nuñez about the projections and goals for the FPA during the validity of the agreement, not only for VSC but for all clinical methods offered by ASHONPLAFA.

CAPACITY OF THE FPA FOR VSC PERFORMANCE

I agree in the feasibility of assigning to surgical contraception three of the four contracted medical hours in the ASHONPLAFA clinics, but I am not sure whether it will be possible and practical to try to reach in three hours an average of eight VSC procedures, since there are many variables different from the time of the surgeons, that influence the output of a surgical unit. Among them, the number and skills of the auxiliary paramedical personnel, a stock of surgical instruments for at least 8 minilap sets, space enough for the recovery of 8 patients (especially in ASHONPLAFA where general anesthesia is a current procedure) and, the most important, enough demand for the method in the respective areas and clinics. Where there is money, it is not difficult to build up a facility for 8 VSCs a day; but even if there is money the development of the demand will take an impredictable lapse of time, so that it is not realistic to project an average of 8 daily cases during the duration of the agreement. It makes more sense to think that for a given clinic, no more that the traditional 3 cases per day should be projected for the first year after the opening of the services, and then, depending on the demand, add one or two daily cases each year until the goal of eight is gradually reached.

this isn't appropri

FUNDING PROTOCOL FOR VSC

"For the first year, AID will make up 100% of the difference of cost per procedure, after the amount recovered is deducted. Each subsequent year, the cost per procedure will be reduced." Once again, it doesn't look realistic that the absolute costs of VSC procedures will be reduced each year 10% of the cost of the previous year; it is true that a larger volume of procedures may lower the unitary costs but, on the other hand, devaluation will not permit the reduction

87

and, in the best of cases, the absolute costs might be kept stable.
The recovery of part of the costs from fees charged to the users is something different. In spite of the unfortunate policy of giving all services for free, that has been followed in Honduras for years, I still think that an effort could be made to initiate a change in this policy and try to recover something from the patients. I accept that it will take time and generate some problems, but it is high time to begin with a new policy of recovering part of the costs, especially in VSC. Most Latin American Countries have succeeded in their efforts to charge some fees in the VSC programs, and the only difference with Honduras is that others have tried and Honduras has not.

#12 Recommendation: The establishment in ASHONPLAFA of a policy of charging fees to the users of the VSC program, on the basis that no patient will be rejected for lack of money.

TRANSPORTATION OF VSC PATIENTS

"FPA will explore the feasibility if arranging transportation for women in remote rural areas as a way to assuring equal access to all services." The APF is already trying some different approaches to the problem in its clinic of Choluteca, with the idea of expanding the solution, if found, to other clinics. My only comment in this regard is that one must be careful in providing this type of services to poor rural communities, because of the risk of creating in the people the custom of receiving everything for free and make not the least contribution (be it transportation) to the solution of their problems. The case of the CBD/VSC program in El Salvador is a good example: CBD provided plenty of first class transportation for VSC patients to the surgical centers; but when this service had to be finished because of the extremely high costs, the rural people were already used to free transportation and didn't come anymore to the clinics unless the vehicles of the VSC program were transporting them again.

QUESTIONS FROM THE CONSULTANT's SCOPE OF WORK

a).- In my opinion, the proposed medical-clinical program is in full accordance with the accepted medical practice in VSC. The fact that the medical director of ASHONPLAFA is Dr. joaquin Nuñez, who has been in close contact with AVSC since its initiation, and who was chairman of the International Project of AVSC for a two years period, is a guarantee for the quality of services. Besides that, the Cooperative Agreement states that AVSC will provide periodic supervision of the program.

b). It is difficult to establish the level of the cost of the VSC services in Honduras, in relation to the costs in other Latin American Countries. Lacking a direct knowledge of the matter, I inquired for figures in the Regional Office of AVSC in Bogota, Colombia, and I was told that the only documented figure they have is a study made in PROFAMILIA, Colombia, in which it was found a cost of US$35 per procedure; besides that, the Regional Office of AVSC works with an estimated figure of US$30-35. Comparatively, the costs of ASHONPLAFA estimated at US$70 per case of VSC, are quite high.

#13 Recommendation: That AID and ASHONPLAFA make a joint study of the actual costs of AVSC in Honduras, in order to be able to make more realistic budgeting and projections.

FINAL REMARK ON CLINICAL PROGRAMS
In the Program Paper Draft there is no mention of the services with reversible methods provided by the clinics of ASHONPLAFA.

#14 Recommendation: In order to have a complete overview of the FPA activities, all the program aspects of the temporary clinical methods should be considered in the agreement, with projections and goals proposed by ASHONPLAFA.

VI "NATURAL FAMILY PLANNING"

It looks like it is a policy of AID to include "natural" methods in the FP projects and that, although this is not considered a reliable way to do family planning, its inclusion into the programs could serve to build up an image of comleteness and respect for other ways of thinking.

#15 Recommendation: If it is necessary for political reasons, "Natural FP" should be included in the programs of ASHONPLAFA, starting with the training of personnel and with the establishment of a pilot program that could be eventually extended to other services according to results. "Natural methods" extremely costly in terms of time of the IEC personnel, and ASHONPLAFA is already overloaded with the commitments of the Cooperative agreement to waste time and efforts in "natural family planning".

VII INFORMATION, EDUCATION, COMMUNICATION

"The new project will place heavy emphasis on an integrated mass communication strategy to increase awareness of ASHONPLAFA as an organization as well as to increase (create?) demand for its services." I agree, on the condition that the IEC work of promoters and education personnel of the programs will not be neglected, and that the growth of the mass media communication not be made at the expenses of personal IEC. Mass media should be taken as an important complement, but not a substitute for personal communication in all contraceptive delivery programs: Clinical, CSP, AQV, CSM.

"The IEC Dept. will assume responsibility for product advertising associated with the CSM effort." I do not agree. IEC activity in FP programs is for information and promotion and creation of demand for FP as a social and public health activity. CSM is a strictly commercial program managed by businessmen, and thus requires a strictly commercial type of advertising that cannot be made by IEC communicators but needs the services of professional publicity agencies, in the same way that a professional advertising agency will do not a good job in the promotional activity or in the preparation of IEC material.

#16 Recommendation: The IEC Dept. of the FPA should be strengthened through observational trips and technical assistance to carry out the communication strategy, both personal and mass media, and a professional advertising agency will be hired for the CMS commercial publicity but not for promotion of FP.

 # 17 Recommendation: When possible, the FPA should consider the utilization of the IEC materials developed by other neighboring FPAs, particularly Guatemala, and should purchase, adopt and/or adapt the already existing useful materials, in order to save time and resources trying to create what has already been developed. Same for the training and updating of its IEC personnel.

<u>AQV PROMOTERS OR FP PROMOTERS?</u>
Since the Overall Program Evaluation and Management Audit (OPE/MA) carried out in ASHONPLAFA in November/88, I have been against the idea that a promoter of a FP program should promote one single method, AQV, for the following reasons: a) Promoters should promote FP as a whole and inform the clients about all the methods available in the programs; b) promoters should work for the FPA and not for a particular Dept. or program; c) the reason for a promoter not having

interest in referring clients to other Depts. because he/she has to meet a pre-determined goal, is not valid since the referral can easily be credited to the promoter performance for goals purposes; d) the diversification of promoters means duplication of activities (i.e. costs) in a given area.

#18 Recommendation: All promoters in the FPA should promote all methods and refer the clients to all departments according to the choice of the client or the most suitable method for each case. All promoters must be trained for this purpose, and the referrals will be credited for the accomplishment of goals.

PUBLIC RELATIONS

During the mentioned OPE/MA of 1988 I commented about the isolationism of ASHONPLAFA in regard to other institutions, particularly the Ministry of Health, United Nations Development Program and the big private enterprises for social action or industrial activity. Now, I would like to go a little further:

#19 Recommendation: ASHONPLAFA should have a special office or officer in charge of the public relations of the FPA vis-à-vis other important organizations, to improve the image created by the current attitude of isolationism.

QUESTIONS FROM THE CONSULTANT's SCOPE OF WORK

They are answered in the text.

CONTACTS WITH JOURNALISTS

This might be an interesting field to explore in Honduras. I don't want to be negative when I comment the rather unhappy experience we had in Colombia when in multiple occasions the FPA tried to have meeting and different ways of motivating journalists to write and make some social publications about FP; almost nothing came out of this effort and the journalists paid more attention to trips, congresses and meetings than to family planning promotion. Nevertheless, I consider it worth trying.

VII MONITORING, EVALUATION AND STATISTICS

"ASHONPLAFA's consultants routinely comment about the absence of data with which to understand the functioning and performance of the various components of the program and its interrelationship to cost data." These opinions are particularly stated in a report by Dr. Gabriel Ojeda (1987) and in the already quoted OPE/MA report of Nov. 1988; in

these documents and regarding to this field, there are plenty of recommendations that have not been implemented yet. I think it isn't worth to repeat what I wrote in the OPE report since the comments and recommendations are still valid. During the present visit, the situation was openly discussed in ASHONPLAFA with the Executive Director and the Assistant Director, the Head of the Department and the Technical Council, and in all instances the FPA admitted the existence of the problem and expressed its will to tackle it. One of the arguments raised as a reason for not having re-structured the Department was the stage of transition of the collection and processing of service statistics data from the manual to the electronic system. Everybody knows the difficulties and problems faced by the FPA with the technical assistance and the establishment of the new and modern Management Information System but, in my opinion, this is not a completely valid reason. If there is a "political will" to tackle the problem of the data in the FPA, the immediate and necessary action should be taken.

20 **Recommendation:** The reports from Dr. Ojeda and the OPE/MA mission must be carefully reviewed, all the recommendations studied, and a clearly defined plan for reforms and improvement of the Department made. For this purpose, immediate action should be taken by the Executive and Assistant Directors, the Head of the Department and the Technical Council of ASHONPLAFA: the formers to order and direct the implementation of the necessary methods; the second, to insist before the formers on a quick solution. and the latter to ensure that the solutions are convenient and fit with the needs of the Association.

#21 **RECOMMENDATION:** As soon as possible, the FPA should request from IPPF/WHR the necessary technical assistance for the reorganization of the Department, particularly in the field of service statistics, and adapt it to the new electronic equipment now available in ASHONPLAFA. IPPF/WHR has a well known and recognized capability and experience in these fields and, with their TA, the new information and data system will be compatible with the information of the other federated Associations.

Finally, in regard to the special interest manifested by USAID in the establishment in the FPA of a correct and opportune service statistics, as well as for evaluation and research, the two quoted reports have all the recommendations that I could make in this field.

IX FAMILY PLANNING IN THE PRIVATE SECTOR

Two chapters on FP programs with the private sector are found in the Project Paper Draft: one deals with Technical Information on Population with the Private Sector (TIPPS) and is based on bringing the big industrial enterprises of the North Coast to the conviction of the economic profit they will have if they offer FP to their employees; the other, through Enterprise Project, to include FP as a part of the activities on infant survival in the Private Voluntary Organizations (PVOs). Although it looks like these two projects are not part of the Cooperative Agreement between USAID and ASHONPLAFA, the paper draft makes insistent mention of the participation of the FPA with the delivery of services, while the PVOs will carry out the promotion activities and will refer the users to the health centers of the MOH or to the FPA clinics. Furthermore, the project counts on the FPA to do the training of the personnel of the PVOs.

#23 Recommendation: The part of ASHONPLAFA in these projects will receive ample discussion between the involved institutions to clearly establish how far the Association is willing to distract the time of its personnel in these activities, coexistent with the tremendous pressure generated by the extension of the AID agreement.

#24 Recommendation: USAID and/or its technical agency, Enterprise Project, should pay special attention to the PVOs with which they are going to work in this project, to avoid the experience of other countries where a "demographic explosion" of PVOs has occurred. Quite often the PVOs are not real organizations but individuals with no infrastructure at all for the delivery of counseling and services in FP and primary health care, and that look as if they were more interested in a share of the generous budgets that usually come with this type of projects.

X TECHNICAL ASSISTANCE

"The SOMARC project will give the TA to de Social Marketing Project, and the Population Council will help in the Operation Research. TA will also be needed for the Management Information System, communications, logistics, and National Prevalence Survey." Everybody agrees in the need for technical assistance to enable the FPA to face the responsibilities originated by the new Cooperative Agreement. In this regard, I quote once again the OPE report of 1988

where this need is discussed jointly with the importance of the fact that TA be requested by the FPA, who will determine when and for what the TA is needed and, in some cases, the institutions or persons who will act as advisors or consultants. If AID considers that the FPA needs some assistance not yet requested by the Association, the Liaison Officer will discuss the need with the FPA and obtain a formal request for it.

#25 Recommendation: Before hiring TA, there must be a formal request or approval from ASHONPLAFA, who will determine the specific object of the TA, the dates, the duration, and the institution or person(s) who will provide the TA.

Gonzalo Echeverry, M.D.

Apartado 89313

Bogota, Colombia

March 20, 1989

MEMORANDUM

TO: Anita Siegel, USAID/Honduras

FROM: J.J. Pansini, Consultant/URC

SUBJECT: Project Social Analysis

PROJECT TITLE: PRIVATE SECTOR POPULATION: PROGRAM II

EXECUTIVE SUMMARY

The social analysis focuses on the major program components of the Project identified in the PID: these are the Community Service Program (CSP -- known in the present Project as CBD, Community Based Distribution); the Contraceptive Social Marketing program (CSM); the Servicios Medicos (SM) clinical services program; the Information, Education and Communication, and Education of Leaders program (IE/C) under which mass media will be used in different formats; an Employee Based Family Planning program and a PVO program. Other Project components are related to management and administrative needs: they include Program Statistics, Evaluation and Operations Research, and Administration.

The Project design is in fundamental compliance with the major features of Honduran culture and tradition. After a quarter of a century of family planning under the leadership of ASHONPLAFA, the Project appears to be regarded as a genuine Honduran institution. The Project is, moreover, in strict conformity with the stated formal policy of the GOH. However a number of socio-cultural and policy problems do exist and need to be critically examined and addressed. A major problem is that GOH family planning implementation has not kept pace with its policy. The analysis assesses the socio-cultural implications of constituent programs in light of assumptions and constraints stated or implied in the PID.

Major assumptions are that: 1) family planning has a positive effect on economic development; 2) and the Nation's overall health status; 3) there is a strong desire for smaller families;

4) the GOH will not reverse its supportive family planning policy; 5) the bulk of family planning services will continue to be delivered by the private sector -- primarily ASHONPLAFA; 6) the greatest potential impact for reduced fertility will come from the increased use of contraceptives in rural areas.

Discussions on constraints include: 1) the extent to which family planning success is dependent on development and 2) on education; 3) the extent to which family planning is impeded by poverty; 4) by rural isolation; 5) by illiteracy; 6) by "verguenza" (shame); 7) by the lack of confidentiality, and 8) by the lack of male involvement.

The analysis found that the degree of acceptability of Project components has varied in the past with the socio-economic condition of targeted populations and will, most likely, continue to be so in the future, i.e., those most and best served by the Project are urban dwellers; and among rural beneficiaries by those with the most years of formal education.

Component acceptability was found to range from easily acceptable for the better educated and more economically advantaged urban residents; acceptable-with-difficulty and not-acceptable for less- and non-formally educated rural poor. According to ASHONPLAFA staff (and according to medical anthropological literature on illness and curing) a major reason for this relatively low level of acceptability is the difficulty of the Project to provide confidentiality. "Verguenza" (shame, shyness) is a feature of all animal behavior which is overcome by confidence. Its importance will be described in some depth. Moreover, SECPLAN data will suggest that ASHONPLAFA pricing schedules for rural families are beyond the financial means of rural women, many of whom receive only in-kind support from their spouses but not cash.

Potential conflict areas are identified in the area of management, in part due to different cultural viewpoints. Other factors appear to be political and interpersonal. Finally the criticism of the religious groups towards family planning and ASHONPLAFA is examined and found to be less significant as an obstacle to family planning than generally believed by major donors.

I PROJECT DESCRIPTION

Population Project. Follow-on to Private Sector Population Program I ending June 1989.

PROJECT RATIONALE

The rationale for this project is derived from the Mission's Population Strategy. It aims to satisfy the unmet need for family planning services. That such a need does exist was confirmed in the 1987 family health survey which was utilized in its two versions, one in Spanish without commentary: Encuesta Nacional de Epidemiologia y Salud Familiar (borrador) by the MOH/S&T epidemiological studies unit; and a more final version in English: National Epidemiology and Family Health Survey by Family Health International (FHI). An earlier 1984 study by the MOH and ASHONPLAFA, with the assistance of FHI and Management Sciences for Health (MHS), was used for comparative purposes.

TARGET GROUP OF BENEFICIARIES

Although women in the 20 to 29 years age group are experiencing the highest fertility rates, younger women (aged 15 to 19) and women over 35 years of age experience greater risks to their health during childbirth as do their children. Therefore the target group identified for the Project includes all women in union between the ages of 15 to 44 years.

STATEMENT OF THE PROBLEM

According to the <u>direct</u> method of estimating infant mortality rates (IMR) the Honduras IMR has declined substantially in the past 15 years: from 117 per 1000 live births in 1971-72, to 47 per 1000 in 1985-86, a reduction of about 60 per cent. However, if the <u>indirect</u> method of estimating IMRs is used, then the reduction is about 52 per cent over a roughly one generational span -- since 1967-68. By whatever measurement used to estimate IMRs, the reduced rate is significant. What makes the accomplishment striking is that the decline occurred under economic conditions that are not at all favorable. At US$ 740 dollars, Honduras has the lowest per capita rate in Central America. According to the indirect rate, the Central American IMRs appear as follows:

COUNTRY	IMR/000
Costa Rica	18/000
Panama	23 "
Honduras	61
El Salvador	61 "
Guatemala	61 "
Nicaragua	64 "

Indirect IMR estimates for 1986
Source: Estado Mundial de la Infancia

At 61/1000 Honduras (with its closest neighbors) has one of the highest infant mortality rates (IMR) in Latin American. It nevertheless has one of the highest total fertility rates (TFR) at 5.5 children per woman. This combination of a very high IMR and TFR gives Honduras a 3.1 percent annual growth rate, one which will cause the Honduran population -- like its neighbors -- to double its 1988 population of 4.8 million in approximately 22 years (7 million by the year 2000). It is important to note that by this date more than half of the population will be under 16 years of age.

The significance of this exceedingly rapid pace of population growth in Honduras can be better understood by comparing its 22 year population doubling time with Belgium's over one-thousand years (1034), Italy's well over three thousand years (3,465); and Denmark's, Austria's, West and East Germany's, and Hungry's decreasing populations (assuming that present rates remain constant in those countries.)
Such a rapid population growth has its most adverse effects on women and their children, the vast majority of whom are poor by any standard. Uncontrolled population growth greatly increases infant and child mortality -- especially during childbearing years -- and it dramatically decreases life expectancy for mothers and children.

With respect to marriage, high birth rates force countless young teenagers into very early marriages and child-bearing unions where very low contraceptive prevalence is the rule. In such contexts a low educational level is generally the rule for parents (countless of them single parents) and their children, many of whom never get beyond the first primary grades.

The employment situation of Honduras is very bleak, but especially so for the Country's poorest women. Unable to earn adequate income or locate credit to assist the micro entrepreneurial endeavors in which countless of their numbers attempt to eke out a living, women are forced into the most menial of employment situations, in which contexts they are regularly pressured to give up children -- frequently permanently -- to the care of others: or to let them suffer the consequences of a street life leading to illiteracy, malnutrition, chronic unemployment, discontent, openness to political extremism and delinquency.

One of the attendant problems which rapid population growth suffers is the poor access which the poorest women have to birth control information and assistance. It is well known that the vast majority of contracepting families are the best formally educated and those with significant incomes relative to their poorest neighbors -- whether in urban or rural contexts, but most

notably in the latter. ASHONPLAFA data regarding the educational levels of contraception acceptors indicate that those least involved in ASHONPLAFA family planning and birth-spacing activities are those without any formal education.

Distribution of Total Number of Acceptors by Type of Program According to Educational Level Attained

	Medical	Surgical	CBD
No Formal Schooling	2.6%	17.4%	9.8%
Primary (incomplete)	16.2%	54.3%	40.0%
Primary (graduated)	24.6%	21.3%	29.8%
Secondary (incomplete)	16.2%	2.4%	12.3%
Secondary (graduated)	33.1%	4.4%	6.8%
Superior School	7.3%	0.2%	0.4%
	100.0	100.0	100.0

Given the generalized lack of opportunity for formal education and of jobs that pay enough to feed, clothe and house a family, the Project has little choice but to reach out to those that it can with family planning information and services, who are most disposed by their education and socio-economic status: in the hopes that in time a critical mass of women of child-bearing ages (ages 15 to 44) will become family planning acceptors, and in so doing play an influencing role on those socio-economically below them which the Project is unable to reach in significant numbers at the present time.

PROJECT GOALS AND STRATEGIES

The project Goal is to reduce the current Total Fertility Rate (TFR) from 3.9 urban and 6.8 rural, to 3.0 urban and 5.8 rural. Behind this goal is the assumption that neither the GOH, nor the U.S. Government will change its policies in support of family planning. The Project Purpose is to increase contraceptive prevalence (the percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50.4% in 1993. In order to achieve this level of prevalence, 362,500 Honduran women nationwide will need to be practicing contraception with their partners during 1993, up from the 1987 number for all of Honduras of 231,250 -- a difference of 131,250.

The Project's contribution to the National Contraceptive Prevalence Rate, therefore, will be more than 50%.

USAID's population strategy is to support Honduras in implementing its policy of reducing the crude birth rate, calculated at 39/1000 for 1988, by assisting in the strengthening and expansion of family planning services in both the private and public sectors.

The Mission's Project strategy is to increase self-sufficiency, increase cost-recovery, improve efficiency and reduce costs for those programs, like the Medical Clinical, which will require deficit financing. Regionalization of operations will continue as regional staff plan and budget their own programs and identify volunteers to support local family planning programs.

ONE PROJECT/TWO CONTEXTS: ASHONPLAFA AND THE OTHER PVOs

To more effectively reach the market of women aged 15 to 44 so that contraceptive prevalence may be increased to 50% by the end of this five year project. the Project calls for the continued support of ASHONPLAFA and for the expansion of its Community Service Program (CSP.) This program includes promoting and selling contraceptives commercially through a Contraceptive Social Marketing (CSM) program; as well as providing voluntary surgical contraception through ASHONPLAFA's Medical Clinical (M/C) program in five regional centers.

USAID's strategy for this new project includes a much smaller second context within which additional targeted women may be reached, namely the provision of support to other PVOs which are already supplying primary health services to their beneficiaries (Foster Parents, Save-The-Children, Meals for Millions and Horizontes de Amistad). Another organization is a common cause and advocacy group associated with the Christian Democratic Party called the Union Nacional de Campesinos (UNC) which has no experience with the provision of health services but which has expressed an interest in collaborating with ASHONPLAFA in the provision of family planning services.

TIME SPAN OF THE PROJECT

A five year project is planned for two reasons. First because the project strategy emphasizes greater cost-recovery and steps toward self-sufficiency for all the ASHONPLAFA components. Five years is a reasonable period of time to enable the Mission to measure changes brought about by this strategy. Second, because Honduras will require assistance in family planning until the year 2000 if it is to reach 60 percent contraceptive coverage. This project can be viewed as the second phase of the Mission's

support to both public and private sector population programs.

USAID has supported family planning programs in the public sector through its Health Sector I and Health Sector II projects. Under Health Sector I, funding was provided for family planning training, commodities, information & communications campaigns through mass media and technical assistance to the MOH. Under Health Services II, funds are available for supervision of family planning services at regional and local levels, training, technical assistance and for the purchase of contraceptives. Although the Honduran public sector has the greatest potential, in the long run, for providing family planning services because of its extensive network for health centers, survey results show that the private sector continues to be the principal provider of family planning services.

II. U.S.A.I.D./HONDURAS SUPPOSITIONS

o Family planning (FP) will have a positive effect on the Nation's overall health status;

o Family planning will have a positive effect on economic development;

o There is a strong desire for smaller families by Honduran couples;

o There is an unmet demand for family planning. This demand can be met by increasing the availability of family planning information and services;

o Neither the public nor private sectors have the means to adequately finance the needed expansion of family planning services without external resources;

o The GOH will not reverse its supportive family planning policy;

o The bulk of family planning information and service will continue to be delivered by the private sector -- primarily by ASHONPLAFA;

o The greatest potential impact for reduced fertility will come from increased use of contraceptives in rural areas.

COMMENTS ON SUPPOSITIONS

1. Positive Effect of FP on Health: Every authority on public health supports the contention that women are especially

prone to health problems during periods of pre- and post-natal pregnancy -- as are the children in their care. Not even the most pro-natalist advocates would deny the fact that child-spacing will significantly diminish the dangers to a mother's health and well-being.

2. On Economic Development

It is difficult for those of us convinced of the need for reduced fertility to argue against the theoretical basis that both micro and macro economic situations will improve to the extent that fewer persons share available resources for individuals, families and institutions. In this theoretical sense, family planning and child-spacing cannot but help to improve the poverty situation of poor nations. What is problematic is the extent to which one is dependent on the other, or that one is the cause of the other.

Nevertheless some do argue against the wisdom of reduced fertility when it comes packaged under certain labels (Family Planning, Yes! Birth control, No!) and this on grounds based on economic and market theories. One such argument maintains that in some countries, including Honduras (as Bolivia), the development of the economy needs increased, not decreased, population growth.

As described by M. Bacardit in Poblacion y Religion this argument suggests that birth control programs (but not family planning) are fundamentally expatriate in origin and have, as an essential part of the program's motivation, the de facto well-being of developed countries through the maintenance of some world areas as reserves for raw materials. This topic is one of several being widely discussed in the field of Ethics.

Another argument against (even) family planning for the poor in Third World countries (obviously, not authored by the same ideology) maintains that a constant and on-demand cheap labor supply of campesinos is the mainstay of agriculturally based for-export economies, and must not be jeapordized by significantly reduced populations. Such a situation, it is strongly maintained, endangers the supply of, especially, seasonal workers for the agricultural exploitations upon which everyone depends -- both rich and poor. Such topics are among the ethical issues being widely debated under fertility reduction policies and poverty.

Another popular argument is that in sparsely populated countries, such as Bolivia with a less than 1 person/kilometer population density, countries need an increased population in order to provide a domestic market for manufactured goods, so that economic development can proceed. In these situations development problems will not be solved by reducing the birth

rate. In such contexts solutions require serious redistribution of wealth schemes, new jobs paying a living wage, more capital and credit at all levels, and an overhauling of public administrative systems.

FERTILITY AND DEVELOPMENT

The populations of European nations are highly educated and their economies highly developed. It is also clear that most have very low fertility rates. The both Germanys. Denmark, Austria and Hungary have negative population growth rates: their populations are diminishing: they will never double. At Italy's current fertility rate its population will double in 3,460 years, while Belgium's will take well over a thousand. In contrast, the Honduran -- and other Central American countries -- will double in approximately one single generation. Comparisons closer to the socio-cultural situation of Honduras are more difficult to make, but at least two Caribbean populations with large populations (Cuba and Puerto Rico with 10.4 and 3.4 millions) have reduced fertility rates during the past decades. The population doubling time for Puerto Rico is 56 years while for Cuba it is 69 years. The differences in doubling time between North and South Korea is also supportive of that belief that development is the best of all contraceptives: 28 years in the North; 52 years in the now highly industrialized South.
It is worthy of note that in many developed countries of the West, there have never been family planning efforts for its populations <u>in proportion</u> to the efforts which have taken place in developing countries like Honduras and Guatemala.

The literature on declining fertility is very complex, but some elements stand out, namely that in developed countries reduced fertility has come about as a consequence of two overarching phenomena: economic/educational development and a intellectual climate of opinion -- a vogue -- among a critical mass of people, which enabled/facilitated the masses to make appropriate contracepting decisions. Contraceptive information and accessibility to services were <u>sine qua non</u> for assisting the process of reducing fertility. But they appear not to have been the fundamental cause of reduced fertility

3. <u>THE DESIRE FOR SMALLER FAMILIES BY HONDURAN COUPLES</u>

It is widely held that the desire for smaller families rises to the taking of appropriate contraceptive actions in direct proportion to educational and socio-economic levels attained. It is at that point where the availability of resources facilitating contraception is utilized at a more efficient level.

IDEAL FAMILY SIZE

Data from the 1981 Contraceptive Prevalence Study indicate that women aged 15 to 44 held that 2.5 and 3.5 represented the ideal number of children in urban and rural areas respectively. In the 1984 study the same question regarding ideal family size elicited almost identical responses for younger women, but climbed to ideal numbers of 4.0 and 4.9 for ages 40 to 44, against actual numbers for that age group of 4.5 and 6.2 children for urban and rural women respectively. The 1987 study shows a mean ideal family size of 3.2 children per family. The actual number has been calculated at 5.5 children.

All contraceptive prevalence studies indicate that the ideal number of a family becomes smaller or larger accordingly as the respondent to the question is urban or rural based; and to the extent that the respondent is formally educated. The 1987 study indicates the percentage of women who did not want their actual or last pregnancy (39.8 per cent), and those that wanted it, but wanted it later (60.2 per cent). The study also shows the immediate fertility expectation of mothers surveyed: 52.4 per cent wanted another child, as opposed to 39.9 per cent who did not.

4. THERE IS AN UNMET DEMAND FOR FAMILY PLANNING. THIS DEMAND CAN BE MET BY INCREASING THE AVAILABILITY OF FAMILY PLANNING INFORMATION AND SERVICES

It is well known, that many people hesitate to obtain what they need, and want, from easily available sources. There are many reasons for this. They range from the pressures of tradition and culture not to do some thing, which have not been dulled by education and socio-economic status (feelings of fear and shame are, frequently, linked to such restrictions): to idiosyncratic psychological fears proper to specific personalities rather than to specific cultures. With respect to contracepting, especially culturally based fears are more conducive for inaction in rural contexts than urban ones. The major reason appears to be the difficulty of widely known programs like ASHONPLAFA to provide the overriding need for privacy and confidentiality which many rural campesino peoples have.

This issue of privacy and confidentiality is why the inclusion of support for healthcare-providing PVOs in the Project Paper design is exceptionally significant and needs to be closely monitored in order that valuable lessons may be learned for appropriate policy determinations.

Many rural primary healthcare clinics, even those operated by religious organizations and churches (for example many of the 163 parish clinics assisted by CRS) succeed in assisting many women with information and services about family planning and child spacing -- but this is done in a context that does not single out

one's in any aspect of human reproduction. Given the tightness of social networks in rural areas and the rapidity of communication between points in those networks, many rural poor people around the globe have hang-ups about airing anything related to their personal sexuality in what they interpret to be a public situation.

5. NEITHER THE PUBLIC NOR PRIVATE SECTORS HAVE THE MEANS TO ADEQUATELY FINANCE THE NEEDED EXPANSION OF FAMILY PLANNING SERVICES WITHOUT EXTERNAL RESOURCES

Like all country private sectors, the Honduran private sector is a multi-faceted phenomenon and should not be lumped together with respect to its inability to finance some significant part of the expansion of family planning services. It might be worthwhile to undertake a rapid assessment study to determine the financial ability/inability of different sub-sectors of the for-profit private sector to provide integrated healthcare for its employees, in the context of which family planning services could be offered. The PID indicates that a discussions have already taken place regarding this issue by its mention of ASHONPLAFA's exploration of the use of employee health programs. Given the interest expressed in the PID about employment related programs for expanding family planning opportunities, the following comments are offered about the utilization of the private sector.

PLANTATIONS

One very large sub-sector which employs huge numbers of the Country's poorest rural campesino families, are the Country's plantations: large numbers of which are located in most difficult to reach, almost inaccessible, rural areas. This rural isolation represents a major constraint for the CSP(CBD) Program. Farmworkers, both permanent and seasonal, constitute a significant part of the Honduran rural work force, which work force often includes women and children of the household -- especially during harvest periods.

Given the relatively few latifundia-type coffee and cardamon plantations in Honduras, which utilize large numbers of resident workers (so common to other countries of the Region) it will be difficult to market many fee-for-service primary care programs (with family planning as an integral component) for the poorest rural families, as many seasonal/migrant farmworkers are known to be. But the theoretical possibility of reaching a significant number of these poorest of rural poor through plantations is not a pie-in-the-sky idea. It should be one of the options considered in the planned intensive review of the use of PVOs to reach greater numbers of rural peoples.

The 1979 Census of the Instituto Hondureno Del Cafe lists a total of 40,000 fincas, the vast majority of them under 20 manzanas in

size. But there are almost one thousand between 20 and 50 manzanas; 178 between 50 and 100 manzanas; and 78 plantations which are listed as being over 100 manzanas in size.

Another plantation related study, the 1982 Country Environmental Profile done for the USAID/Honduras Mission by JRB Associates states that 5.9 per cent of all the farms in Honduras are commercial/private farms -- many of them owned by transnationals. The smallest of these 667 largest farms are properties of 340 hectares (acres) or larger, many of which employ large numbers of resident and seasonal workers. These cultivate 57.2 per cent of all the farm land; while 93.6 per cent of the farms, largely subsistence farms, cultivate 36.8 per cent of the land. An important point of the discussion is that in spite of the relatively small number of plantations with resident populations, relative to other Central American countries, there are, nevertheless, a significant number of large plantations/farms employing large numbers of workers.

It is important to point out that plantations employing more than a minimum number of workers are required by Honduran law to provide minimum healthcare for its workers. Given the practical impossibility of monitoring observance, however, how this requirement of the law is observed by the planter depends on a wide range of factors, but uppermost is the personal concern -- great or little -- of the planter for his/her workers. The area of fincas and farmworkers in one in which one or several PVOs can be of significant service. One such program in Guatemala, named AGROSALUD, was established by planters in 1977 on a fee-for-service basis with no expatriate financial assistance, except for the aid received from APROFAM (the Guatemalan counterpart of ASHONPLAFA -- Asociacion Pro-Familia.) Albeit at a reduced level due to several factors, including a civil war which has ravaged the countryside, the AGROSALUD program is still functioning.

6. THE GOH WILL NOT REVERSE ITS SUPPORTIVE FAMILY PLANNING POLICIES

On paper the policy of the GOH in support of family planning is difficult to fault. In the past several years the Government has increased its commitment to formulating and implementing explicit population policies as a means of attaining development objectives. The GOH's most recent effort in this regard is the formulation of the Population Law, which is presently in congressional committee for discussion prior to promulgation. The Population Law follows a Government decree of 1983 which made family planning a priority area within the national primary health care program.

However, while the government's de jure policy record is an

impressive one, its de facto commitment to implementing its policies is weak. One reason for the Government's apparent reluctance to put its money where its political mouth is has been attributed to the very sharp criticism leveled against the Government by the most influential elements within the Catholic Church, notably the Archbishop and other senior prelates, and the largely social elite Opus Dei group, some of whom are known to be close to senior government officials and capable of influency policy decisions.

Two indications of the Government's reluctance to have as strong a de facto policy position as it has a de jure one, are found in the relative little use being made of its over 500 primary health CESAMO and CESAR clinics for the provision of family planning information and service; and in the reduced number of contraceptive surgical procedures being preformed in the eleven hospitals of the Ministry of Health over the past three years: from 2,501 procedures in 1986 to 1,414 in 1988.

At worst (and said to be the most probable) the Government will continue to permit family planning activities to exist without any significant support for the growth of those services within the CESAMO/CESAR system. The best possible scenario regarding the role of the MOH, would be the provision of family planning information/education and service within that system, by personnel trained/sensitized to make appropriate inquiries of patients who have not directly requested family planning assistance as an integral part of its primary healthcare program.

7. THE BULK OF FAMILY PLANNING INFORMATION AND SERVICE WILL CONTINUE TO BE DELIVERED BY THE PRIVATE SECTOR -- ESPECIALLY BY ASHONPLAFA

The USAID/Honduras decision to develop closer working relations with established PVO organizations and the UNC is an extremely important one, as in many areas of the developing world such clinics provide a full range of family planning information and services as an integral part of their primary health efforts: and in a manner which provides a pretty good guarantee of confidentiality being maintained. The importance of providing confidentiality to potential beneficiaries cannot be overstated, as in many instances women request advice on preventing another pregnancy in the face of a husband's direct order not to do so.

Given ASHONPLAFA's quarter-century of experience and its preeminence and dominance in the field, it is appropriate that it continue to deliver the lion's share of USAID/Honduras family planning funds. If the use of PVOs proves successful for the enhancement of the program, then the PVO aspect of the program could develop into a highly desirable competitive situation in which performance, measured by predetermined criteria, would

determine what part of the Mission's family planning budget each subsector is granted.

Of course, the possibility of such a development is years away. In fact, the Mission does not have another choice at the present time: and that is not an ideal situation for creativity, program development and quality enhancement.

Given that situation, the family planning activities of PV clinics involved in the Project need to be closely monitored in holistic primary healthcare context. Lessons need to be learne about how to best expand collaboration with these other PV clinics, in order that they may more successfully compete amon themselves and ASHONPLAFA in the very best sense of the word.

8. THE GREATEST POTENTIAL IMPACT FOR REDUCED FERTILITY WILL COM FROM THE INCREASED USE OF CONTRACEPTIVES IN RURAL AREAS

The supposition is sound given the actual rural situation o Honduras, i.e., given the extremely difficult-to-overcom constraint of lacking and/or poor educational facilities an employment opportunities. These latter appear to offer mor certain solutions for reduced fertility. See the discussion o the relation between fertility and development in Assumptic Number 2.

III CONSTRAINTS

Constraints are distinguished into various categories. The mos difficult to overcome are usually policy related, followed b resource availability. With respect to Honduras (as anywhere policy constraints need to be distinguished into formal (de jure and informal (de facto) categories -- the former frequentl having the force of law when implementing authorities so wish it.

In Honduras there are no major de jure policy constraints by th Government with respect to family planning. On the contrary, th GOH has a very supportive family planning policy -- to the poin that at the present time a Population Law has been written an proposed to the Congress for promulgation. In spite o supportive formal policy, however, there appear to be strong d facto constraints at play within the Government which i preventing that policy's implementation within the widespread clinical resources of the Country's CESAMO and CESAR facilities.

There are eight categories of socio-cultural constraints which have in depth and complex social and cultural ramifications for

this Family Planning Project. They relate to the following:

- o education
- o rural poverty
- o rural isolation
- o gender
- o shame ("verguenza")
- o administration and management
- o financial
- o opposition

1. EDUCATION

There is general shortage of educational facilities and opportunities throughout Honduras, especially for its poorest populations: a situation which is significantly aggravated by the urban-rural distinction. It is well known and widely accepted that this shortage has a very negative impact for reducing fertility rates, as it appears incontroversial that there is a direct relationship between educational levels attained by females and their individual fertility. Moreover, in spite of the success which ASHONPLAFA has had in informing large sectors of the Honduran population about family planning and child-spacing options, there is still an admitted lack of knowledge about family planning among large sectors of the population, and a lack of opportunity to obtain it in many rural areas of the Country -- and this especially by its poorest people. However data from the 1987 National Epidemiology and Family Health Survey illustrate that knowledge of contraception among Honduran women has increased since the 1984 survey. As indicated in the PID, the need for additional information will be addressed, in some measure, by the planned mass media communication efforts within the IE/C component of ASHONPLAFA. The following table from the MOH/FHI National Epidemiology and Family Health Survey of 1987 (Table III, D4) illustrates the distribution of women by education and urban/rural residence:

Education	Teg/SPS	Other Urban	Rural
None	4.7%	9.9%	23.6%
Primary 1 to 3rd Grades	12.3%	15.6%	34.6%
Primary 4 to 6th "	31.0%	31.4%	33.8%
More than 7 years	52.0%	43.2%	8.0%
	100.0	100.0	100.0
Total No. of Women	(2724)	(1546)	(5869)

2. GENDER

The ASHONPLAFA experience spanning a quarter of a century indicates that contraception is a woman's world. One of the problems about the male factor in family planning is the great amount of belief about what it is. It is widely believed, for example, that there is a general lack of male involvement in family planning, especially in passive roles. In support of this belief, the fact is quoted that there is little demand for voluntary vasectomies by men. It is also believed by many that in general, Honduran (and many other Latin American) men are not involved with their spouses in coming to decisions about contraception. However, one report and a study do exist and these give another view of the issue.

A brief ASHONPLAFA report on a focal group discussion of seven men who had undergone vasectomies is significant for the detail of the personal experiences they portray. They are also important for pointing the way to additional research topics.

A more in depth study in which ASHONPLAFA participated with Tulane University was seen in draft version. It is an unpublished 1987 survey of 959 men, randomly selected in three Honduran communities, between the ages of 30 and 50. The study was commissioned in order to obtain information about how to increase the demand for vasectomies. The study maintains that 6[illegible] per cent of the respondents were actually practicing some form of contraception with their spouses; and that 36% of their spouses had been surgically sterilized. These are remarkable findings which the authors noted as such. They are especially remarkable given the 35 per cent national contraceptive prevalence rate existing during the time of the study, and the fact that while 8,255 female AQV procedures were preformed in 1987, men underwent only 34 AQVs. None of the men surveyed had submitted to vasectomy.

Another indication of positively affecting Honduran male thinking about the need for contraception is found in the well known and widespread "comunidades de base" and "concientizacion" education programs, now frequently associated, in some quarters, with liberation theology and leftist political movements. One of the fundamental modules of many such programs, as practiced in many church contexts, is responsible fatherhood which includes the responsibility of the man not to endanger his spouse's, and his childrens' health by frequent and successive pregnancies of his wife. The positive implications for the growth in the number of family planning acceptors is obvious.

3. RURAL POVERTY

The PID describes as a principal objective, the expansion of the CSP(CBD) program to 310 additional distribution points over the 1400 expected to be in place by the end of the current Project. It points out that this expansion will focus on undeserved rural areas in Lempira, Gracias a Dios, Copan, Ocotepeque, Islas de la Bahia, Intibuca and La Paz. Most of these areas have been reported to be some of the poorest in the Country.

Based on per capita calculations, Honduras is the poorest countr in Central America, with US$740. However it is well know tha per capita rates say little atout specific population sectors o geographical areas. Per capita calculations are valid primaril as an indication of how a national economy is preforming vis vis other national economies. with respect to total salaries pai to the work force. Per capita income says nothing about persona incomes in any sector or geographical area. Obviously the pe capita income of Honduras at US$ 740 dollars is significantl less than the legally established minimum wage of roughly US 1,300 dollars annually (L.200/month for 13 months.) That large part of the workforce earns less than minimum wage i incontrovertible. It is also incontrovertible that many ear significantly less than the per capita amount.

One reported INA study (reported by ASHONPLAFA staff) of pe capita income for specific rural areas of the Country comes u with an estimate of an annual per capita income of less than on hundred lempira in some isolated rural areas. The possibility o such a low annual income figure being the case for anywhere i Honduras was denied by several persons consulted. As the titl of the study was not known, a search in numerous INA office proved futile in locating the study. However inquiries i SECPLAN turned up a recent (1988) study entitled Encuest Permanente de Hogares de Propositos Multiples in which ar presented a wide range of data by region and in recapitulat form for the entire rural area of the Country. Among its dat are five tables (appended as Appendix I) which relate to incom levels in rural areas for men and women.

Table 23 (Poblacion Ocupada. Por Grupo de la Ocupacion Principal Segun Niveles de Ingreso Mensual y Sexo), lists a total rura work force of 765,991, 621,088 (81%) of whom are men. A total o 169,311 are shown in the data as being "without income". Most o these (87%) are also men. The table gives a monthly incom breakdown of both men and women listed. Those figures follow:

INCOME OF RURAL MEN AND WOMEN

MEN	Number

Total Number	621,088	
Without any income	149,872	(24%)
Only in-kind income	2,332	(0.3%)
Less than 60 Lps./month	155,770	(25%)
From 61 to 100 Lps./month	79,658	(13%)
" 101 " 200 " "	129,543	(21%)
" 201 " 300 " "	40,200	
" 301 " 400 " "	20,651	
" 401 " 600 " "	24,680	
" 601 " 800 " "	5,706	
" 801 " 1200 " "	4,790	
" 1201 " 1600 " "	2,504	
" 1601 " 2000 " "	1,046	
" 2001 Lps. and up "	4,336	

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WOMEN	Number	
Total Number	148,903	
Without any income	19,439	(13%)
Only in-kind income	1,364	(9%)
Less than 60 Lps./month	64,996	(44%)
From 61 to 100 Lps./month	17,812	(12%)
" 101 " 200 " "	19,269	(13%)
" 201 " 300 " "	8,228	
" 301 " 400 " "	4,540	
" 401 " 600 " "	6,972	
" 601 " 800 " "	2,287	
" 801 " 1200 " "	1,783	
" 1201 " 1600 " "	596	
" 1601 " 2000 " "	171	
" 2001 Lps. and up "	1,446	

While the above data give some indication of the cash income o rural populations in Honduras, there are cultural/traditiona problems which exacerbate the implications of the data, as the impact directly on the amount of cash available for purchases o contraceptives. Especially at issue is the male tradition o giving the women of the house as much as he can in terms of th basic necessities of life such as foodstuffs and firewood, bu usually no, or very little, cash -- as cash is regarded to be fo the personal needs of the husband, which often includes suppor for one or more other families he has sired. Cash is also neede for the males' social obligations during which significan alcoholic beverages are consumed.

This practice is widespread in many Central American campesino communities, but primarily among non-Indian cultured populations -- such as those called "Ladino" in Guatemala. The Hondura version of this "little-cash tradition for woman" is described in an Oscar Lewis type book published by the Institute for Food and

Policy Studies (San Francisco) by Mejia Benjamin entitled "Don't Be Afraid Gringo", in which taped interviews with an Hondura activist woman closely associated with the UNC (Union Nacional d Campesinos), Elvia Alvarado, are transcribed. The book describe what it's like to be a peasant woman in Honduras.

The poverty of rural families is an issue for the Project, giv the importance being given in the PID to the ability of progra to pay their own way by the end of the five year period. I rural poverty is as severe as suggested in the SECPLAN data a described by informants, it will be difficult for families afford the one to two per cent of minimum wage cost whi participation in the program requires. All persons with whom t ability of rural families to pay the planned amount w discussed, denied that most could.

4. RURAL ISOLATION

Rural isolation is a major reason why access to the lower-low socio-economic sector of the population is so difficult access. According to informants, many of the additional ru areas targeted by the PID are among the most remote a inaccessible in the Country by public transportation. Much of is accessible only on foot and horseback -- even in dry perio This rural isolation of an undetermined number of the Countr rural population (put at 61% of the total Honduran population) a major concern for ASHONPLAFA senior staff with whom t analysis was discussed. By all estimates the number of th isolated families is large. Parelleling their isolation is lack of educational and health facilities and the Country's wo poverty, youngest marriages and unions, and the largest famili

In such regions of the Honduras (and the globe) many children regarded as an inexpensive and valuable labor and supp resource which can be depended upon. Evidence which data. Cuadro 2 (page 2 of the Total Rural volume -- appended) analyzed in terms of such an attitude can be seen in the S shows a total rural household population of 2,629,396. This figure is broken down into 449,345 household heads; 349,374 wives or companero; 1,446,051 children; 54,390 other family members; and 331,206 others without any family members in the household ("otros no parientes".) Many of these "otros" are children who have been either place in the care of, abandoned or as close to literally given to the household as one can imagine. The custom is known in many peasant societies. This category of numbers supports such an analysis. The point here, is that smaller families make sense for such people only when there are other support systems to take their place. Clearly the problem is a difficult one to unravel, but a beginning can be made in the context of the Project's planned Mass Media Communication effort to bring about behavior modifications.

5. "VERGUENZA"

Another indication of the Project's clash with culture and tradition is the high level of verguenza (shame) experienced by many women and men entering the program for the first time. The phenomenon of shame is universal to all societies. Levels of shame, however, are relative to specific contexts within a culture, and these vary greatly from one culture to another. The verguenza at issue in this specific context of human sexuality in Honduras diminishes significantly with familiarity and the growth of confidence in the program and its personnel. To what extent this phenomenon is responsible for keeping the number of contraceptive acceptors lower than they could be can never be known, but the best guess, and some evidence regarding religious belief, is that verguenza keeps away many more potential beneficiaries than does either poverty or religious belief. "Verguenza" is discussed in greater length below, under No. 4 of the Scope-of-Work (page 29.)

6. ADMINISTRATION AND MANAGEMENT

One management problem with significant social implications for the increased use of family planning was noted in the course of meetings with ASHONPLAFA which merits mention here, as it is the opinion of this analyst that, given the present polarization, it is a problem which can be addressed and resolved, but in a de facto rather than formal way. The problem has to do with the conflict between the Catholic Church hierarchy and ASHONPLAFA senior officials. This will be covered in detail under the subsequent section on "Opposition". Suffice for the moment to point out that while there have been a multitude of attacks by the Catholic hierarchy against ASHONPLAFA in the public media for years (but with especial vigour during the past seven months) ASHONPLAFA unintentionally, but effectively (and understandably) rejected a recent initiative by a CARITAS senior staff person to explore the possibility of collaboration with ASHONPLAFA on the family planning effort.

7. OPPOSITION

The literature review for this analysis included a perusal of five years of local newspaper clippings maintained by ASHONPLAFA relating to the public statements made, primarily, by the hierarchy of the Roman Catholic Church against ASHONPLAFA. Especially during the last six or seven months of late 1988, the polemic of the Catholic hierarchy against ASHONPLAFA became extreme.

One article in la Prensa of July, 11, 1988 quotes the Archbishop of Tegucigalpa's accusation of ASHONPLAFA as an organization which has been "assassinating children for 25 years before they are conceived." The statement is a contradiction in terms even in the context of the most conservative pro-life Catholic theologians. But just about one year earlier, on May 18, 1987 in La Tribuna, the same Archbishop made a statement in which he could have been speaking as an ASHONPLAFA spokesman: a statement which presupposes the need for Catholic couples to practice family planning, when he declared that "The Church does not ask spouses that they have as many children as they can possibly have; only that they have as many as they can raise and educate."

Criticism against contraception is not a strictly Catholic phenomenon. A strong criticism of the practice of contraception by unmarried youngsters was voiced by the Evangelical, Brother Pablo, in Tiempo on July 16, 1988. He uses the example of the development of the pill as the cause of a disastrous climate of opinion which allows for total incontinence in sexual behavior among youth -- something he views as destructive of human nobility.

What is misleading about the criticisms and opinions of church spokespersons is that their thinking is, frequently, taken as being representative of the entire membership of those churches. This is a fallacy. In the Catholic churches of Honduras, (as in different churches, temples and mosques everywhere) there is a very wide range of thinking about what is, and what is not, ethical behavior according to those traditions. Informants consulted during the course of this analysis confirmed this analyst's many years of personal experience with primary healthcare clinics belonging to religious organizations. They indicated that family planning and child spacing is an integral part of most church related programs in Honduras, but that this information and service is not publicly heralded, but is provided in the strictest confidence, and within the primary healthcare context of their clinics.

Several ASHONPLAFA staff pointed out that ASHONPLAFA's inability to provide confidential treatment was a serious problem they had no way of overcoming by themselves. ASHONPLAFA's confidentiality problem was believed aggravated by the Government's de facto policy of not significantly implementing family planning services within the over 600 CESAMO and CESAR health centers. Verguenza is believed by many to be, very frequently, a difficult obstacle to overcome for many women (and men). If they can't keep their interest is contraception private, they won't go anywhere.

According to an ASHONPLAFA informant, an opportunity for a collaborative family planning and child-spacing effort between ASHONPLAFA and the Catholic Church of Honduras was frustrated

when a senior level staff person of CARITAS, the social service arm of the Honduran Catholic bishops, took the initiative to visit ASHONPLAFA, in order to express his interest in family planning collaboration between the two organizations. ASHONPLAFA was in agreement with the idea, but requested that the CARITAS executive send him a letter formally requesting ASHONPLAFA's assistance. Of course, the former could not comply with a letter, as he knew that such a letter could be used by ASHONPLAFA against the bishops, whose criticism was sure to continue. As a result the letter was never received: the possibility was no longer discussed. In the end Hondurans who need the services came out losers -- not ASHONPLAFA; not the bishops.

A similar case is FOPRIDEH, a USAID/Honduras Mission supported funding organization/consortium of about 32 Honduran PVOs which between them include approximately 45 primary health clinics among the other services they are able to provide. The possibility of including the organization as part of the Project's PVO component was questioned in an early version of the PID because of the organization's presumed anticontraception position. In fact on June 22, 1987, Tiempo carried a story on FOPRIDEH indicating that the consortium went on record against birth control and in support of the position of the Catholic Church. However it needs to be pointed out that the FOPRIDEH statement was made in 1987 when much ado was being made about the distinction between "family planning" (OK) and "birth control" (not OK) -- a distinction which ASHONPLAFA also likes to make. This was also the time when the Archbishop of Tegucigalpa was sounding like a strong supporter of family planning and was quoted as such in the press -- as indicated above.

The FOPRIDEH executive director was interviewed during the course of this analysis. He indicated that the press statement was made in the context of the aforementioned distinction in order to avoid what was viewed by the organization's board of directors as a politically sensitive situation. The statement made to the press also included a statement that FOPRIDEH would not become involved in refugee programs for the same reason -- it was too hot, politically, to do so. It was also pointed out that as regards family planning, all consortium clinics run their own programs in their own ways. The clinics provide as many services as they can or wish to provide, including family planning.

IV SCOPE OF WORK

1. GENERAL DESCRIPTION OF SOCIO-ECONOMIC & DEMOGRAPHIC CONTEXT OF PROJECT

According to per capita calculations, Honduras -- with $740 dollars -- is the poorest country in Central America. One reported INA study of per capita income of rural Honduras comes

up with an estimate of an annual per capita income of less than one hundred lempira. Significantly less than the national per capita or minimum wage amounts is well known to be the case for rural Honduras, and this because large parts of the Country are made up of sparsely populated rugged mountain ranges, a factor which according to a 1985 UN analysis (Population Policy Compendium) has made communications difficult and has slowed the process of national and social integration as well as the movement of currency. According to the 1988 Censo Nacional de Poblacion y Vivienda (CNPV) Honduras has a population density of 39.05 persons per square kilometer, one of the less densely populated countries of Central America.

CENSUS DATA

Honduras has held thirteen national censuses since 1844, the most recent of which was conducted in 1988 (the data of which has yet to be analyzed and made available to any extent.) Previous to this most recent census the Country's data base was considered to be seriously deficient. Between the censuses of 1910 and 1940, Honduras grew at an average rate of more than 1.5 per cent per annum. The rate of population growth reached 2 per cent after 1940 and 3 per cent after about 1955. By 1970-75 the rate of natural increase was estimated to be about 3.5 per cent per annum, due to the net effect of a crude birth rate of 49/1000 and a crude death rate of about 14/1000 during those years. It is currently calculated at 3.1 per cent.

POPULATION SIZE

According to a demographic profile for Honduras, done by Palacio Garcia in 1983, the population of Honduras was at four million in mid 1982. At that time the population was growing at a 3.5% rate, the fastest in Central America. The latest provisional estimates by the aforementioned recent Censo Nacional de Poblacion y de Vivienda (CNPV) of 1988 indicates a population of approximately 4.4 million (4,376,839), a figure which is significantly lower than the 4.8 million shown in the 1988 World Population Data Sheet of the Population Reference Bureau (PRB).

CRUDE BIRTH AND DEATH RATES

In comparison to a crude birthrate of 47/1000 in 1982, the 1984 crude birthrate was 37/1000 according to the MCH/FP census; and the current 1988 total crude birthrate, according to the 1987 ENESF census data, is 38/1000. In spite of this accomplishment, the 38/1000 figure represents, according to the data of the UN's

117

Population and Vital Statistics Report, the fifth highest crude birthrate in the entire LA/C region: behind Nicaragua (43/1000), Haiti and Guatemala (41/1000)and Bolivia (40/1000). Those data also show that the crude death rate has also decreased since 1982 -- from 12/1000 reported in the Garcia data, to 8/1000.

RURAL-TO-URBAN MIGRATION STREAMS

In 1982 only 36 percent of the population was estimated to be urban, 61 percent of whom were employed in the agricultural sector -- up from a total of 23 per cent urban residents in 1961. In 1988 the urban based population of Honduras was estimated by the Censo Nacional de Poblacion y Vivienda (CNPV) to have grown to 42 percent, with a corresponding lessening of employment dependency on agriculture. As is occurring everywhere in the world, rural-to-urban migration streams are flooding the globe's largest cities. In Honduras migrant streams are flowing into the Country's two major cities, Tegucigalpa and San Pedro Sula. The current annual growth rates of these two cities are estimated at 4.2% and 5.2% respectively, significantly faster than other urban areas. The total population of Tegucigalpa and San Pedro Sula represent 13.7 and 6.4 percent of the total 1988 Honduran population. Projections put the population of Tegucigalpa at about one million by the year 2000, i.e., about 14.3 per cent of the Country's projected seven million population by that year.

The migrations to urban areas is due more to economic expulsion than from an attraction for the cities. In 1974 almost two-thirds of all migrants were less than 24 years old. In urban areas these represented 65.2 per cent. Most migrants to the cities face a difficult time once they arrive, and in many cases the reality of city life proves to be as difficult as the situation left behind. Men arrive basically ill-adapted to preform any work other than manual labor, and as a result are absorbed with great difficulty into the work force, given the already great supply of manual laborers.

Women leave rural areas for the same reasons as men, but arrive with a different set of handicaps. While the stereotype for all Honduran women, rural or urban, is to care for the home and children, in rural areas women make a real contribution to many of the agricultural, animal husbandry, and myriad other tasks needed to sustain a rural family. In contrast, in the cities women find it difficult obtaining employment other than in marginal activities. The squatter settlements of the Country's (and the globe's) cities give testimony to the very low quality of life's amenities sustained by countless migrants from rural areas.

One of the major concerns of the GOH is the rapid growth of its

cities, the service levels of which are believed to be extremely low. This was said, by one informant, to have been another major reason for the GOH's expulsion of Salvadorans from its territory in 1969, as many were succeeding in resettling to urban areas. At the present time refugee movements of about 33,000 Salvadorans, Miskito and Guatemalan Indians constitute the country's major immigration flows. Most of these are cared for by the UN High Commission on Refugees. Repatriation is a major objective of the UN program.

TOTAL FERTILITY AND CRUDE DEATH RATES

The total fertility rate of Honduras has decreased from 7.5 children per family around 1972 (5.3 and 8.7 along the urban-rural split; 5.8, 7.9 and 8.1 with respect to middle, low and lower class distinction) to 5.5 in 1988.

The crude death rate is currently calculated at 8/1000. This contrasts sharply with past crude death rate data. For 1950-1955 it was calculated by CELADE at 28.5/1000; and at 14.2/1000 for 1970-71 by the Honduran Demographic Survey. That latter figure represented a reduction of approximately 50 percent in a twenty year period. Mortality varies significantly according to region, place of residence, education and socio-economic status.

INFANT MORTALITY RATES

The 1987 National Epidemiology and Family Health Survey (NE/FHS) shows the decreasing IMR figures since 1967-68. The FHI version of the Study's Table IV C1, is reproduced below to illustrate those figures. IMR data, calculated according to the indirect method, suggest that in spite of the outstanding achievement of lowering the IMR in the face of the lowest per capita income rate in Central America (i.e., statistically the poorest country in Central America), the Honduran infant mortality rate is still high -- along with its adjoining Central American neighbors. But the fundamental achievements is indisputable: significantly less than the 127/1000 figure reported by EDENH I Survey of one generation ago, and less than the 85/1000 quoted by the EDENH II Survey of 1978.

IMR Estimates From Various Sources

(Source: FHI Version of 1987 NE/FHS)

Source	Estimate	Time	IMR
EDENH I	Indirect	'67-'68	127
1974 Census	Indirect	'68-'70	112
EDENH I	Direct	'71-'72	117
ENPA (1981)	Indirect	'76-'78	90
EDENH II	Indirect	'78-'80	85
MCH/FP (1984)	Indirect	1981	71
EFSH (1987)	Indirect	1985	61
NE/FHS	Direct	'85-'86	47

POPULATION UNDER 15 YEARS OLD

According to the MOH/S&T draft of the tables of the NE/FHS (Cuadro II-1) 47.6 per cent of the population of Honduras is under 15 years old. This is virtually identical to the figure estimated by the UN Statistical Office, and the 46.9 per cent estimated by Garcia for 1975. In contrast, 44.6 per cent of the population was under 15 in 1950. According to Garcia, Honduras contained about 620,000 children under 15 years old in 1950, in contrast to over 1.6 million in 1980. He projected a figure of about three million under the age of 15 by the year 2000. This projection was pretty much on target, given the most recent finding of the 1988 Census which places the medium age of the population at 16.1 years.

DEPENDENCY RATIO

The increase in the under 15 year old age group has had a direct effect on the dependency ratio. In the quarter-century between 1950 and 1975 the dependency ratio has increased from 89.7 to 98.8. According to the 1974 census, the dependency ration was 89.3 in urban areas and 113.4 in the rural countryside.

THE GOVERNMENT OF HONDURAS' VIEW OF POPULATION POLICY

The formal (de jure) population policy of the GOH is committed to formulating and implementing explicit population policies as a means of attaining overall development objectives. During the 1970s, the Government's development plans contained mainly implicit population policies. Following the establishment of a

120

technical planning unit for population studies within CONSUPLANE, a five-year population strategy was formulated in 1982 termed the Plan Nacional de Poblacion.

In 1983 the Government issued a decree which made family planning a priority area within the national primary health care program, a development which was apparently applauded as an outstanding initiative, as it is widely held that it is within the context of primary healthcare that the most significant family planning/child-spacing and other contraceptive information and service can be imparted with optimum confidentiality -- a feature which increases in importance in proportion to the socio-economic and sophistication level of targeted beneficiaries. Although confidentiality is an delicate issue at any socio-economic level, it is especially so for traditional rural poor population.

The Government's most recent reaffirmation of strong support for a national family planning policy can be seen in the development of a new population law, the wording of which has already been developed. The proposed law is now being discussed by the Congress prior to expected promulgation.

DE FACTO POLICY

However, the de facto policy of the GOH is significantly less enthusiastic in support of family planning than its de jure policy formulations. The reasons for this are unclear. Predictably, the Government was strongly criticized for the development of its populaltion policies by pro-life groups, and by some very influential groups within the Catholic Church, e.g., most leaders of the hierarchy and the Opus Dei group whose members are said to include at least one cabinet member (the Minister of Health) and numerous lesser officials -- but with major positions capable of influencing policy formulation and implementation. Some evidence suggests that precisely this has happened, i.e., some family planning policy has been formulated but not implemented.

Given the formulation of the proposed Population Law, it is doubtful that the Government will reverse itself on family planning. At worst (and said to be the most probable) the GOH will continue to permit FP activities to exist without any significant increase in support for the growth of government provided services. In fact, data for female voluntary contraceptive surgical procedures in the eleven hospitals of the Country indicate that fewer women are being surgically attended than previously. Since 1985 the number of such procedures have decreased by about 46 per cent.

YEAR	NUMBER OF PROCEDURES
1985	2485
1986	2501
1987	2213
1988	1414

An ideal scenario would be for the GOH/MOH to agree on the provision of the full range of family planning information and services within its primary healthcare network of CESAMO and CESAR clinics -- over 600 in all. The utilization of such clinics is suggested in the wording of the population law currently being discussed by the Congress. This would be an ideal development in the cause of family planning and child spacing in Honduras, given the generalized low rate of education and socio-economic status of those targeted beneficiaries most in need of family planning assistance, i.e., the poorest of rural campesino women. This is probably unrealistic, however: not for de facto policy reasons but for resources. According to the CRS office in Tegucigalpa, about 10 per cent of its annual allocation of medicines (over one-half million dollars worth) for the 165 Catholic parish-associated clinics, is donated to mostly CESAR, but also CESAMO, health centers of the MOH in those rural areas closest to the parish clinics -- and this because MOH clinics are frequently without basic medicines.

2. DIRECT AND INDIRECT BENEFICIARIES

The stated target group indentified by the draft PP are all women in union between the ages of 15 to 44 years of age. Men also are direct beneficiaries as users of condoms and acceptors of AQV surgical procedures. The most important indirect beneficiaries are the children of mothers, whose fewer pregnancies through child-spacing will, indisputably, result in her improved physical health. This is an especially vital concern in poor urban slums where single female-headed households are frequently the rule rather than the exception, and where dangers to childrens' health are many, great and frequently fatal.

One reason for high infant mortality rates this is the widespread lack of sanitary conditions in the homes of the poor. Poor water and sanitation facilities is known to increase the transmission and ingestion of pathogens which are the principal cause of diarrhea long the number one debilitator and killer of children under five.

Mothers in such housing conditions spend a great amount of time caring for sick children; and the death of a mother in poverty spells disaster for surviving children. A mother's chance of

death from childbirth is normally high among the poor. A worldwide calculation in a 1984 study by Rinehart, Kols and Moore, estimates the likelihood of death through childbirth to be 60 deaths per 100,000 women, for women under age 35. The possibility ascends to 160/100,000 for women over 35.

It is important to point out that the above quoted mothers-chance of-death (MCoD) figures are analagous to per capita income figures, in that while it is true that Honduras has a per capita income of US$ 740, it is well known that poor Hondurans earn much less, as the aforementioned SECPLAN data illustrate to be the case for the poorest rural poor. In other words, 60 or 160 childbirth deaths per 100,000 women are national-level figures for those respective age groups. Those MCoD rates, then, need to be understood in higher terms for the poor, and it is even much higher in those many cases of poor rural women who have a rapid succession of childbirths.

The Project has other direct and indirect beneficiaries proper to other Project components listed in the PID. Other than CSP(CBD), CSM, Clinical Services and management and administrative changes, the Project includes Information, Education and Communication (IE&C) for a wide range of persons, including community leaders and students. The employees of Employee-based Family Planning programs facilitated through employers are also potential direct beneficiaraies: as are all of those who could be reached through PVOs and other collaborating resources suggested in one of the PID drafts by "unemployed physician" type of program model.

3. HOW HAVE THE PERCEIVED NEEDS OF WOMEN AND MEN FOR FAMILY PLANNING BEEN DETERMINED. BY WHOM WERE THEY DETERMINED?

Several surveys, studies and reports demonstrate the needs of women and men for family planning services. In the FHI 1987 National Epidemiology and Family Health Survey data illustrate that nearly half of surveyed women in over 11,000 households desired no additional children. Some responses for not using contraception are also indicative of need. These include reasons of fear, opposition of husbands, lack of knowledge and distrust. A large number of women not contracepting expressed an intention to use family planning methods in the future. The two principal methods mentioned were pills (23.5 percent) and AQV surgical procedures. The most likely provider of family planning services was believed to be the Ministry of Health.

In the 1987 MOH/S&T study of 11,732 households nationwide it was found that 40.2 per cent of 7,343 women surveyed did not choose to conceive their last child or their current pregnancy. That study also found that 50.2 per cent of 2,953 women interviewed did not desire their last or current pregnancy. (Cf. cuadros III,

number 6 and 7 of the MOH/S&T draft of the 1987 NE/FHS study.

With respect to men, one focal group discussion of seven men who had undergone a vasectomy described some of the difficulties involved in doing so. One of the most salient problems mentioned which, probably, deters significant numbers of men is the insults and jokes of friends and neighbors when learning of the decision.

An applied research project based on a survey and a series of focal group discussions involving 959 men in three peri-urban communities by ASHONPLAFA and AVSC, in search of data which would yield lessons regarding how to more effectively market vastectomies. One quite remarkable finding (so remarkable that it is questionable, but very worthwhile replicating) was that while the participants are said to have been randomly selected, it was found that 67 per cent were actually using a family planning method, and that fully 36 per cent of their spouses had undergone AQV surgery. The findings included an indication that a significant number of the men were agreeable to undergo AQV surgey when they finish building their families.

The sessions also yielded information about ideal family size (between 2 and 4 children), beliefs about the effects of vasectomies and female sterilization and about the attitudes of persons who have undergone contraceptive surgery and of spouses, friends and neighbors of these. The data also indicates opinions about condoms and their appropriate use (primarily for use outside of marriage as they are used to prevent disease; they are not used with spouses because they endanger the health of spouses.) One important suggestion which emerged from the discussions was the need to protect confidentiality.

4. DESCRIBE PROJECT RESOURCES AND ACTIVITIES, AND THEIR APPARENT FIT OR CLASH WITH HONDURAN TRADITION AND CULTURE

The PID describes five programs (one other * is possible), one management and one administrative components as follows:

Program

- o Community Service Program (CSP/CBD)
- o Contraceptive Social Marketing (CSM)
- o Clinical Services
- o Information, Education & Communication, and Education of Leaders (Mass Media -- IE/C)
- o Employee Based Family Planning
- * PVOs (for further intensive review)

Management

- o Statistics, Evaluation & Operations Research

Administration

-124'

- o Computerization of financial management system
- o Inventory management

Clearly, one the most voiced concerns of ASHONPLAFA staff is the difficulty of reaching the poorest households in rural Honduras where roughly 61 per cent of the population live, as well as the poorest of the urban poor. According to the illustrated socio-economic class categories, the beneficiaries of ASHONPLAFA were estimated based on ASHONPLAFA data on education levels attained by beneficiaries, and by the differences of urban/rural situations as reported in numerous studies and reports. ASHONPLAFA staff were asked to comment and revize estimates according to their best impressions.

SOC.ECO CLASS	RURAL	PERI-URBAN	URBAN
upper-upper	n/a	none	none
upper-middle	n/a	none	none
upper-lower	none	none	none
middle-upper	5%	5%	5%
middle-middle	15%	15%	15%
middle-lower	25%	25%	25%
lower-upper	32%	35%	30%
lower-middle	20%	17%	20%
lower-lower	3%	3%	5%

As has been discussed above (No. 5) rural isolation is a major reason why access to the lower-lower sector of the population is so difficult. Coupled to the almost total absence of formal educational opportunities, the task of enabling the rural poor to exercise their right to undertake effective family planning is, indeed, a challenge. The PID calls for the employment of eight additional CSP(CEI) promoters each attending to an average of 65 distribution points. The possibility of the use of motorcycles is discussed. This would certainly facilitate the reaching and training of many more volunteers during the dry seasons, if the proper maintenance of motorcycles can be assured. Other motorized transportation is being considered, and would be appropriate for the winter/rainy seasons.

But in spite of the serious problem of rural isolation, there are other reasons at play for why there is not a greater number of the rural poor involved in ASHONPLAFA family planning programs. As has already been mentioned, the rural poor are also those who have the least opportunity for a formal education, and this is clearly related to higher individual fertility rates. In great part, of course, the lack of educational opportunities frequently is a consequence of living in remote regions where the only means of transportation in or out of an aldea hamlet is by foot or on

horseback.

Another reason is the cost of contraceptives. An early PP draft points out that the ASHONPLAFA pricing structure for all CSM products is based on the "generally accepted social marketing price parameter of one to two per cent of minimum wage for contraceptive protection." Given that the minimum wage in Honduras is L.200.00 per month (US$100), it then follows that the cost of one month's worth of contraceptive protection is L.3.36 for condoms; L.2.00 for Nominest and L.1.50 for Perla. Of course it is well known that very few rural workers earn the minimum wage. But if the aforementioned SECPLAN data about rural monthly income is anywhere near correct then ASHONPLAFA products are priced beyond the reach of those rural poor which that figure represents. Analagous reasons may keep the involvement of the poorest urban dwellers low.

Still another reason for the low number of poor involved in the ASHONPLAFA program is verguenza (shame). For many people around the globe -- but especially rural women with little formal education -- human sexuality is not a topic of normal discussion -- especially with strangers. The usual contexts in which the traditions of many societies maintain that sexuality may be discussed by women relate to jokes, domestic disputes, the birth process: and this among close kin and friends. The anthropological literature is filled with descriptions of sexual taboos and the extreme sensitivity that many peoples have about discussing the subject.

Discussions about sex are accepted as normal occurances among men, but not among women -- an attitude which includes the almost universal belief that casual and extra-martial sex is an acceptable weakness for men, but worthy of scorn for women, at best: at worst she is to be killed. None other that our Judeo-Christian scriptures call for a women's death by stoning when caught in adultery. In one Tegucigalpa taxi a colorful sticker reads "Yo soy soltero; es mi esposa que es casada." (I'm single. It's my wife that's married.) Such attitudes are widespread, even among so-called "sophisticated people" and stems from very ancient traditions -- in the West, anyway.

The point about the above discussion is that such sensitivities are alive and well in Honduran society, and most probably plays a part in why so few poor Honduran rural women, relative to their total number, avail themselves to existing opportunities to use family planning methods. But some rural poor women are family planning acceptors. So while the challenge to market the service to them is extremely difficult, it is not impossible. Given the impossibility of providing even a few years of a primary school education to the many rural Honduran communities without schools (that would be a most significant "contraceptive" program) the following suggestions may be helpful.

It is crucially important that the CSP(CBD) promoters be trained in cultural sensitivity so that they understand and can articulate its importance to the volunteers they will have a major role in selecting. It is also important that promoters themselves have superb inter-personal skills, and that they are able to recognize those skills in potential volunteers. This qualification is of the greatest importance for relating to traditional rural poor people -- to such a point that it needs to be given greater weight in the promoter and volunteer selection criteria than technical and administrative abilities. It is also advisable to develop formal alliances with the elder women and midwives of rural communities, as these are generally persons of relatively high status and influence in their communities. Needless to say, such persons need to be regularly and publicly recognized for their collaboration and service.

5. DESCRIBE THE DESIRED EFFECTS RESULTING FROM THE INVESTMENT OF THESE RESOURCES AND ACTIVITIES: BY USAID; BY ASHONPLAFA.

The desired effects resulting from the Project are articulated in the PID under the Project Description (II), Sections B (Project Goal and Purpose) and C (Expected Achievements/Accomplishments). The principal desired effect is the reduction of the Country's crude birth rate by assisting in the strengthening and expansion of family planning services in both private and public sectors.

Given that the the GOH's implementation efforts have not kept pace with its policy, a desired effect is to see improvements in this area. A greatly increased role in family planning for the widespread network of Government CESAMO and CESAR primary health clinics has the potential of increasing the number of women using family planning services by significant numbers, and this because the use of primary care clinics guarantees confidentiality to a much greater extent than can the utilization of services by organizations exclusively dedicated to family planning.

The goal of the Project is to reduce the current Total Fertility Rate (TFR) from 3.9 urban and 6.8 rural, to 3.0 urban and 5.8 rural. Another desired outcome is expressed as the Project Purpose, which is to increase contraceptive prevalence (defined as the "percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50.4 % in 1993. The key expected achievement/accomplishment according to the Mission's CDSS, is to increase access to voluntary planning services and contraceptive prevalence from 41% to 50% in 1993.

The primary measurement of achievement will be the level of fertility rates as measured in contraceptive prevalence surveys to be carried out in 1990 and 1993. Measurable results will be

the number of acceptors, an increase in the variety and quantity of contraceptive products offered, the expansion of distribution outlets, and the number of surgical procedures preformed.

6. DEVELOP PROFILES FOR PROGRAM BENEFICIARIES

When the ASHONPLAFA program began, the typical beneficiary was over 35, with an average of four children whose basic reason for seeking service is their wish not to have additional children. This is still the general pattern for newly implemented outreach programs, particularly the CSP(CBD) program. The initial phase of ASHONPLAFA's work with these women is education, in the course of which fears are allayed and confidence in the program established. This confidence on the part of the new acceptor is important, as it is the basis upon which younger women of the community are encouraged to come for assistance.

There are three basic demographic characteristics which ASHONPLAFA uses to characterize its beneficiaries. These are age, number of children and years enrolled in formal education, and this with respect to each of the three major programs: Servicios Medicos (SM), Community Service Program CSP(CBD) and Anticoncepcion Quirurgica Voluntaria (AQV).

Servicios Medicos (SM): In the context of the Servicios Medicos program, service is provided to women between the ages of 20 and 29 years of age. This age group represents 71 per cent of the total SM program beneficiaries. This is consistent with the fact that the 20-29 age group represents those women with the highest statistical fertility rate.

Community Service Program (CSP): The age of the typical CSP acceptor gets older in this primarily rural program, i.e., the age group attended is primarily rural and is between the ages of 30 and 34. Of the total 71 per cent, 43 per cent are between the ages of 30 and 34. Given as a major reason for the high percentage of women over 30 in this CSP program, is the fact that the program is carried out in a primarily rural context where there is no other choice.

Anticoncepcion Quirurgica Voluntaria (AQV): Women targeted for this program are between 25 and 39. 66 per cent are between the ages of 30 and 34. The percentage climbs to 83 per cent when the age group from 35 to 39 is added, i.e., for women between 30 and 39. Approximately 17 per cent are between the ages of 25 to 29.

According to the three major variables of age, number of children and years of formal education, ASHONPLAFA data indicate that the typical ASHONPLAFA beneficiary uses the organization's three major programs to the extent indicated in the tables below:

178

BY AGE	SERVICOS MEDICOS	AQV	CSP/CBD
15 to 19	9.4%	0.4%	5.8%
20 to 24	33.5% 47.9	11.1%	21.1% 26.7
25 to 29	38.2%	35.1% 46.6	29.8%
30 to 34	10.5%	30.9%	20.8%
35 to 39	5.2%	17.8%	13.0%
40 and Over	3.1%	4.7%	9.4%
	100.0%	100.0%	100.0%

BY NUMBER OF CHILDREN			
NO CHILDREN	5.2%	0.0%	1.3%
1 CHILD	35.1%	0.8%	36.5%
2 CHILDREN	30.9%	3.3%	38.0%
3 "	15.2%	22.3%	12.1%
4 "	6.3%	30.2%	12.1%
5 OR MORE	7.3%	43.4%	
	100.0%	100.0%	100.0%

BY FORMAL EDUCATION			
NONE	2.6%	17.4%	9.8%
PRIMARY/INCOMPLETE	16.2%	54.3%	40.0%
" /GRADUATED	24.6%	21.3%	29.8%
SECONDARY/INCOMP	15.2%	2.4%	12.3%
" /GRADUATED	33.1%	4.4%	6.8%
SUPERIOR SCHOOL	7.3%	0.2%	0.4%
	100.0%	100.0%	100.0%

In the Servicios Medicos program the principal intention of the participants is reported to be child-spacing. 71.2 per cent of

those enrolled in the SM program have two children or less. In comparison, 93% of the AQV program users are those with three or more children. The CSP program provides temporary contraceptive services for women with significant numbers of children: 24.2 per cent of these have five or more children.

Regarding formal educational levels, the great majority (81.2%) of the acceptors have completed at least primary school. Only 2.6% of those in the CSP program have had no formal schooling; 16.2 per cent have had some primary education. In other words, only 18.8 per cent have have little or no education. Yet in that same category of women with little or no formal education, a fully 71.7 per cent underwent surgical sterilization.

7. ASSESS THE DE JURE AND DE FACTO COMMITTMENT OF THE GOH TO FAMILY PLANNING AS DESCRIBED IN THE 5 YEAR SECPLAN, AND THE RECENTLY FORMULATED POPULATION LAW.

As indicated above under Comments on Suppositions, the formal de jure policy of the Government strongly supports family planning. It cannot be faulted. The GOH's health objectives are largely those established by the Pan American Health Organization for the countries of the Americas for the year 2000. As regards family planning/child-spacing, a principal stated objective of the SECPLAN is,

> "to increase contraceptive prevalence to 60 per cent of women in union in the fertile age group."

The GOH's and USAID's benchmarks for monitoring progress in the attainment of this objective are the following

	1980	1985	1990	1995	2000
Contraceptive Prevalence	25%	35%	45%	53%	60%

The above being the case, this Project is fully consistent with the GOH's National Development Plan for 1987-1990, and the health sector policy statement developed by the current Honduran Administration in March 1986 and published in the document entitled Politica Nacional de Salud. In the context of that plan the Government identifies and describes basic programs and the strategies to be used for implementing them, and stresses the importance of strengthening the basic health system which includes Maternal and Child Care in which family planning is conceived of as an essential/integral part. The strategies for implementing these programs include community participation, inter and intrasectoral coordination aimed at behavior modification, appropriate technology, human resource development,

improvement in the logistics system, and making more effective use of external financing and technical assistance.

KEEPING PACE WITH POLICY

As has been noted above, the formal policy of the GOH with respect to family planning is widely believed, primarily by ASHONPLAFA staff, to be far ahead of its de facto achievements. Reference is made to the above discussion on this topic, under Comments on Suppositions, Number 6.

8. REVIEW AND ESTIMATE THE EXTENT TO WHICH BENEFICIARY PARTICIPATION CAN BE ACHIEVED DURING PROJECT DEVELOPMENT.

The writer is assuming here that "beneficiary participation" means participating as a volunteer in the cause of the program. In that sense,"beneficiary participation" is an ideal for many human service programs and has a well developed international literature within the schools of social work and community development.

How difficult or easy it is to attain benficiary participation depends on a host of factors: many of them cultural, but maybe as many depending on accidentals -- the luck of having the right beneficiaries, at the right time, in the right place; and the luck of having the right staff members. With respect to family planning programs, the participation of beneficiaries is an extension of the creativity of donors, program designers and administrators, consultants, etc. In a recent consultant report to the USAID/H Mission, Ana R. Klenicki suggested numerous creative programming possibilities which could involve a wide range of beneficiaries on a volunteer basis, in activities which would be informative for them and conducive for the recruitment of other clients, as well as activities which would be fun to do.

One type of indirect beneficiary program, directly related to family planning, has proved successful in relatively small PVO primary health clinics among indigenous peoples in the Guatemalan Indian Highlands. "Indirect beneficiary" is stressed, because the volunteers used to break the constraint of the verguenza of Indian women to enroll in a child-spacing program were elder women, some of them traditional midwives; numerous of them the spouses of the community's formal council of elders called the principales. As such they carried the highest status and prestige in the community.

The purpose of these women (referred to as the "ancianas") was to visit every extended family compound in the town (of over 20,000 population in 1973) to ask if anyone was sick. Illness, rather than health, was stressed, because a semantic feature of the

131

Mayan word for "sick" included the notion of pregnant. In other words a women became "sick" as soon as she became pregnant. Pregnancy was a condition requiring special care and special rituals and prayers of protection: some of them against death, as death in childbirth was not a rare occurrence. So while the birth of a child was a fundamentally joyful event, it was also a dangerous time. The cultural milieu, therefore, was right for such an initiative.

What was also "right" was the well known local PVO nurse who had exceptional interpersonal skills; and who gave and received kindness with ease. The ancianas asked her help. She responded. In time references for family planning assistance became an integral part of the compound visiting program.

Can such an effort be made in the rural areas of Honduras? There is one anthropological monograph on compadrazco in the Oriente region of Guatemala (bordering on Honduras) by Doctor Carl Kendall, of Johns Hopkins University, which suggests that Ladino (non-Indian) campesino elder women also have high status and corresponding influence in their communities. In other words, the cultural basis for making such an effort in rural Honduras is probably existent. Whether the financial and appropriate "right stuff" staff resources are available is another issue which needs to be examined. It cannot be overstated, that success or failure of many such programs depends heavily on the selection of the right volunteers and the right staff people.

PERSONS CONTACTED

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LITERATURE & MATERIALS CONSULTED

ASHONPLAFA & Tulane University, Encuesta Para Determinar Las Actitudes y Conocimiento de los Hombres Hacia La Vascetomia (no date)

ibid Informe Evaluativa de la Actividades Realizadas por ASHONPLAFA en 1986

ibid Boletines Estadistica de los anos 1986, '87 y '88

ibid Acuerdos: Reunion Interinstitucional, 1988

ibid Cost per Couple CYP Work Spreadsheet, 1988

Bacarit, M Poblacion y Religion, Centro de Orientacion Familiar La Paz, Bolivia 1987

Bogue, Brackett, Mamlock, Tsui: Una Proyeccion de las Necesidades y Los Costos de la Planificacion Familiar de 1985-2000, (1986)

Boone, Farley, Samuel: "A Cross-Country Study of Commerical Contraceptive Sales Programs: Factors That Lead to Success", in Studies in Family Planning -- 1985

Brown, Coeytaux, Chipoma, Manda and Muntemba: "Characteristics of Contraceptive Acceptors in Lusaka and Zambia, in Studies in Family Planning -- 1987

Correa, H., Economic Analysis of the Private Sector Population Program II -- March 1989

Davies, M., Educacion de Adultos, Proyectos Comunitarios y Planificacion Familiar: IPPF/RHO -- 1981

Demeny, P., The Economic Rationale of Family Planning Programs. Center for Policy Studies Working Papers; The Pop Council -- 1987

Echeverry, G Acduerdo Cooperativo Entre USAID/H y ASHONPLAFA: Comentarios y Recomendaciones -- 2/1989

EHENH II Encuesta Demografica de Honduras: Informes Generales Volume 2 y 4 -- 1983

FHI Version National Epidemiology and Family Health Survey -- 1987

Findlay, A., Population and Development in the Third World. Mathuen Introductions to Development: NY/London -- 1987

Futures Group, Central America: Effects of Population on Economic and Social Development -- 1983

GOH/MOH & ASHONPLAFA (with MSH and FHI) Maternal-Child Health and Family Planning: Honduras -- 1984

Hernandez, D.J., "Fertility Reduction Policies and Poverty in Third World Countries: Ethical Issues" in Journal of Applied Behavioral Science -- 1984

Hess, P.N., An Eclectic Model of Contemporary Fertility Transition. Carolina Population Center, Univ. of North Carolina -- 1987 (unpublished)

Holzhausen, W., "The Population Problem in Turkey: Perspective of a Foreign Donor" in the Turkish Journal of Population Studies -- 1987

Jain, A.K., "The Impact of Development and Population Policies on Fertility in India" in Studies in Family Planning -- 1985

JRB Associates Country Environmental Profile: A Field Study. (For USAID/H) -- 1982

Kim, I.K., Socioeconomic Development and Fertility in Korea. Population & Development Studies Center, Seoul National University -- 1987

Klenicki, A.E., Development of a Mass Media Strategy for ASHONPLAFA. URC -- 1988

Knoldel, J and E. Van de Walle "Lessons From the Past: Policy Implications of Historical Fertility Studies" from the Proceedings of the Conference on European Fertility: Princeton University -- 1986

Mejia, E., Don't Be Afraid Gringo. Institute for Food Policy Studies, San Francisco, CA -- (no date)

MOH/ASHONPLAFA Encuesta Nacional de Salud Materno-Infantil de Honduras (done with MSH and FHI) -- 1984

MOH/S&T and FHI National Epidemiology and Family Health Survey (MOH/S&T Draft Version of Tables) -- 1987

Monteith, R.R. et al. "Contraceptive Use and Fertility in Guatemala" in Studies in Family Planning -- 1985

Ni Bhrolchain, M., "The Interpretation and Role of Work Associated Accelerated Childbearing in Post-War Britain" in European Journal of Population/Revue Europeene de Demographie -- 1986

Nemeth, R.J., Fertility Decline In The Modern World Economy. University Microfilms International, Ann Arbor, MI 1987

PRB, Contraceptive Saftey: Rumours and Reality. Washington, D.C. 1988

Palacio-Garcia, J., Perfil Demografico de Honduras. ENLACE 1983

Poston, D and B. Gu "Socioeconomic Development and Fertility in China" in Demography -- 1988

Satter, M.A., "Population Resources and Development" in Feedback, Sept-Dec; #13 -- 1987

SECPLAN Encuesta Continua Sobre Fuerza de Trabajo. (Volumes on Regions 1 to 6; and Volume on Total Rural) 1987

SECPLAN Monografia de la Poblacion de Honduras -- 1985

Schneider, E.L., "Prospects and Implications of Extending Life Expectancy" (from PRB Library, journal not identified) -- 1987

Schuler, McIntosh, Goldstein & Raj Pande, "Barriers to Effective Family Planning in Nepal" in Studies in Family Planning in Nepal -- 1985

Suazo, M., and R. Aplicano, Poblacion y Desarrollo Social en Honduras. ASHONPLAFA -- 1986

Suazo, M., Analisis del Situacion Demografica Actual en Honduras. ASHONPLAFA -- 1986

United Nations, The Major Proximate Determinants and their Contribution to Fertility: Selected Findings From the World Fertility Survey Data -- Dept. of Int'l Economic and Social Affairs: Population Division (unpublished) -- 1986

Universidad Nacional Autonoma de Honduras, Diagnostico Socio-Demografico de Honduras. Dept. of Economics, Population Unit -- 1989

USAID Demographic and Health Data for Child Survival Projects -- 1988

USAID/H PID for Population II -- 1/12/88

USAID/H Project Paper, Health Sector II -- 2/10/88

USAID/CDIE The Sustainability of U.S. Supported Health, Population and Nutrition Programs in Honduras: 1942-1986 -- Dec. 1988

Wheeler, D., Female Education, Family Planning, Income and Population: A Long Run Simulation Model. World Bank Staff Working Papers No. 677 -- 1985

Xu, D (N.Birdsall, Ed.) The Development of National Economy and Family Planning in China. China Population Association, Beijing -- 1986

ECONOMIC ANALYSIS OF THE PRIVATE SECTOR POPULATION PROGRAM II

HECTOR CORREA

Executive Summary

This document has two parts:

a) An economic evaluation of the Private Sector Population Program II, and

b) An analysis of the price elasticities of different contraceptives.

The first part could be useful to decide whether Program II should be implemented. Part b) is likely to provide some guidelines for pricing policies. Under ideal conditions, these two components should be integrated because different pricing policies would determine different costs and benefits for the program. However, with the statistical data available it is not possible to do so. In addition, the results of the economic evaluation of the Program showed that it is in sufficiently solid grounds, so that moderate changes in pricing policies are not likely to eliminate its economic soundness.

1.- Economic evaluation of the Private Sector Population Program II. Well known methods of economic evaluation are used in this economic evaluation of the Private Sector Population Program II. These methods include the following steps:

a) Forecast of the total number of births and persons of different ages avoided. Description of this step is presented in appendix 1.

b) Forecast of medical expenditures per birth and of other health related expenditures per person in the population. This step is described in appendix 2.

c) Forecast of consumption expenditures per person in the ages relevant for the program being evaluated. The approach used in this step is presented in appendix 3.

d) Forecast of the educational expenditures per child. This step is described in appendix 4.

e) Forecast of the costs of the program. The estimates of these costs prepared by AID are used below. The values in dollars were transformed to lempiras using the official rate of exchange of 2 lempiras per dollar.

The birth, health, consumption and education expenditures per person are multiplied by the estimated number of births and persons avoided with the population program to obtain total expenditures avoided. The results obtained with this procedure are presented in Tables 1-A in dollars and 1-B in lempiras. The transformation is done using the official rate of exchange. These total expenditures avoided are considered the economic benefits of the program.

The economic benefits and the costs are compared in Tables 2-A and 2-B in dollars and lempiras. First, the values of gross benefits, gross costs and net benefits are presented, next discounted present values of the gross figures and of the net benefits are computed, and finally, the internal rate of return is calculated. The results in Table 2 clearly indicate that the Private Sector Population Program II is justified from an economic point of view.

The net present values of costs and benefits of the program discounted at a 12% rate, show that the benefits are about 2.5 times the costs. The internal rate of return indicates that only if the discount rate would reach a value of more than 31%, the program would not be economically justified.

2.- Impact of the changes in prices of contraceptives on their utilization.

The method used for the estimation of the price elasticities of contraceptives for which a minimun of required information is available is described in appendix 5. To a large extent it is simply an adaptation of standard methodologies to a situation in which data are extremely scarce.

The results obtained are presented in Table 3. The interpretation of these results shows that a 10% increment in prices would reduce the utilization of condoms in a 2%, of ovral in a 20% and of Lofemenal in a 30%. This suggests that using revenues obtained increasing the prices of condoms increases in prices of Ovral or of Lofemenal could be avoided or limited. This policy could be adopted if there is evidence that the contraceptive efficiency of condoms is lower than that of the other two contraceptives.

It is worthwhile to notice that further research in the topic outlined above might lead to substantial improvements in the cost/effectiveness of the population program.

TABLE 1-4

TOTAL EXPENDITURES AVOIDED
(1988 DOLLARS)

YEAR	CONSUMPTION	HEALTH	EDUCATION	TOTAL
2000.00	0.00	0.00		0.00
2001.00	1[illegible]162.56	60009.00		526171.56
2002.00	2076720.00	145197.55		2221917.55
2003.00	4149397.36	244630.28		4794527.64
2004.00	2483896.56	355435.60		6841032.16
2005.00	8361764.24	474026.68		9335790.92
2006.00	11822900.77	587035.35		12409936.12
2007.00	16194242.29	663993.09		16858235.38
2008.00	21019232.50	740642.09	2241499.50	24001374.49
2009.00	1[illegible]77632.00	816754.03	5395088.53	32349674.55
2010.00	28028702.90	915335.60	6226410.96	35210449.46

TABLE 1-B

TOTAL EXPENDITURES AVOIDED
(1988 LEMPIRAS)

YEAR	CONSUMPTION	HEALTH	EDUCATION	TOTAL
1990	0.00	0.00		0.00
1991	922325.12	120015.00		1052343.12
1992	4153440.00	290395.09		4443835.09
1993	8299794.72	489260.56		8789055.28
1994	12971193.12	710671.19		13682064.31
1995	17722729.48	948051.35		18670781.83
1996	23458841.54	1174070.70		24814872.24
1997	32388484.59	1327986.17		33716470.75
1998	42036505.80	1481264.16	4482999.00	48002768.96
1999	52275664.00	1633508.05	10790177.05	64699349.10
2000	58137406.79	1930671.20	12452821.92	70420898.91

TABLE 2-4
(1988 DOLLARS)

COMPARISON OF COSTS AND BENEFITS OF POPULATION PROGRAM

YEAR	TOTAL BENEFITS	TOTAL COSTS	NET BENEFITS
1989	0.00	3469400.00	-3469400.00
1990	0.00	5528903.00	-5528903.00
1991	526171.56	5475968.00	-4949796.44
1992	2221917.55	5743628.00	-3521710.46
1993	4394527.54	6113242.00	-1718714.36
1994	6841032.16	3380464.00	3460568.15
1995	9335390.92		9335390.92
1996	12409936.12		12409936.12
1997	16656235.38		16656235.38
1998	24001394.49		24001394.49
1999	32349674.55		32349674.55
2000	38210449.46		38210449.46
TOTAL	119821.04	24234617.44	
TOTAL RATE OF RETURN			0.[illegible]

TABLE 2-B
(1988 LEMPIRAS)

OMPARISON OF COSTS AND BENEFITS OF POPULATION PROGRAM II

EAR	TOTAL BENEFITS	TOTAL COSTS	NET BENEFITS
1985		6938800.00	-6938800.00
1986	0.00	11057806.00	-11057806.00
1987	1052343.12	10951936.00	-9899592.88
1988	4437835.09	11487256.00	-7043420.91
1989	8789055.28	12226484.00	-3437428.72
1990	15682064.31	8760928.00	6921136.31
1991	18670781.83		18670781.83
1992	24819872.24		24819872.24
1993	33716470.75		33716470.75
1994	48002788.98		48002788.98
1995	64699349.10		64699349.10
1996	70420898.91		70420898.91
TOTAL	342910432.08	40469234.87	

INTERNAL RATE OF RETURN 0.31

Table 3

PRICES AND UTILIZATION OF CONTRACEPTIVES IN HONDURAS

CONTRACEPTIVES	P.ELAST.	IMPACT 10% INCRES.
PILL	-1.108	-11.08%
CONDOM	-3.811	-38.11%
IUD	-0.204	-2.04%

APPENDIX 1

FORECASTS OF THE TOTAL NUMBER OF BIRTHS AND OF PERSONS OF DIFFERENT AGES AVOIDED

The point of departure in the computation of the forecast of the total number of births and of persons of different ages avoided is the estimates of the total fertility rates (TFR) presented as project goals in the PID. These rates were used to estimate the age specific fertility rates to be used to estimate the births avoided. The estimation of these fertility rates was done using the total fertility rates and the age specific fertility rates used in to forecast the population growth in Honduras up to year 1990. (Secretaria Tecnica del Consejo Superior de Planificacion Economica y CELADE "Honduras: Proyeciones de Poblacion, Volumes I and II).

In agreement with the PID, the program is supposed to last up to 1995. To prepare the forecast up to year 2000, it was assumed that the age specific fertility rates achieved with the program will change between 1995 and 2000 in the way they would have changed if the program would not have taken place.

After the computation of the age specific fertility rates to be used to forecast number of births, the actual computations were made using the standard methods available.

The forecasts of births with the project were used to compute population by single years of age between 1990 and 2000 in the ages relevant for the analysis of the program. The estimate number of births and of persons avoided presented in Table 1-1 were obtained substracting from forecast prepared from data in the official population projections those prepared using the fertility rates computed assuming that the targets of the project will be achieved.

TABLE 1-1

POPULATION AVOIDED WITH PROGRAM II

AGE	1990	1991	1992	1993	1994	1995	1996
0	0	3816	7798	11951	16282	20796	25708
1			9202	12746	16434	20269	15638
2				9304	12193	15188	19406
3					8183	10399	14508
4						9827	8721
5							5498
6							
7							
8							
9							

AGE	1997	1998	1999	2000
0	27135	28626	30185	31814
1	18447	20603	32870	35255
2	14407	17919	30055	32291
3	14821	14179	27407	29503
4	7828	13097	18447	26283
5	14887	15405	19121	13913
6	4966	11553	19677	14519
7		10340	12848	11134
8			10587	8100
9				6019

APPENDIX 2

FORECAST OF MEDICAL AND OTHER HEALTH RELATED EXPENDITURES

The point of departure for the computation of the expenditures in health were input costs - excluding personnel costs - provided by the MOH. This information is presented in Table 2-1. It was assumed that the costs will increase 2% per year in constant prices.

It should be observed that the estimates of health costs and their rate of growth tend to under estimate the benefits of the births and persons avoided with the population program. This point is important because, as mentioned in the executive summary, the benefits are substantially larger than the costs. The under estimation mentioned here is another reason to believe that the program is economically sound.

TABLE 2-1

EXPENDITURES IN HEALTH SERVICES

EXP. PROVIDED PER BIRTH	
7 PRE NATAL VISITS	17.37
DELIVERY BY TRADITIONAL ATT.	3.08
POST NATAL CARE	2.61
COMPLETE SCHEDULE OF VACCIN.	3.05
TOTAL	26.11

ANNUAL EXP. FOR CHILDREN 0-4	
7 EPISODES RESPIRAT. INF.	1.16
GROWTH AND DEVELOP. VISITS	2.955
TOTAL	4.115

NOTE: PERSONAL SERVICES ARE NOT INCLUDED
QUANTITATIVE INFORMATION PROVIDED IN THE MON

APPENDIX 3

FORECAST OF THE CONSUMPTION EXPENDITURES PER PERSON

The point of departure for the estimation of the consumption expenditures per persons is the data in Table 3-1. This information was elaborated from data in the 78/79 household survey (Secretaria Permanente del Tratado General de Integracion Economica Centroamericana - SIECA - "Patron del Gasto y del Consumo de Alimentos en los Hogares en Honduras", Documento No. 31/82, Octubre 1982). Only the weighted average of the figures corresponding to the 0-100 and the 100-300 income levels also presented in Table 3-1, was used for the estimations utilized here. The reason for this is that the project benefits mainly women in low levels of income. In any case, the worst scenario is that with the procedure used the consumption expenditures under estimated. If this is the case, the observations made with respect to the under estimation of the health costs also apply here. This means that there are additional reasons to believe in the economic soundness of the program.

It can be seen in Table 3-1 that expenditures in health are included among the family expenditures presented there. It is assumed below that these private health expenditures are not included in those considered in the Appendix 2 that deals mainly with public expenditures. In any case, even if there is some duplication, the fact that the proportion of the family expenditures in health is a very small proportion of the total family expenditures shows that the margin of error introduced is not likely to be important.

Special attention was given to the distribution of the total family expenditures between persons of different ages. For this it was assumed that total expenditures were distributed among persons of different ages in the same proportions as the consumption of calories and proteins are distributed. To estimate these proportions, information in Recomendaciones Dieteticas Diarias for Centro America y Panama produced by INCAP (1973) were used.

It was also assumed that the average family size is 5.16 persons, i.e., the figure given in the 78/79 Household survey and that a family is formed by 3/4 of a child 0-4, 3/4 of a child 5-9, 3/4 of a child 10-14, 3/4 of a child 15-19, and 2.16 adults.

The results obtained with the assumptions made above and used for the analysis of the benefits of Program II is presented in Table 3-2.

TABLE 3-1

RESULTS OF 78/79 HOUSEHOLD SURVEY

INCOME [illegible]	N.HOMES	FAM.SIS.	AV.INCM.	TOT.EXP.	PROPORTIONS OF EXPENDITURES		
					SAVINGS	FOOD	DRINKS
3-100	757.000	4.292	73.246	65.630	0.103	0.679	0.102
[illegible]	[illegible].000	5.350	138.754	170.920	0.094	0.627	0.090
[illegible]	[illegible].000	6.025	384.219	343.589	0.105	0.542	0.065
[illegible]	[illegible].000	6.362	696.599	590.665	0.152	0.433	0.055
[illegible]	748.000	8.336	2103.382	1400.327	0.335	0.268	0.034
[illegible]	[illegible].000	5.160	167.948	151.954	0.096	0.637	0.084

	HOUSING	CLOTHING	HEALTH	ENTERTEIN	TRANSPOR	OTHER
[illegible]	0.152	0.037	0.015	0.002	0.007	0.001
[illegible]	0.137	0.071	0.042	0.014	0.017	0.011
[illegible]	[illegible]	0.087	0.059	0.025	0.021	0.031
[illegible]	[illegible]	0.095	0.070	0.032	0.036	0.055
[illegible]	[illegible]	0.090	0.094	0.037	0.064	0.150
[illegible]	[illegible]	0.066	0.036	0.012	0.018	[illegible]

TABLE I-2

EXPEN. PER PERSON

AGE	
0-4	244.32
5-9	335.69
10-14	438.51
15-19	491.[illegible]
20-	1254.53
TOTAL	2804.82

APPENDIX 4

FORECASTS OF EDUCATIONAL EXPENDITURES PER CHILD

Educational expenditures per child were computed on the basis of the information presented for elementary education in the Anteproyecto del Presupuesto General de Ingresos y Egresos de la República para el Ejercicio Fiscal 1988, published by SECPLAN, and information on the number of students in elementary school provided by AID/HRD. The estimates of costs per student at constant 1988 lempiras were forecasted up to year 2000. The results are presented in Table 4-1.

TABLE 4-1

EDUCATIONAL EXPENDITURES PER STUDENT
LEMPIRAS PER YEAR

YEAR	EXPEN
86	221.28
87	227.41
88	238.92
89	251.55
90	265.65
91	281.56
92	299.24
93	318.46
94	339.03
95	360.59
96	383.31
97	407.46
98	433.14
99	460.43
2000	489.44

APPENDIX 5

ESTIMATION OF THE PRICE-ELASTICITIES OF CONTRACEPTIVES

The data used for the estimation of the price elasticities Ovral, Lofemenal and Condoms are included in the PID, and are summarized in Table 5-1. It should be clear that only the basest minimun of data are needed are available, and, as a consequence the results obtained cannot be considered definitive.

No attempt was made to correct the information of the use of contraceptives to consider changes in income and size of the population of potential users. It was considered that income per capita has remained stable, or even decreased in the last few years in Honduras. No information is available on the number of potential users of Ovral and Lofemenal. It was considered that it was more appropriate to simply treat changes of income and size of potential users, together with the efforts made in the last few years to increase the use of contraception, as determinants of a time trend.

The actual estimation of the elasticities was done with a regression equation of the form

$$c = a + b*t + c*x$$

where the notation means

c natural logarithm of contraceptive utilization,

t time index, and

x natural logarithm of prices

The following results were obtained for these regressions:

$$\ln OVRAL = 10.265 + .262*t - 1.108*\ln PRICE$$

$$\ln LOFEMENAL = 2.552 + 1.556*t - 3.811*\ln PRICE$$

$$\ln CONDOMS + 10.924 + .270*t - .204*\ln PRICE$$

In these equations, the coefficients of lnPRICE are the elasticities of the different contraceptives with respect to their prices.

TABLE 5-1

USE AND PRICES OF CONTRACEPTIVES IN HONDURAS

YEAR	ORAL		LOFEMENAL		CONDOMS	
	USE	PRICE	USE	PRICE	USE	PRICE
1983	28198	1.5			110164	.10
1984	32982	1.5			154997	.10
1985	47142	1.5	14146	.50	217574	.10
1986	61671	1.5	186726	.50	257926	.10
1987	110049	1.5	317385	.50	329510	.10
1988	117946	2.0	340374	.80	389380	.20

ASHONPLAFA

ADMINISTRATIVE ANALYSIS

A. ORGANIZATION

I. Legal Status

The Honduran Family Planning Association (ASHONPLAFA) was established in 1963 and obtained its "Personería Jurídica" (Legal Authorization) under Resolution No.64 by the Ministry of Government and Justice dated May 13, 1964. It is a tax-free, non-profit organization entirely in the private sector with no racial, political, religious or social affiliations or policies. ASHONPLAFA acts upon its own authority and does not require approvals from any other Host Country Agency or governmental entity to act in any area of its operations.

II. Financial Status

ASHONPLAFA is an affiliate of the International Planned Parenthood Federation (IPPF) and, as such, receives part of its operating funds from that organization. The Implementing Agency must submit an annual budget with supporting detail and a program of activities for approval by IPPF to receive its contribution. Very limited funds are also received by member contributions and Association dues, random bequests or other private sources. No funds are received from the Government of Honduras and ASHONPLAFA needs none but their own authority to commit and disburse funds related to all and any financial transaction.

III. Pattern of Organization

1. Introduction and Background

This Project Paper provides for a continuation and expansion of activities begun under Project 522-0286. The Implementing Agency for the major share of project activities will be ASHONPLAFA. The purpose of this analysis is to assess the Implementing Agency's administrative capabilities to execute the project as designed.

The analysis must be viewed within the context of the recent and relatively rapid expansion of ASHONPLAFA's organization. Until 1985, ASHONPLAFA was a small operation which received the largest part of its operating funds (approximately $300,000 per annum) from the IPPF. Hence, the organization and functions of the Association's rather simple administrative structure sufficed. In 1985, however, ASHONPLAFA entered into an agreement with USAID/Honduras which called for, inter alia, provision of increased economic assistance and a relatively rapid expansion of its activities, developments which have placed a heavy burden upon ASHONPLAFA's administrative structure. It is important to recognize that there are problems inherent in the sudden expansion of an organization that has thought and operated on a small scale for some twenty years prior to 1985. Of greatest significance for successful project implementation is the need to continue, probably for the LOP, the Mission's on-going policy of providing technical assistance to the Implementing Agency on a broad spectrum of operational areas.

2. Organizational Structure

The Organigram of the Implementing Agency is attached. The organizational structure places the General Assembly of Members as the highest authority of the Association. The Assembly is a group of private citizens who are concerned about the problems of population growth in Honduras. The Assembly provides very limited financial assistance to the Association - mostly in the form of monthly dues. At the present time there are 66 members from among whose number a Board of Directors is selected. The Executive Director reports to the Board of Directors on a regular basis.

Line functions are distributed among seven separate Departments: Administration, Evaluation, Human Resources (Personnel), Medical Services, Information Education and Communications, Community Distribution, and Social Marketing. An eighth Department is defined as

Regional Offices Supervisor. Price Waterhouse has drawn up a comprehensive Organization Manual for the operation of this structure. The Manual contains an organigram of each operational department and a detailed description of its objectives and functions. Additionally, the Manual includes tables outlining the levels and limits of authority of each department with complete job descriptions and lines of command for each key post within those departments. If the substance of this Manual were put into practice the Agency would problably function more smoothly, but this is not the case.

The Executive Director is the most important figure in the Association. There is little or no delegation of authority for independent action and decision making by the Department Chiefs. The Executive Director has no deputy, and whenever he is absent from Tegucigalpa all decisions must await his return. Operationally, the structure is vertical and highly centralized with each Department Head reporting independently to the Director. There is little inter-departmental exchange of information. This structure, if not modified, will be a serious obstacle to successful implementation. (See B. MANAGEMENT for a more detailed discussion.)

Regional Offices

ASHONPLAFA's expansion program includes planning for the establishment of five regional centers providing family planning information and services. Medical clinics for AVC and IUD insertion would be provided at each of the centers. These locations would also serve as the base for CBD and IEC programs and personnel. Two such centers are now in place - Choluteca and San Pedro Sula. Of the rest, La Ceiba is nearing completion of the construction phase. Santa Rosa will begin construction soon and the land for the Juticalpa center was purchased early in 1989. The operating centers of San Pedro Sula and Choluteca have some administrative problems, mostly connected with newness, but these are being addressed by each of the Regional Directors.

San Pedro Sula

This regional office is undergoing both physical expansion and operational reorganization. Until 1986 the CBD, IEC and Medical Services were housed in three separate locations in San Pedro Sula and each reported directly to its counterpart office in the Capital. Communication with each other was at a minimum. In 1986 the operation was finally housed under a single roof. Administrative and organizational problems continued, however. A new Regional Director was named in June 1988 and had succeeded by the end of CY 1988 in straightening out most of these problems.

The San Pedro Sula Regional Office is organized along the same lines as the Tegucigalpa operation: a Director with functional Departments covering IEC, CBD, Clinical Services and Administration. (The Evaluation function has not been regionalized.) The Director has instituted regular staff meeting attended by Division Heads, and, upon occasion, by the entire regional staff. All Departments Heads report to the Regional Manager and all information flows, to and from the Tegucigalpa office, are through the Regional Director. The CY 1989 Regional Office budget and supporting detail were prepared in situ for the first time. A substantial number of actions must be taken to fully regionalize this office, but what is most important is that the regionalization process is progressing steadily. Greater operational flexibility at the regional level will be a major element in successful project implementation.

Choluteca

This Regional Office was established in March of 1988. Hence, the Director has been able to work with his staff right from the beginning and has not, as in the case of San Pedro, had to devote energies to correcting inherited problems. Additionally, the Choluteca Office is smaller than the San Pedro Sula operation and is, therefore, organized

along somewhat different lines. The Regional Director also acts as Supervisor over the CBD and the IEC promoters. Experience in these areas prior to being named as the Regional Director, plus the current size of the Choluteca Office, makes this arrangement less onerous than it would appear on the surface. The only other function of the Regional Office - Clinical Services - reports to the Regional Director. The Regional Director also holds regular meetings with his personnel in which the free flow of ideas and suggestions for improving the operation is encouraged. All contacts between Tegucigalpa and Choluteca flow through the Regional Director. As in San Pedro Sula, the budget and supporting detail for 1989 were prepared locally, and the Choluteca Director has put together an Action Plan for 1989, as well. Considerable expansion of activities in the Choluteca Region are anticipated under this project which will require both enlargement and restructuring of the Choluteca organization.

As noted above the Regional Directors nominally report to the Regional Offices Supervisor in Tegucigalpa. This position has been vacant for some time, however, so until it is filled or other administrative arrangements are made the Regional Directors continue to report to either the Executive Director or to Departmental Heads in Tegucigalpa on activities related to that Department.

B. MANAGEMENT

I. Project Management

Up to the present ASHONPLAFA has managed to deal successfully with increased levels of activity called for in the 1985 Agreement with the USAID without major changes in its organizational structure, managerial practices or staffing levels. Supporting evidence of this success is indicated by the fact that contraceptive prevalence has risen from 36% in 1985 to 42% in 1988, with ASHONPLAFA's efforts accounting for

most of the increase. Nevertheless, if ASHONPLAFA is to manage the new project successfully, changes in organization, attitudes and practices will have to take place.

First, a real continuing and workable pattern of delegation of authority must take place. The expanded program called for in the Project Paper cannot function if literally all decisions must continue be made by the Executive Director. For example, the Director must approve all personnel actions, even down to replacements in the janitorial services contract.

There are even more serious repercussions from this overcentralized system besides slowing operational actions to a snail's pace. For one thing it creates an ambience which induces otherwise capable staff not to act until specifically directed to do so for fear that the results might be contrary to the Director's wishes or point of view.* The Division Chiefs are neither lazy nor incompetent - quite the contrary - but their initiative in several areas has been dulled by past experience.

Yet another unfortunate spin-off from this excessive centralization of authority is the low level of communication and cooperation between the departments. Each Department Chief reporting independently to the Executive Director, without necessarily sharing the information with others, has resulted in a "turf protection" mentality and defensive attitudes in the face of perceived criticism or suggestions for improvement. It is difficult to modernize in this atmosphere.

*For example, on a recent occasion the USAID submitted a draft portion of this project for ASHONPLAFA's collective comments to be ready at a precise date three weeks thence. In this interim the Executive Director went on a trip abroad without leaving, or delegating, specific action for handling this important matter. As a result no action was taken by the Department Chiefs until told to do so upon his return, literally on the eve of the scheduled meeting - circumstances which did not lead to carefully considered and thoughtful commentary and suggestions.

Fortunately, it appears that ASHONPLAFA's top management has recognized, if only to a limited degree so far, that changes must be made. The Executive Director has taken specific steps to improve operations, the most important of which is the appointment of his most competent and experienced Department Chief as "Assistant to the Director," Much depends on how this Assistant is used and to what degree authority is delegated to her to act independently. Moreover, if she is to play a large interdepartmental coordination role, implementation of the new project should improve. Another step forward is the Director's approval for the Regional Directors' preparation of budgets and programs for their 1989 operations. (Heretofore, Tegucigalpa has controlled all such matters.) Other procedures towards true regionalization should improve ASHONPLAFA's capacity to successfully implement the new project.

Secondly, the Implementing Agency must be expanded and reorganized. Detailed recommendations need not detain us here, but, in general, the following should take place:

(i) A Public Relations Department must be created to vigorously pursue improvement of ASHONPLAFA's public image, respond to unwarranted attacks by the opposition, establish cordial relations with the professional groups, business and industrial and labor leaders, private and public sector decision makers, ad infinitum.

(ii) The IEC Department must be expanded and organized into sub-divisions to deal with specific information, education and communications areas, e.g. training, mass media. This Department should view itself as supportive of the service delivery function of the Implementing Agency.

(iii) The Evaluation Department must be redirected towards becoming a support group responsive to the informational needs of the service delivery and IEC functions. Concomitantly, the later must define their needs to the Evaluation Department.

(iv) The largest and most important service delivery function is carried out but the CBD program. The Department must be expanded with regard to personnel and must be decentralized. The Department Chief, presently bogged down in detail, must be freed up to concentrate on the overall direction and policy of the CBD program. There has been ample evidence on past occasions that she is fully capable of handling this enlarged role. Central to the problems is the need for a multi-year departmental strategy that relates the activities of the CBD program to the overall objectives of the Implementing Agency.

(v) Clinical services is technically in good shape and is capable of assuming increased operations. It is, however, weak in such areas as cost/benefit analysis and forward planning. These is no reason why this could not be done given clear and firm management action.

Summary

ASHONPLAFA's present organization and management practices render it incapable of efficiently implementing the proposed project or of attaining the objectives therein. By the same token if, at a minimum, the charges and adjustments suggested above are carried out there is every reason to believe that ASHONPLAFA can successfully implement the project.

166

II. Financial Management

Assessment of this function is perhaps best stated by a recent Price Waterhouse study of the Administrative Department, which handles financial management.

> "Personnel are fully experienced and identify with the department and its Chief which facilitates functional integration. With regard to accounting, it is attuned to the requirements of the donor agencies, and there is close cooperation among them. Computer installations are very good and presently a computerized accounting system is being installed which will be able to quickly generate needed information." (Free translation)

The financial management of the Implementing Agency is deemed capable of handling the expanded project.

III. Contrating

The Implementing Agency does not now handle any contracting except for local goods and services. Contraceptive commodities -the single largest procurement activity- is handled by the A.I.D. Mission. Additionally, the Mission contracts for off-shore technical assistance, in cooperation with and as approved except for local goods and services. Contraceptive commodities -the single largest procurement activity- is handled by the A.I.D. Mission. Additionally, the Mission contracts for off-shore technical assistance, in cooperation with and as approved y ASHONPLAFA. The Mission is capable of continuing to adequately perform these functions under the expanded project without additional personnel or organizational changes.

IV. Reporting

ASHONPLAFA has in the past satisfactorily responded to USAID/Honduras reporting requirements. Compilation and arrangement of information needed in these reports needs to be speeded up, but this is not seen as a serious obstacle to project implementation.

C. Staffing

All of ASHONPLAFA's senior staff and much of the subordinate, or second ties, staffing have several years experience working in the organization. Hence, rapid turnover of staff is not a problem. As noted elsewhere additions to staffing ought to be made in the CBD and IEC Department and an additional Department - Public Relations - should be created. The total number of additional personnel at Tegucigalpa Headquarters probably does not need to exceed a half-dozen persons. Naturally, additional staffing at regional centers will be required as present centers are expanded and new centers phased in. A sales manager for the Contraceptive Social Marketing program has been recently hired.

The largest staffing problem affecting the implementation of the project by the Implementing Agency has more to do with attitudes and mind-sets. It is a small organization that has thought small and acted small for most of its life. It is an overcentralized organization with regard to its general directorship, as well as within the departments, each jealously guarding its "turf." It is an organization with no clear idea of where it want to go or even of what it wants to be. ASHONPLAFA must decide these issues and define the organization and staffing it needs to be where it wants to be, say, five years hence. The creation of a strategic multiyear plan would tend to pull together what is now a vertical, fragmented operation.

D. Implications for A.I.D

The Mission must do two things to assure that the changes and improvements needed if ASHONPLAFA is to implement the project with a reasonable degree of success are carried out:

1. The Administrative improvements that must be carried out by ASHONPLAFA should be detailed in the Conditions Precedent to disbursement. The Mission must stand firm on the issue of their satisfactory compliance by ASHONPLAFA. IPPF must also cooperate in both complementing and supporting A.I.D.'s position.

2. The Mission must make an analysis of the Technical Assistance requirements over the LOP and be prepared to assist ASHONPLAFA to comply with A.I.D.'s exigencies.

ADMINISTRATIVE ANALYSIS
PLAN EN HONDURAS

A. Introduction and Background

A major activity programmed under project No. 522-0369, Private Sector Population II is cooperation with a number of Private Voluntary Organizations (PVOs) to promote and educate family planning among the rural populations they serve and to refer potential acceptors to the nearest ASHONPLAFA or MOH service provision points. To facilitate and simplify financial and administrative activities an "umbrella" implementation mechanism has been decided upon. Among the participating PVOs PLAN en Honduras (hereafter referred to simply as PLAN) was identified as having a predominant capability to perform this task. The purpose of this analysis is to assess the capacity of PLAN to execute this function.

B. Organization

I. Legal Status

PLAN operates in Honduras under the provisions of an agreement signed with the Ministry of Public Health and Social Assistance on June 18, 1976 and subsequently ratified on January 20, 1977 by means of publication in the "Official Gazette". It is a non-profit tax-free organization with no racial, political, religious or social affiliations or policies. PLAN is free to operate upon its own authority and does not require approvals from any Host Country agency or governmental entity to act in any area of its operations.

II. Financial Status

PLAN is an affiliate of Foster Parents Plan International headquartered in Warwick, Rhode Island, USA. There are national organizations in eight countries: Netherlands, Belgium, Germany, Great Britain, Japan, Australia, Canada and the United States. Funding sources are 90% from individual pledges as Foster Parents and the rest, or 10%, from other sources. No funds are received from the GOH. PLAN must submit a three year

budget and program for estimated expenditures to PLAN International. This triennial budget is adjusted and updated yearly. PLAN needs none but their own authority to commit and disburse funds once approval is received from the Foster Parents International headquarters.

III. Organization

An organigram of PLAN is attached. The most important figure on the local level is the Country Director (he is also the director of the Tegucigalpa office) who reports only to the International headquarters. The PLAN regional operations in San Pedro Sula and in Santa Rosa de Copan are independent. Nonetheless, they operate under the same agreement with the GOH, are structured the same and pursue the same program strategies as the Tegucigalpa office. The PLAN Tegucigalpa Director, while nominally having no supervisory powers over the regional offices, in his role as Country Director does influence the regional operations.

Functions are distributed among five sections, namely: Program Department, Program Resource Unit, Management Assistance Unit, Donor Services and General Services, all of which report to the Director. While the last three mentioned sections are rather tightly supervised by the Director's Office, the Program Department and the Program Resource Unit are delegated considerable latitude for implementation of projects in the field once they have been approved by the Director. PLAN describes itself as "essentially a field operation" and sees little to recommend tight control by central office authority in this area of their operations.

C. Management

I. Project Management

All three of the regional operations making up PLAN en Honduras have extensive and detailed experience in planning and implementing projects. At

present, projects are being carried out in such areas as health center construction, potable water, vaccinations, latrine construction, bridge building, rural electrification, community centers, establishing lending libraries, school construction, income generation, assisting in land purchases, seed improvement, kitchen gardens, fruit tree planting, irrigation systems and others. An examination of individual project documentation reveals that program objectives and their relationship to country goals are clearly stated. Activities to be carried out and responsibilities of donors, project supervisors and specialists involved are set forth in detail. Project impact is assessed and an evaluation plan is laid out. Paragraphs on how women are benefited and an abbreviated environmental impact statement also form part of project documentation.

These practices so clearly paralled A.I.D. project requirements that there is little doubt as to the capacity of PLAN to plan and execute this project.

II. Financial Management

Financial management is good. PLAN has a FAX, is computerized for word processing, accounting, tracking donor services, information systems and evaluation. Financial indicators must be stringently adhered to. For example, not more than 30% of total program costs may be used for administrative costs. Failure to adhere to this norm brings intense scrutiny for corrective action. All other monies are used for project operations costs. In the past PLAN has had projects financed by USAID/Honduras and thereby is familiar with A.I.D. financial management requirements.

PLAN is audited every year by its own auditor stationed in Guatemala City and every other year by Price Waterhouse. The financial management of PLAN is considered capable of handling its project responsibilities.

III. Contracting

PLAN does no contracting for goods and services, nor is it expected to do so under this project.

IV. Reporting

As previously noted, PLAN has received A.I.D. support for projects in the recent past. For these occasions PLAN has adjusted the reporting format used to inform its International Headquarters in a manner compatible to USAID reporting requirements. Additionally, participation in projects with A.I.D. has provided PLAN with experience and familiarity with the agency's financial and project reporting requirements, formats and procedures.

D. Staffing

The 30% rule for administrative costs compels PLAN to keep its staffing trim and lean. Key executive personnel have several years experience working in the organization. Excessive turnover of staff at these levels is not a problem. Last year PLAN experienced a 12% turnover rate at the lower staffing levels - drivers, security guards, secretaries, promoters - but this was due to a one time reorganization and consolidation of functions.

To carry out the functions required of it under this project it will probably be necessary for PLAN to employ a secretary, and a field supervisor. One administrative assistance/accountant may also need to be hired.

E. Implications for A.I.D.

Implications for A.I.D. are few. Given the superiority of the PLAN organization special monitoring will not be needed. The Project Liaison Officer should have no difficulty in monitoring this project in addition to his duties vis-a-vis ASHONPLAFA.

ANNEX F

Presented to:

USAID/Honduras

TRIP REPORT

PVO STRATEGY

2/13/89 - 2/21/89

Prepared by:
Ana R. Klenicki
The Enterprise Program

PVO Strategy

As part of an ongoing search of PVOs (outside of the family planning association - ASHONPLAFA), The Enterprise Program has identified 8 PVOs and 1 Cooperative who have asked for assistance in providing child spacing services to their beneficiaries. These PVOs have established projects in rural areas, cover an extensive section of the rural areas, have relationships with the MOH regional personnel and are already providing other child survival interventions (vaccination, ORT, growth monitoring, breast feeding, etc).

These PVOs are:	Number of beneficiaries
Plan en Honduras (San Pedro Sula) Plan en Honduras (Tegucigalpa)	16,000 families (between the 2)
Save the Children	3,000 families
Horizontes de Amistad	700 women (single mothers)
CASIEMH (Comisión de Acción Social Iglesia Evangélica Menonita de Honduras)	500 families
Meals for Millions (Out of a total of 1,500. They expect in 1991 to have a general area of 2,000 families. With increased resources they could service the present 1,500 families)	700 families
AIEH (Asociación de Iglesias Evangélicas de Honduras)	400 families
Hermandad de Honduras	1,000 families
AHDEJUMUR (Asociación Hondureña para el Desarrollo de la Juventud y la Mujer Rural	1,500 families
Total number of families.....	23,800 families

By families it is understood family nucleus of at least one parent with a number of children. In rural areas there is a large number of single mothers, who may not be married or in union, but are sexually active. Moreover, the PVOs above work with an adult population that is 100% on child bearing age.

Using and average of 7 children per family (6.8 is the average for the rural areas, except that it increases as the remoteness augments), the total number of children in the 23,800 families is 166,600. Out of these, 16,194 are in the 15-19 age bracket (9.72%).

The number of 15-19 together with the 23,800 women that the PVOs work with brings the total population that is at risk to 39,994. According to the latest CPS, in 1987 of all women in union in child bearing age that used some form of contraception (41%), 30% were rural women. Thus, 11,998 women could be using some form of contraception. However, because many of the areas where these PVOs work are remote and not serviced by either MOH or ASHONPLAFA, this figure of 11,998 could be significantly lower.

Using the figures above, the total target population to recieve services from the 8 PVOs would be 27,996 all in child bearing age, but not necessarily married or in union.

The PVOs offer services in the following departments:

Francisco Morazán, Comayagua, El Paraíso, La Paz, Intibucá, Copán, Lempira, Santa Bárbara, Choluteca, Cortés, Yoro, Atlántida, Olancho.

Most of their work is conducted in remote villages within the above departments. Initially, it is important to schedule field visits to observe the communities involved in order to assess the PVOs work, observe the staff operating in the field, collect impressions from the actual program beneficiaries, and thus be able to match the information provided by headquarters with the field data.

Project Components

Promotion (demand creation)

The identified PVOs may be instrumental in increasing the knowledge of and demand for family planning services. Most of the PVOs identified are interested in offering family planning training, promotion, and referrals. They will require training of their existing staff who in turn will become trainers of community leaders and promoters. There are however, two PVOs that could engage in direct family planning service delivery. They are:

Plan de Honduras (San Pedro Sula, Tegucigalpa, Santa Rosa de Copán) with the largest number of beneficiaries (26,886 possible users), expects to engage in family planning service delivery. Plan de Honduras expects to open Centers for Family Orientation and Infant Recuperation (Centro de Orientación Familiar y Recuperación Infantil - COFRI) in those villages where there are no public health services and they would add family planning services in these centers. The creation of these COFRIs is already in their programatic plan. The project would have to guarantee the supply of commodities as requested, and other support needed for promotion and training.

176

Horizontes de Amistad (Choloma, Dpto. de Cortés) works with a large number of single mothers. They have indicated that if they could increase their human resources they could also reach more women. They also work with 100 men in an agricultural development program. This number could also be increased if they haf more resources.

Promotion (demand creation)

Save the Children, CASIEMH, Meals for Millions, AIEH, Hermandad de Honduras and AHDEJUMUR would promote family planning services by referring their target populations to MOH facilities and/or ASHONPLAFA CBD posts.

Traditional promotion would be through out reach in the community (visits, informal community chats, development of materials, training of promoters, training of health staff, etc.), these activities could be strengthen by using mass media, particularly radio (See p.).

Training

All of the PVOs identified have indicated a need to train their personnel in family planning methods and family planning promotion (with particular attention in how to deal with certain cultural behaviour (machismo, reluctance by the male population to become involved in what is perceived as a "woman's problem"), and negative religious attitudes).

To maximize the use of existing resources and a wide national infrastructure, ASHONPLAFA, with its extensive experience in family planning, should be the institution to provide the training to the PVOs.. ASHONPLAFA's major constraints in satisfying this need are twofold: lack of an institutional training staff to satisfy training needs outside of the organization and lack of uniform training materials. Presently, ASHONPLAFA has a total of 5 trainers:

2 in San Pedro Sula (1 educator and 1 vsc supervisor who gives support to the educator)

3 educators in Tegucigalpa

Four of the 5 trainers are paid with IPPF funds, and they must satisfy schedules determined by IPPF.

The approximate number of people that would have to be trained are:

Physicians.....6
Nurses.....6
Nurses Aid.....9
Nutritionsts.....9
Community Promoters.....175
Others (Comm. volunteers).....107

The training manual should include the following subjects:

* Detection and prevention of reproductive risk;
* Family planning methods (they should include natural family planning, breast feeding, and any valid indigenous practices);
* Responsible parenthood;
* Sexually transmitted diseases;
* AIDS;
* Adolescent pregnancies;
* How to address: religious opposition;
  cultural patterns (emphasis on machismo)
* Male involvement.

Each PVO that receives training should receive a copy of the training manual (which should be printed in a loose leaf binder for easy up date).

ASHONPLAFA should also produce audio visuals to accompany the training covering the different subjects indicated above. Copies should be made available for the PVOs. However, the PVOs have expressed a need for audio visual equipment and energy generators for use in non electrified rural areas.

As part of the effort to attract the male partner in the couple, efforts should be made to train staff who can communicate more freely with male members in the community.

The PVOs will need the first year of the project to cover all their training needs. The following is a recommended schedule:

Initial training	1 week	July'89
Refresher session	2 days	Oct.'89
- -	2 days	Jan.'90
- -	2 days	Apr.'90
- -	2 days	July'90

After this first year of training and refreshing sessions, the PVOs should be able to start their own training in the communities they operate. ASHONPLAFA should offer permanent technical assistance as needed and to update materials.

Mass Media

The country has an extensive radio network covering all corners of the country. A great deal of the promotion should be conducted via radio programming (particularly reinforcing the personal community work that will be done through promoters and community workers). Since the project contemplates a substantial line item for I,E & C for ASHONPLAFA, the latter should produce the materials needed by the different PVOs.

Among the production of necessary materials, ASHONPLAFA should produce generic radio programming for use by the different PVOs allowing them to add their own identifying logo.

Generic pamphlets should also be produced in order for the PVOs to distribute materials after each training session.

Coordination among the PVOs and ASHONPLAFA is essential in order to guarantee that the needs of the PVOs are met, there is continuity in the effort, and the radio coverage becomes an integral part of a family planning coverage strategy.

Since the media production capabilities in Honduras are limited at best, it is recommended that the project contemplate engaging the technical assistance of CREA (Centro Regional de Audio Visuales) an AID funded production center in Guatemala. Technical personnel from CREA should visit ASHONPLAFA, meet with the different PVOs and be engaged for the design and production of the promotional radio materials. CREA should offer general assistance for ASHONPLAFA's overall mass media strategy.

An issue that requires careful planning and coordination is that if demand for family planning services will be increased, there has to be adequate supply of services. Since most of the PVOs will not engage in direct service delivery, and there is no MOH presence in all of the rural areas, it behooves that ASHONPLAFA's Community Based Distribution Program contemplates expanding their posts to include areas serviced by the PVOs. This will require a commitment from ASHONPLAFA, not only of resources, but a willingness to work with other organizations in a coordinated way.

The project should contemplate recruiting a neutral person who would be in charge of the coordination between ASHONPLAFA, the PVOs and AID.

Data collection, evaluation and monitoring

A uniform MIS system should be designed to generate useful, relevant and timely data in order to facilitate the regular analysis of administrative data and speedy managerial feedback. Small scale surveys using rapid, low cost methods should be encouraged.

There should be close monitoring of the number of training sessions held with the number of participants.

The PVOs should develop action plans defining all the activities they will be involved with after the initial training year. Technical assistance may be needed to help them project number of users/referrals in the following 4 years of the project.

Cooperatives

The cooperative identified is the National Peasants Union (Union Nacional de Campesinos) with a national membership of 245,000 peasants distributed throughout the country. The organization has no health infrastructure. Supporting them will require a greater effort than the required for the PVOs since they all had some health infrastructure.

The UNC membership may represent 36,730 women in child bearing age (22% of 245,000 = 53,900. Assuming 30% use some form of contraception - 16,170, brings the total to 36,730. This figure does not take into consideration the amount of women 15 - 19 that would be children of these peasants.

The UNC has 2 training centers and 6 regional offices. They offer to their members:

cooperative promotion and organization;
cooperative-political education;
legal and technical assistance in production and economy;
managerial training;
development and implementation of educational and productive programs.

The UNC leadership will require extensive training in child survival and family planning services (the latter with emphasis on detention and prevention of reproductive risk). In order to implement a family planning program with the UNC it may be necessary to also give them assistance in developing a maternal and child health program.

The above would require an independent project from the one being planned for the PVOs. ASHONPLAFA eventually can be tapped for the training once the maternal and child health program is in place.

KAP studies using focus groups should be planned initially in order to find out what are some of the limiting factors, at the peasant level, of implementing family planning programs. These studies would be very helpful not only in working with the UNC, but with the PVO strategy also.

Identification of one PVO to act as administrative umbrella organization

Among the PVOs mentioned in this report, none came forth and declare its willingness to act in this capacity. However, Plan en Honduras has an administrative and managerial infrastructure that could allow for this extra activity.

A major constraint would be that the organization has two autonomous offices (one in Tegucigalpa and the other in San Pedro Sula). For the purposes of working with AID funds, it would have to be the office in Tegucigalpa the one chosen. It remains to be investigated whether an arrangement of this sort is acceptable to the office in San Pedro Sula and the other PVOs.

Lista de participantes confirmados al Taller

" EL BIENESTAR FAMILIAR Y EL SECTOR PRIVADO "

6 - 9 de febrero de 1989
El Zamorano, Honduras.

ORGANIZACION	PARTICIPANTES	TELEFONO
1. ODEF (Organización para el Desarrollo Empresarial Femenino). San Pedro Sula.	Blanca Iracema Canales	52 - 83 - 49 52 - 35 - 71
2. Plan en Honduras San Pedro Sula.	Sofia Wayllace Pedro Mejía	57 - 08 - 04 53 - 42 - 89
3. Save The Children Tegucigalpa, D.C.	Dr. Ernesto Godoy Rita Chimilio Jorge Ponce	31 - 09 - 58 32 - 34 - 32
4. AHDEJUMUR (Asoc. Hondureña para el Desarrollo de la juventud y la Mujer Rural). Tegucigalpa, D.C.	Melba Patricia Nelson J. Yesenia Mena	32 - 06 - 82 32 - 71 - 96
5. Hermandad de Honduras San Marcos de Ocotepeque	Jorge Nery Aguilar R. José Luis Pineda	
6. UNC (Unión Nacional de Campesinos). Tegucigalpa, D.C.	Marco Antonio Reyes Elias Alvarez (La Ceiba)	37 - 66 - 80
7. FEDECOH (Federación de Desarrollo Comunitario de Honduras). Tegucigalpa, D.C.	Ricardo Acosta Angel Antonio Pineda	31 - 21 - 92
8. Plan en Honduras Tegucigalpa, D.C.	Dr. Raúl Gomez Carlos Enamorado	32 - 44 - 24
9. AIEH (Asociación de Iglesias Evangélicas de Honduras). San Pedro Sula.	Joaquina de Ayala Concepción Mejía	53 - 41 - 18
10. Horizontes de Amistad. San Pedro Sula.	Isabel de Zapata Francisca Funez	57 - 31 - 16
11. CASIEMH (Comisión de Acción Social Iglesia Evangélica Menonita de Honduras) San Pedro Sula.	Francisco Machado Leiva Nelson García	57 - 22 - 50
12. Meals for Millions Tegucigalpa, D.C.	Camila Elvir Galindo	37 - 30 - 04
13. FEHCIL (Federación Hondureña de Cooperativas Industriales Ltda.). Tegucigalpa, D.C.	Nubia Yaneth Chinchilla Esly Banegas	37 - 88 - 05 37 - 33 - 43
14. CARPROMACOL (Cooperativa Agrícola Regional Proyecto de Mecanización Agrícola "La Concepción". Juticalpa, Olancho. Aptdo. postal #43	Luis Armando Mendoza	

Lista de organizaciones invitadas que no asistieron al Taller

" EL BIENESTAR FAMILIAR Y EL SECTOR PRIVADO "

6 - 9 de febrero de 1989
El Zamorano, Honduras.

ORGANIZACION	PARTICIPANTES	TELEFONO
1. FECORAH (Federación de Cooperativas de al Reforma Agraria de Honduras). Tegucigalpa, D.C.	Hernán Sierra Francisco Bueso	32 - 54 - 28
2. FEHCAFOR (Federación Hondureña de Cooperativas Agroforestales). Tegucigalpa, D.C.		
3. FECOHVIL (Federación Hondureña de Cooperativas de Vivienda Ltda.). Tegucigalpa, D.C.		32 - 76 - 28
4. Apostoles de la Salud Tegucigalpa, D.C.		
5. Asociación de Esposas de Oficiales de las Fuerzas Armadas de Honduras. Tegucigalpa, D.C.	Audelina de Mendoza Presidenta.	
6. FACACH (Federación de Cooperativas de Ahorro y Crédito de Honduras). Tegucigal[illegible].C.		

182

ANNEX G

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

LAC-IEE-89-43

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Honduras
Project Title	:	Private Sector Population II
Project Number	:	522-0369
Funding	:	$16,000,000 (G)
Life of Project	:	Five and one-half years
IEE Prepared by	:	Margaret Kromhout USAID/Honduras
Recommended Threshold Decision	:	Categorical Exclusion
Bureau Threshold Decision	:	Concur with Recommendation
Comments	:	None
Copy to	:	John A. Sanbrailo, Director USAID/Honduras
Copy to	:	Lars Klassen, USAID/Honduras
Copy to	:	Frank Zadroga, ROCAP/San Jose
Copy to	:	Donald Boyd, LAC/DR/CEN
Copy to	:	IEE File

James S. Hester Date MAY 31 1989

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

May 17, 1989

MEMORANDUM

TO: James S. Hester, LAC/DR/E

FROM: John A. Sanbrailo, USAID/Honduras

SUBJECT: Private Sector Population II Project (522-0369) - Threshold Decision of Categorical Exclusion for IEE.

Project Description: The purpose of the Private Sector Population II Project is to contribute 50% to increasing contraceptive prevalence (percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50% in 1994. Project activities will contribute to a reduction in the fertility rate through expanded family planning services provided principally by the private sector with emphasis on expanding coverage to rural areas.

In order to increase the availability and accessibility of voluntary family planning services in Honduras, support will be provided to three service delivery programs of the Honduran Family Planning Association, ASHONPLAFA: Community Services, Social Marketing, and Medical/Clinical. Other private groups will receive support to initiate delivery of family planning services, and/or to upgrade their referral relationship with ASHONPLAFA. Grant funding will cover the cost of contraceptives, purchase of audiovisual equipment, technical assistance, and local operating expenses of the implementing organizations, mainly ASHONPLAFA.

Statement of Categorical Exclusion: It is the opinion of the Mission's Environmental Officer that this project does not require further environmental analysis because its activities fall with the class of actions subject to categorical exclusion, as described in Section 216.2, paragraph c.viii of Chapter 22 of the Code of Federal Regulations. This section states that programs involving nutrition, health care or population and family planning services except to the extent those designed to include activities directly affecting the environment, are categorically excluded from further review.

Recommendation: That you approve the threshold decision of a categorical exclusion for the Project given that the activities to be funded are family planning activities and technical assistance which will not directly affect the environment and which are included in the classes of actions not subject to the full A.I.D. environmental assessment procedures.

Mailing Addresses: From USA: USAID / Honduras, APO Miami, Fl. 34022 Tel. 011-504-32-3120
In Honduras: Apartado Postal Avenida La Paz, Tegucigalpa, D. C. Tel. 32-3120. TELEX 1593

15V

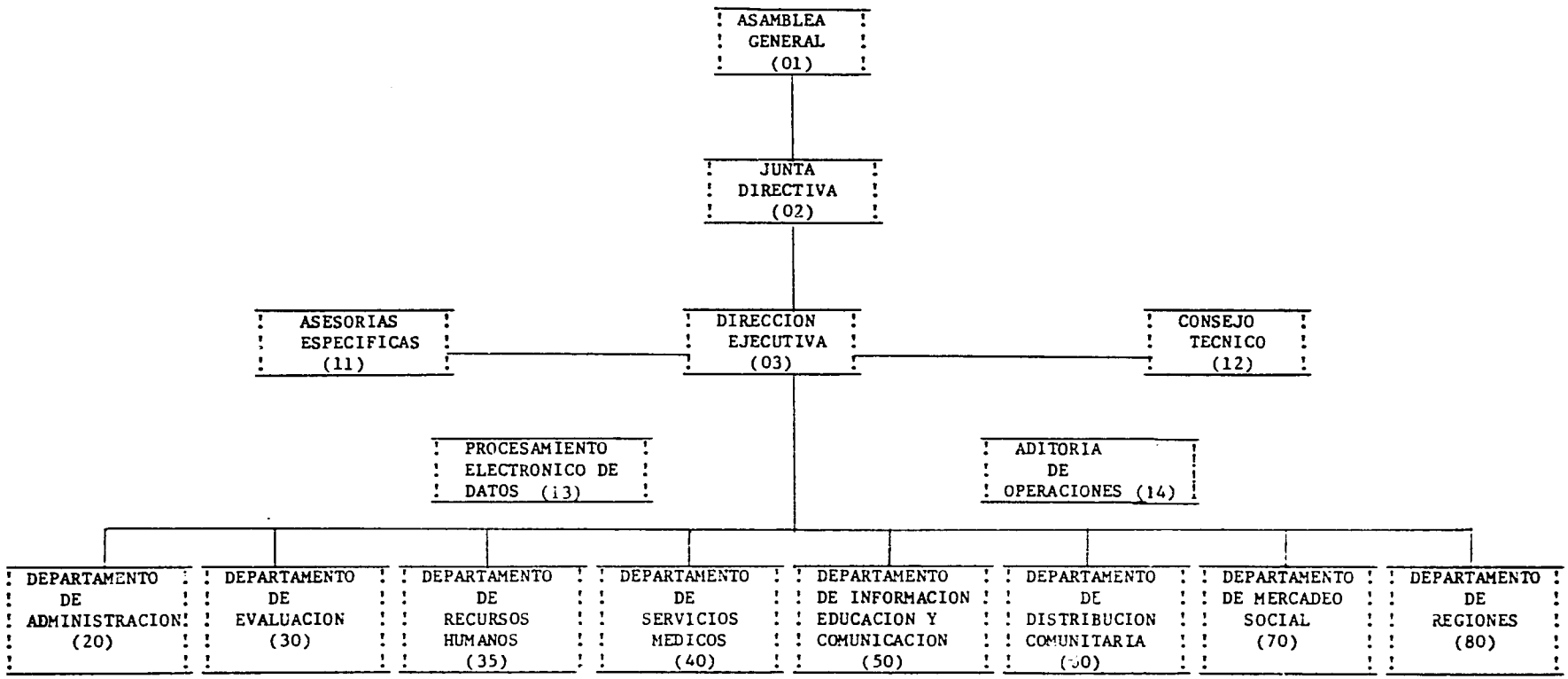
ANNEX H

LIST OF ACRONYMS

ACRONYM	DEFINITION
ASHONPLAFA	ASOCIACION HONDURENA DE PLANIFICACION DE FAMILIA
CPS	CONTRACEPTIVE PREVALENCE SURVEY
CREA	CENTRO REGIONAL DE AUDIOVISUALES
CSP	COMMUNITY SERVICES PROGRAM
CYP	COUPLE YEARS OF PROTECTION
GOH	GOVERNMENT OF HONDURAS
HMI	HOSPITAL MATERNO INFANTIL
IEC	INFORMATION, EDUCATION AND COMMUNICATION
IPPF	INTERNATIONAL PLANNED PARENTHOOD FEDERATION
IQC	INDEFINITE QUANTITY CONTRACT
IUD	INTRA UTERINE DEVICE
LAC	LATIN AMERICA CARIBBEAN REGION
MCP	MEDICAL/CLINICAL PROGRAM
MIS	MANAGEMENT INFORMATION SYSTEM
MOH	MINISTRY OF HEALTH
NFP	NATURAL FAMILY PLANNING
ORT	ORAL REHYDRATION THERAPY
PSC	PERSONAL SERVICES CONTRACT
PVO	PRIVATE VOLUNTARY ORGANIZATION
SMP	SOCIAL MARKETING PROGRAM
SOMARC	SOCIAL MARKETING FOR CHANGE
ST/POP	SCIENCE AND TECHNOLOGY/POPULATION
TA	TECHNICAL ASSISTANCE
TFR	TOTAL FERTILITY RATE
UNC	NATIONAL UNION OF CAMPESINOS
VSC	VOLUNTARY SURGICAL CONTRACEPTION

ANNEX I

ASOCIACION DE PLANIFICACION DE FAMILIA
ORGANIGRAMA GENERAL



PLAN EN HONDURAS

ORGANIZATIONAL CHART FY 90, 91, 92

DIRECTOR

ASSOCIATE DIRECTOR

PROGRAM DEPARTMENT			PROGRAM RESOURCE UNIT			MGMT. ASSISTANCE UNIT			DONOR SERVICES			GENERAL SERVICES		
#	TITLE	ACCT.	#	TITLE	ACCT.	#	TITLE	ACCT.	#	TITLE	ACCT.	#	TITLE	ACCT.
7	Coordinators	12.01	1	Evaluator	12.01	1	Adm. Assistant	54.01	1	Department Head	17.01	1	Gen. Serv. Head	53.01
75	Promoters	12.01	1	HRD Specialist	12.01	3	Accountant	54.01	4	Translators . . .	17.01	2	Drivers	52.01
10	Peace Corps Vols.		1	Child Surv. Spec.	13.03	1	Comp. Spec.	55.01	.5	Data Processor	17.01			
			1	IG Specialist	16.01	3	Secretaries	55.01						
			1	Prog.Accountant	54.01	1	Cleaner	53.01						
			.5	Data Process	55.01									
82 + 10			5.5			9			5.5			3		105