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EVALUATION OF THE FAMILY PLANNING PROGRAM
OF THE MINISTRY OF HEALTH OF THE
REPUBLIC OF HONDURAS

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FINAL REPORT FOR USAID/HONDURAS AND THE MINISTRY OF HEALTH

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I. EXECUTIVE SUMMARY

At the request of the Ministry of Health (MOH) the AID Mission to Honduras (USAID/H) contracted for the services of a group of international consultants to evaluate the Women's Health Care Program with special emphasis of its Family Planning component. The evaluation took place over a period of 35 days divided into two stages: the first from May 22nd to June 11th and the second from July 11th to 23rd, 1988.

To carry out the objectives of the evaluation the group engaged in the following activities:

1. Review of Documents.
2. Interviews with officials of the MOH and with officials of other institutions with activities in the areas of health and population.
3. Planning, design and execution of a survey of the Health Services to obtain up-to-date data on the units, medical and non-medical personnel.
4. Direct observations in the field on the delivery of FP services.
5. Processing and analysis of the above survey data, as well as information obtained from other sources.
6. Completion of a Final Report with recommendations based on the results of the evaluation.

The most serious problems, along with recommendations for dealing with them, are listed as follows:

P R O B L E M S

Structural

1. A lack of institutionalization of the program.
2. Scarcity of human resources at the Central and Regional levels of the program.
3. Confused and contradictory goals and objectives.
4. Nearly inflexible regulations governing FP services and methods (surgical, IUD, Pills).

5. No manual describing the functions and responsibilities of each level of the system.
6. Deficiencies in the management and operation of the program.
7. Little internal and external program coordination.
8. Very low motivation among hospital personnel.

Services

1. Hospitals do not provide reversible methods of contraception.
2. Hospitals do not adequately meet the demand for surgical contraception.
3. Men are excluded from the program.
4. Low supply and demand for FP at all levels.

Supervision

1. Deficient supervision at all levels of the program.

Training

1. Personnel Training deficiencies at all levels of the program.

Information, Education, Communications

1. Deficiencies in educational materials.
2. No community outreach.

Logistics

1. Deficiencies in the entire system.

Programming and Evaluation

1. Poor programming procedures.
2. Deficiencies in collection and use of data.

RECOMMENDATIONS

Structural

1. Reaffirmation by high-level authorities of the full support by the MOH of the Family Planning Program.
2. Creation of a Department of Family Planning.
3. Review of program goals and objectives and clear definition of strategies to be followed.
4. Bring FP rules and regulations up to date.
5. Prepare operations manuals for each level.
6. Select personnel with experience, knowledge and leadership ability according to program needs.
7. Improve communications channels of program directives internally and to other related institutions.
8. Motivate hospital personnel by:
 - a. Improved training
 - b. Improved contraceptive availability
 - c. Improved access to services

Services

1. Structure a sub-program for men.
2. Devise a contraceptive strategy to deal with the reproductive risks, post-partum and post-abortion.

Supervision

1. Redesign of the supervisory system with appropriate guidelines based on the survey findings.

Training

1. Implement a training program and strategy addressed to the areas of:
 - a. Reproductive Health
 - b. Contraception

c. Community outreach

Information, Education and Communications

1. Establish educational and service delivery goals, and train personnel in them, at community level (mid-wives or other community leaders).
2. Prepare and distribute educational materials for literate and illiterate personas alike, with pre-and post-evaluation of effectiveness (advertising agency).

Logistics

1. Redesign the entire logistics system.

Planning and Evaluation

1. Improve the programming and planning processes.
2. Obtain necessary statistics on a timely basis (unify criteria and concepts).
3. Periodic evaluation of statistical data.

As a general recommendation, the Consultant Group believes that the MOH's FP program should be provided with technical assistance on a continuing and timely basis. This assistance should periodically assess progress toward and attainment of goals and objectives, as well as to detect possible problem areas and to take corrective measures in a timely fashion to resolve them.

II. BACKGROUND

A. Leading Demographic and Economic Indicators.

Honduras is located at the center of the Central American isthmus, bordering upon Guatemala, El Salvador and Nicaragua. The north coast faces on the Caribbean sea for an extension of 650 klms, while the South has 110 klms. of coast line. In the Gulf of Fonseca. Of the 112,088 square kilometers of surface area 63% is mountainous, the highest elevation being 1800 meters above sea level. The remaining 37% of the country consists of lowlands and wide valleys, most of the latter being located on the north coast. There are well-defined wet and dry seasons of approximately six month duration each for most of the country, while rainfall is evenly distributed on the North coast.

Population projections for 1988 are for a total of 4,801,500 inhabitants with 59.6% living in rural areas and 42% in urban centers. Of the urban population 73% is concentrated in Tegucigalpa and San Pedro Sula. Rural population is scattered among some 22,000 villages or hamlets of about 500 inhabitants each. Population density varies from 2 persons per Km² in the Department of Gracias a Dios to 143.8 in the Department of Cortés.

According to the MOH's Health Statistical and Information Bulletin for 1987 population growth for that year was 3.2%, principally as a result of a high birth rate (44/100 live births) and a death rate of 9.5/1000. At this rate of natural growth the population of Honduras will double in only 20 years.

The principal economic activity is agriculture. Honduras is the largest exporter of bananas in Central America, with coffee exports over the past few years nearly rivalling in value these of bananas. The road system connects the major cities and urban centers with the exception of a few towns or villages which are difficult if not impossible to reach.

In the same Statistical Bulletin cited above the following are the principal health indicators of the country. ~~1988)~~

Birth Rate	44/10000
Death Rate	9.5/1000
Infant Mortality Rate	85/1000 (live births)

Maternal Mortality Rate	09
Life Expectancy at Birth	61 years
Rate of Natural Growth	3.2% (1987)
Total Fertility Rate	6
Acute and Chronic Malnutrition (weight/height)	28%
Chronic Malnutrition (height/age)	44.7%
Acute Malnutrition (weight/height)	3.7%

B. Health Services

According to MOH estimates, 70% of the population has access to some kind of health service, either public or private, broken down as follows: 60%, MOH; 7%, the Honduran Social Security Institutes (IHSS); and 3%, the private sector. The remaining 3% with no access to some kind of health service belong to the neediest socio-economic strata and are located principally in marginal urban areas and in rural areas.

At the present time, the MOH provides services through 634 establishments (Hospitals, CESAMOs and CESARs*) with a total availability of 3669 hospital beds. The IHSS provides medical attention at three Regional Hospitals, one Maternal/Child Health Hospital and three out-lying clinics with a total availability of 785 beds.

C. Family Planning Services

The following is excerpted from UNFPA publication dated March 10, 1987:

"The Government's strategy includes the major objective of reducing the rate of population growth, improving and rationalizing the spatial distribution of the population and exercising greater control over international migration.

* CESAMO is a health post providing medical and dental services with both a MD and a DDS in attendance.

CESAR is a rural health post generally staffed only by auxiliary nurses.

With regard to steps affecting population growth the government proposes to provide family planning services by means of a program administered and coordinated by the MOH; promote educational campaigns to raise the consciousness level of rural people of the advantages of child spacing; include materials on population themes in primary and secondary government-run schools as well as in adult literacy programs; and in other programs, such as Agrarian Reform and Integrated Rural Development, apply policy measures complementary to policies on population and spatial distribution of human settlement.."

To attain these objectives in FP, Honduras, in addition to the program of the MOH being reviewed by this report, has FP services provided by the IHSS and ASHONPLAFA (Honduran Family Planning Association) as well as those provided by private doctors.

- D. The Family Planing Program of the Ministry of Health
Between 1965 and 1975 the MOH carried out a FP program almost completely financed by USAID/H. At project termination FP activities diminished markedly.

In November 1983 Ministerial Resolution No.202-83 was published calling for a National FP Program integrated into the Maternal/Child Health (MCH) Division of the MOH. The Resolution also defined the following action areas for the program:

1. Promotion and education on the use of FP services
2. Enlarge FP service delivery facilities in all establishments administered by the MOH, and
3. Provide FP clinical services for those who request them for purposes of controlling their fertility and for the treatment of infertility.

Steps were taken to carry out the objectives of Ministerial Resolution. In 1984 Standards and Regulations were drawn up. The National Program for Planning and Breast Feeding (BF) was begun in 1985, the same year in which training of medical and non-medical personnel was initiated. Training continued until 1987.

To date most of the services have been provided by CESAMOs and CESARs, with a much smaller amount by hospitals.

III. METHODOLOGY USED IN THE EVALUATION

To comply with the requirements set forth by both USAID/H and the MCH Division of the MOH, as well as to afford an integrated look at program development, the consulting group worked on five-step basis.

A. Review of Documents

Thirty-two documents originating from various institutions working in conjunction with the National FP Program were reviewed. (Annex 1)

B. Interviews

With this assistance of the MCH Division, interviews were arranged with officials, mainly at high and intermediate levels, who would be able to up-date and amplify information obtained in the document review. A corollary objective was to establish a two-way channel of communication leading to a work plan acceptable to both institutions. (Annex 2).

C. Surveys

The survey of the Health Units of the MOH's FP programs was designed with two basic objectives in mind: 1) complete the compilation of the data necessary for the analysis of the FP services offered at all levels of the Health Network; and, 2) serve as a model of future surveys as well as methodology for field supervision of the FP program. Three questionnaires were designed: one for the Health Unit per se; a second for Medical Personnel; and the third for Non- or Para-medical personnel. (Annex 3) These questionnaires were field tested and adjusted prior beginning the actual survey.

The sample was a multi-stage design used for covering 136 Health Units consisting of 8 hospitals, 33 CESAMOs and 59 CESARs. Half of those units were visited by the Consultant Group itself and the half by persons contracted and trained to conduct the work. In every case the samplers were accompanied by either Dr. Jose C. Ochoa and/or Ms. Regina Durón both officials of the Department of Women's Health Care.

Following the field work the data were codified, recorded and processed during the months of June and July 1988. Annex 4 provides a detail on characteristics of the sample as well as the major findings of the study.

At this juncture the Consultant Group would like to acknowledge the invaluable collaborative support provided by the Honduran authorities and the staffs of the MOH, USAID/H, Management Sciences for Health and ASHONPLAFA whose help and permission to use their facilities made this task possible.

IV. PRINCIPAL FINDINGS

A. Institutionalization and Structure of the FP Program

The institution was analyzed by considering four program elements:

1. Legal status and legitimization
2. The Program
3. Resources
4. Effective leadership

With regard to the legal basis of the program there exists, as previously mentioned, a clearly stated policy of the GOH that the free choice by couples to determine the number and spacing of their children is considered a human right of Honduran citizens. To assure the effectuation of this policy it has determined to provide FP education and services as a component of MCH.

With regard to the Program, objectives and strategies to be reached or implemented during the development of the Program are spelled out in a document entitled "Plan of Operations: Department of Women's Health Care." Standards and procedures supporting the Program also are in force.

Financial resources have been provided jointly by the MOH budget and by International Donors, USAID and UNFPA who have also financed the provision of contraceptives and other materials.

As for leadership effectiveness it must be said that this program element has not been achieved at neither the Central nor the Regional level. This observation is based on the volume of FP services consultancies obtained to date (2.5 service consultancies per unit per month in 1987). The National Contraceptive Survey for 1987 give MOH coverage as ~~40% of total FP services provided.~~

Under these circumstances, it must be concluded that the MOH's FP program, in spite of enjoying a firm legal status, a defined Program and adequate resources, has not yet managed to reach the institutionalization needed to meet public demand, particularly for those at lower income levels, in terms of program impact on a national basis.

With regard to program structure, the MCH Division has two sub-departments, one for Child Health Care and the other for Women's Health Care. This latter, in addition to being responsible for various programs of care in the areas of pre-natal, birth, post-partum, breast feeding, etc; must also handle programming, setting standards, training, evaluation and administration of FP activities with a staff of only three professionals: one doctor and two registered nurses. The volume of work involved added to the hierarchy of priorities established makes it clear that Family Planning is secondary in importance. By the same token, the functions of the Department are in the main normative, effectively limiting its officials participation in program operations with the resulting loss of control and follow-up of program activities as well as making evaluation functions nearly impossible.

B. Family Planning Medical Services

Medical services provided by the MOH are organized in 8 regions and 34 areas distributed as follows:

Metropolitan Region	1 Area
Regions 4, 5 and 7	4 Areas each
Regions 1, 2 and 6	5 Areas each
Region 3	5 Areas

Within each Area there are a number of CESAMOs and a larger number of CESARs. These latter are the least complex of the service delivery system, are operated by Auxiliary Nurses (AN) and are where most interaction between services provided and the community takes place. The CESARs offer pills, condoms, and vaginal tablets. The CESAMOs add IUD's to these methods, Hospitals concentrate on surgical procedures, although but in limited measure to post-partum and post-abortion. Long waiting room times impair the delivery of FP services, especially with regard to IUD insertion or surgical methods, so patients are usually referred to the next higher level to relieve pressure.

Observations on training, promotion, supervision and logistics will appear later in this section.

C. Supervision

Supervision is fundamental to identifying and correcting operational problem areas, as well as to serve as support, assessment and motivation for officials at various levels. This function has little positive impact on the MOH/FP program due to the non-existence of supervisory guidelines, spreading supervisors over too many of the MOH's programs and by infrequency of visits.

Team visits to the Health Units revealed a considerable number of personnel without supervisory guidelines as well as the fact that responsible persons at the Regional Level lump together supervision of all program areas (besides that of FP). According to the survey 86% of the units visited had not received a supervisory visit for the FP program. It is also notable that frequency of supervision is greater in hospitals (50%) and lower in CESAMO's (9%) and CESAR's (15%) indicating supervisors prefer to visit the more easily accessible facilities (Table 80).

D. Training

Training of personnel enjoys a high priority in the MOH's MCH Division. Training activities are based on a manual bearing the imposing title: "Guidelines for Implementation, Follow-Up and Support for Training in Family Planning and Breast Feeding for Officials and Community Workers". It is noteworthy also that various seminars and courses have been developed and programmed for training at the national, regional and local levels. In addition to this, several officials have attended international seminars and workshops.

Nonetheless, an analysis of the guidelines mentioned above reveals there is no description of the specific objectives sought by training, no clear definition of training needs, nor a ranking of training priorities. Neither is there a component for evaluating the quality of training, skills developed by the trainee through training received, nor of his level of satisfaction.

By the same token, it appears that there has been no testing of course materials used as to the degree of their readability of, understanding by or impact upon the several levels of officials being trained. With regard of this point, it is noteworthy that most of the developed materials have placed major emphasis on human fertility and contraceptive methodology, while themes such as

communications techniques, use of audio-visual aids, development and promotion of group participation and education are lacking. Hence, while officials at various levels of the system may be able to grasp the material presented, they may be, in turn, frequently unable to transfer this acquired knowledge to others. This is an extremely negative factor for a program of this nature where the "teaching-learning process" is a basic element.

Additionally, there is no discernible correlation between the technical content and other course elements and the functions and duties of the officials on varying levels and with differing responsibilities who are receiving the training. The result is, as supported by the survey data, large disparities in the levels of knowledge of contraceptive methodology among personnel of different ranks as well as by geographical location. For example, the survey highlights the following problems in the training area:

For example, the survey shows that 80% of non-medical considered their training to have been only so-so while only 14.6% regarded their training as good. The evaluation of excellence of training dips somewhat for CESAMO's and CESAR's (only 6% and 8% respectively felt they received good training) compared with Regional and Area Hospitals (15% and 32% respectively) [See Table 1 - Non-Medical Personnel]

Of all non medical health personnel, 47% have university level education, and 80% of them were evaluated as having low to ordinary skills. (Table 3 - Same Section) It is also notable that of non-medical health personnel, 73.4% have 6 or more years of service, nonetheless 85% of this were evaluated as having low to ordinary skills. (Table 5-Same Section).

One positive note is that there is a profound preoccupation among all personnel - medical and non-medical - to receive more training in the family planning area. Specifically there were a number of suggestions that RN's be trained in IUD insertion.

E. Information, Education and Communication

To date the IE and C activities of this program have been very limited. The various service points restrict activities to attention for those users that may come to the facility. No community outreach exists. If one takes into

account that around 70% of the population lives in rural areas where there is a high rate of illiteracy, it is urgent that community outreach be improved. This means reaching people who do not know or who may not be able to use FP services and provide them with knowledge and use of modern contraceptive methods.

The service units visited during the consultants' field work revealed an absolute lack of consistency in available educational material. Some places had posters, others pamphlets (usually not distributed to users). Still others had flip charts, some with a simple message, some more complicated. For this latter, it was found that the presentation was difficult for potential users to understand. Additionally, ways to use the different contraceptive methods was not clearly and simply shown. Finally other facilities had manuals entitled "Self-Teaching Models, for Women" which are useful for training nurses and nurses aides but of little use for potential users, especially if they are illiterate.

Survey results in the IEC area were the following:

The survey showed that 34% of the units had no pamphlets at the time of interview, 30% without posters, and 14% without flip charts. Films and slides are non-existent. (Tables 30-35 - Section on Establishments).

In the Central Office a number of pamphlets were found such as:

"Nutrition for Pregnant and Lactating Women"

"Preparing to Breast Feeding"

"Feeding your Baby During His First Year of Life"

"Breast Feeding and Family Planning"

"Photo-Novel "The Lady Next Door"

One notes that most of these materials deal with Mother and Child Care, which is fine, but which has little to do with the FP part of the program. Once again, these publications are designed only for people who are literate. Equally problematical, there is no evidence of a serious effort to evaluate the impact of these materials and their degree of readability. In the opinion of the consultants they have too comprehensive a content and are not easily read. Those

that touch on FP do not describe how to use FP methods and are limited to simply listing them.

Finally, and as mentioned in the Chapter on Training, both medical and non-medical personnel of the several service points have received some training in FP methods, but not on how to pass this knowledge on to users nor to motivate potential users to accept a method of FP. Naturally, under such circumstances little community outreach could be expected.

F. Logistics

The present logistics system adds very little to the efficient functioning of the program. Administration of contraceptive supply is centralized, but control mechanisms and systems for a flow of reliable information upon which to base decisions are lacking.

Analysis of the Various logistics Functions

1. Inventory Management: This function is handled by a number of persons having varying positions and responsibilities, depending upon at which level of the system they operate. The forms which the MOH has designed to record the movement of contraceptive from one level of the system to another thence and to the formal user provide only limited substantive information.

Comparison of contraceptive usage rates against physical inventories are difficult: review and controls of the system inadequate. The system per se is a major impediment to the implementation of procedures to control over-warehousing and shelf-time of contraceptives.

2. Needs Estimates: A review of the estimates of contraceptive requirements over the past four years was made. It was found that the projections made were in line with the real contraceptive needs of the country as calculated on contraceptive prevalence. (There appears to have been a communications breakdown within AID's central procurement process, because the shipments received in Honduras bear no relationship to these estimates). Nevertheless, at lower levels in the system conditions indispensable in making accurate estimates of contraceptive needs do not exist. Field

personnel have not been trained and information generated is inadequate. These factors explain the over-stocking of contraceptives at the central and region levels, (more than 2 million cycles pills and 1.5 million condoms at the central warehouse in San Felipe), while there is a severe lack for users at the field service levels. For example, 51% of the units had no condoms and 57% were without vaginal tablets, (Tables 43 to 47 - Section on Establishments).

3. Customs Clearance Procedures: Responsibility for clearing contraceptives from customs is centralized. There is no regular plan scheduling MOH action to match shipping schedules received by the USAID indicating the approximate time of the arrival in-country of the contraceptives. Legal regulations provide no special status to shipments defined as "Donations" to governmental institutions such as the MOH. In many instances individuals or private sector companies are able to clear their shipments from Customs faster than can GOH institutions.
4. Central Warehouse: Under the project USAID has provided funds for the construction of a modern central warehouse which meets all of the technical and physical requirements for the proper storage of contraceptives. This warehouse is in operation, but contraceptives are not being stored there. According to MOH sources the warehouse is only for the storage of "medicines" and contraceptives are not officially defined as such. Because of this, contraceptives are stored elsewhere under conditions which do not meet even the minimum standards specified by the manufactures. Present conditions of storage at the central warehouse high temperature and humidity and poor stocking contribute to shortening the life of these products well below their Expiration Dates.
5. Processing Orders to lower levels: Theoretically , the supply system works on a basis of shipments from the central to the regional levels, whose requirements are defined by a compilation of requirements received at the regional level from the field units. In reality, however, this model does not function for most of the regions. The logistics system has neither current nor historical information upon which to base the amount of contraceptives to request from the central level nor to send to lower levels. Moreover, lower level personnel have had no training in correctly estimating their needs. Finally, there is no continuity in data collection nor of service statistics essential to

drawing-up accurate requisitions by those levels which provide direct service to users.

6. Shipment to lower levels of the program: There appear to be no plan for periodic shipments or for assigning quantities of contraceptives to the regions. By the same token, the lower levels are not supplied according to a schedule of requisitions and the quantities sent are determined essentially by guesswork.
7. Transport: The logistics system has no transportation facilities exclusively assigned to the FP program, owing to the so called "horizontal" nature of the MOH's resource allocation. Nonetheless, shipments from the central to the regional warehouses do not suffer major difficulties because of this. This is not true for the lower levels, however, where transportation and communications problems explain in large part the scarcity of contraceptives available at these points of use.
8. Warehousing at lower levels: Generally, storage conditions at the lower levels of the system are good, as well as that at the regional levels. Good warehousing standards are maintained despite no training of field personnel in contraceptive warehousing practices.
9. Service to users: In terms of access to a variety of contraceptive methods, service to users at the central and regional levels is good. Such conditions do not exist at lower levels where provision of FP services is poor, principally due to a scarcity of contraceptives.

G. Programming and Evaluation

Planning and programing in this project is mostly based on the conceptual intentions and experience of a few of the central office officials. For this reason there has been ~~neither continuity of operations nor a high level of efficiency in project implementation.~~ The stated objectives of the program are not specific, and in some cases are contradictory. Moreover, national goals are set by the central office with little or no participation by officials working at the local level who are alive to the real situation in the areas where they discharge their duties. Also there does not exist at the national level a well-thought out operations, plan nor a schedule of activities.

Most of the employees at the local level do not know what their goals are because of the lack of adequate coordination and because there is, for all practical purposes, no supervision whatsoever.

With regard to Service Statistics and Evaluation the only information collected is by form AT-1 "Daily Record of Services" which is the basis for filling in form AT-2 "Monthly Summary of Daily Services". On the first form, users are recorded by either first visit for the year or by method used, and on the second simply as FP users, by first time in the program or the area and by control of users for that month. Besides providing very little information, there is no evaluation of what information there is, nor is it checked against the respective goals set. There is no consistency in the use of terminology nor clear guidelines for collecting data for the forms. Hence, there can be no unification of criteria to be used. For example, the term "new users" is for some new to FP and for others new of the entire program. No clear definition of these terms exists.

On top of this, there is absolutely no information collected on the number and method of contraceptive provided directly to users, which prevents a reasonable calculation of couple year of protection (CYP). Without this information it is likewise impossible to know the real needs of each service point for the amount and type of contraceptives for any given period of time.

As a consequence of all the foregoing, advances in the area of statistical information and evaluation is minimal and of almost no impact at all on effective program operations. Of course, procedures and priorities to properly carry out this part of the program have not been established. In spite of all this, it is significant that most of the people interviewed agreed that statistical information and evaluation are vital to the proper functioning of the program.

H. Finances

Financing for this project is derived basically from two sources: MOH budgets and International Donors, the lion's share being provided by USAID/H and the UNFPA.

According to a UN publication: "The UNFPA has provided assistance in the areas of MCH and FP since 1977. The principal objective of this on-going assistance is to

develop and promote MCH and FP by means of improving health services; training, particularly at the community level; provision of commodities and equipment to Health Service Units; and, the development, and implementation of a system to evaluate the impact on primary health care as well as on the results of health personnel in the community..." Expenditures to 1985 reached US\$ 3,100,692.

In June 1985 a new Project was approved whose major component is MCH and FP and whose objective is to assist the GOH with its basic policies on MCH and FP. In view of the prolific assistance available to this area, the project limits itself to training administrative for activities related to encouraging participation at the community level, particularly by groups organized by women. The earmarked amount for the 1985-87 period is US\$ 803,015.

USAID/H financed a program of FP in the MOH from 1965-75. Between that time and 1980 there appears to have been no US assistance to FP programs with the government. In July of 1980 an agreement was signed with the GOH entitled "Health Sector I". The USAID's donation was to be US\$ 3,826,00 in grant funds and US\$10,965,00 in loan funds. Counterpart funding from the GOH of US\$17,061,000 brought the total of available funding to US\$31,852,000. Within the project there is a MCH component for which US\$ 712,000 in grants and US\$56,000 in loans was earmarked. The GOH contribution was US\$302,000, all for the life of the project.

With the publication of the National Plan for Family Planning in November 1983, the USAID quickly responded with additional funds. By FY 1987 the USAID contribution had jumped to US\$3,053,000, mostly from grant funding. The GOH contribution remained as originally planned.

It is clear that the program has not suffered from lack of funding.

V. SPECIFIC RECOMMENDATIONS

A. Institutionalization and Structure of the Program

1. The creation of a Department of Family Planning within the MCH Division is recommended to give greater authenticity to the program. This move would also permit the formulation of a special sub-program to include men in FP. This does not necessarily mean a "vertical" program.
2. Special attention should be accorded the definition of objectives, and strategies and how they should operate.
3. Review and up-date of the "Manual on Standards and Procedures for FP" should be done periodically. A manual for description of the functions for institutional and community personnel should be completed.
4. Coordination of activities within and without the MOH should be strengthened.

B. FP Medical Services

1. Establish a strategy to up-date the forces of improved health as a result of family planning and reducing reproduction risk.
2. Include reversible FP methods in the list of basic drugs, so they can be made available in the Medical Units pharmacies.
3. Include traditional medicines or other trained community leaders in the list of those authorized to deliver pills.

C. Program Supervision

Establish a program supervision for the Central, Regional Levels and for Health Areas based on a well structured plan and staffed with trained personnel.

Adaptation of the supervisory system recommended by the Evaluation Group by use of the sampling model utilized in this evaluation with country-wide representivity.

The objective is to put in place a program of supervision for the next three years designed to identify the most outstanding problems affecting program activities, suggest resolutions of the problems and complement personnel training activities. The program is based on a probability sample, with National and Regional representivity which will collect data on a quarterly basis problems of program operation. Each quarter basic information on varying themes related to the program will be gathered. But from quarter to quarter knowledge about each of these themes will be broader and deeper. A number of proposed themes to be examined would be: a) inventories, b) training, c) services provided to new users, d) services provided by method, e) user continuity in the program, f) personnel attendance, g) conditions of service at health units, h) service provision skills, i) educational and information materials, j) administration and accounting, k) logistics, and so on.

The sample design is that used for the medical units each quarter and which "revolves" over time. The starting point is the sample designed for the program evaluation. Subsequent samples would be determined by selecting the "neighbor" medical unit from a list. Therefore, Sample A = the original, B = first neighbor, C = second neighbor, etc.

Each individual sample would be partially "revolved" each quarter as displayed below.

SAMPLE

QUARTER	A (Original)	B (Neighbor #1)	C (Neighbor #2)
4th 1988	1-2-3-4-5-6-7-8		
1st 1989	4-5-6-7-8	1-2-3	
2nd 1989	7-8	1-2-3-4-5-6	
3rd 1989		1-2-3-4-5-6-7-8	
4th 1989		4-5-6-7-8	1-2-3

In this fashion the first sample (first quarter) would be the original in the 8 Regions; the second would have the original sample Regions 4 through 8 and would incorporate

the "neighbor" Health Units from Regions 1 through 3; the third (third quarter) would have the original sample in Regions 7 and 8 and also include the "neighbor" units Regions 1 through 6, and so on.

Thus each quarter would provide 2/3 of the sample for comparative analysis and every six months would provide 1/3 of the sample. Field work could be supervised by one of the 3 persons at the Central Office, taking terms, and 8 MCH technicians, one from each Region.

D. Training

Due to its importance the training function should be a high priority area in the FP program, should be a continuing process, and should be systematically directed at acquisition of knowledge as well as development of those capacities, skills and abilities which contribute directly to improving the discharge of the duties of any given position within the system.

Overall objectives should be:

1. Prepare and improve the capacity of personnel to better discharge their specific duties, while at the same time developing them personally and professionally. And,
2. Strengthening and developing the FP program.

To attain these overall objectives the first step to make a training needs assessment, i.e., identify the problems adversely affecting program operations and decide which of these can be solved by the training function. Priorities should then be set to deal with to the most immediate requirements.

Next, based on this needs assessment, a general plan should be drawn up for each level of the system, defining both specific and overall goals to be achieved, detailed course content, scheduling and ~~the human, physical and material~~ resources required. Provision should also be made for effective evaluation of this program.

An important aspect to be considered is that the content of each course, seminar or workshop be carefully scrutinized to assure that it responds both to specific requirements while maintaining an adequate balance of the subject matter

presented. An integrated program of training or instruction should always contain at least the general areas of Reproductive Health, Contraceptive and Community Participation. Similarly, supervisory personnel should be alert to fill in wherever encountered knowledge gaps on contraceptive methodology, as well as information and communication activities. All training activities should be carefully evaluated before and immediately after implementation, as well as over the longer term, by means of observation of the trainee and the results obtained. All officials, but especially those working at the local level, should be trained in communication and information techniques so that they may transfer their knowledge of contraceptive technology to users.

Training abroad should be carefully controlled and approved only when there is a certainty that course content meets specific program needs.

The Evaluation Team considers the training function to be of such importance and complexity and its proper functioning to be such a high priority for effective operation that is recommended that USAID and the MOH consider contracting short-term technical assistance for this area. A large amount of training expertise exists within the hemisphere and utilization of such expertise should be neither difficult nor costly.

E. Information, Education and Communications

1. It is recommended that a special effort be made to provide FP information and services through community outreach. Paramedical personnel should be motivated to make home visits and to organize talks and meetings of community groups.
2. To accomplish the above these personnel should receive appropriate training.
3. Once personnel are trained, goals should be set and careful supervision maintained to see that appropriate efforts are made to achieve them.
4. Develop FP education materials (pamphlets, flip charts, etc) for both literate and illiterate people so that the various service units have the tools to effectively carry out the tasks of education in modern safe contraception. All material should be approved before final printing and post-evaluation done to assess impact. It is recommended that the services of

an advertising agency be contracted for this work. An experienced agency can do this kind of work quickly, effectively and efficiently. This same agency can also be utilized to prepare and test material in other media - TV, Press, and radio.

In any event, it must be emphasized that the importance of education as a basic tool in the development of a FP program is unquestionable. For this reason, all officials responsible for program development should be aware of all the methods of communication in order to select and use those that any given project situation might call for. The use of various means of communication does not depend on either chance or whim. Basically, it depends on with whom you are trying to communicate, what you want to say and how you want to say it. Again, as in the case of training, the evaluation team recommends contracting on a short term basis, expertise in the IEC field to assist in setting-up the system and training selected employees is the subject matter.

E. Logistics

1. Shipments from the manufacturers: This should be the responsibility of the donor and/or the cooperating agencies and USAID/Honduras. Care should be exercised on estimating transit times to make sure shipping lines do not cause excessive delays in the arrival of contraceptives.
2. Receipt of contraceptives: Receipt of contraceptive at the port of entry and clearance from customs should be the responsibility of the Central Level. If excessive delays constantly occur the MOH should contract for Customs Agents to speed up the process.
3. Reshipments: Reshipments of contraceptives from the Central Level should be made only in amounts stipulated in request received from the individual regions.
4. Inventory Management

Due to the lack of training of field personnel in logistics and the scarcity of information from which the program currently suffers, a system of administration of inventories by "FIXED ALLOTMENT" is recommended beginning from the central to the regional level and from there on down through the system.

Logistics decision making should be centralized to the maximum extent possible since, at least for the moment, there are following distinct advantages:

- a. It requires minimum personnel training.
- b. It eliminates unrealistic requests for supplies from intermediate levels.
- c. It maintain adequate stocks at distribution points.

Nevertheless, to implement this administrative system, the following problems must be resolved:

- a. Essential information on stocks on hand and amounts of off-take must be provided in a timely fashion so that the central level has the elements upon which to make judgments and decisions for the allotment of contraceptives.
- b. Information on the supply of materials for distribution points and other program levels must be processed opportunely, for the same reasons given above.
- c. Steps should be taken to design a program of logistics training for field personnel, since with a "FIXED ALLOTMENT" supply system, these personnel would lose even more sensitivity to special and/or unusual conditions existing at the field level, than is already the case.

This system will respond best to the program needs of the MOH at a point in time where many informational and other uncertainties exist and where field personnel have little experience in management of supplies. As the personnel gain experience and knowledge it is possible to think about the implementation of a "mixed" system, i.e. delegating to the regional level, the responsibility for making correct estimates of their own needs. Under present conditions it is preferable for the MOH to concentrate on obtaining greater availability and reliability of end-use information and ~~in developing its capacity to process this information~~ than to engage in the lengthy process of training personnel at the lower levels plus the additional time necessary for them to acquire sufficient administrative skills through experience to make logistics decisions.

For all the reasons mentioned above the "FIXED ALLOTMENT" system for supplying contraceptive is strongly recommended:

5. Kinds of Orders

Procedures for routine and systematic deliveries to all levels should be established. It is recommended that the warehousing capacities of the different levels be studied in order to minimize the number of deliveries that need to be made per year to individual units. This will, in turn, minimize losses, delays and transportation costs. Routine deliveries should be implemented on the central level based on the "FIXED ALLOTMENT" system for supplying contraceptives.

6. Stock Levels

To maintain adequate inventories the "Maximum and Minimum" System is recommended, e.g. stock levels maintained based on a determined maximum and minimum number of months of off-take. (Taking into account warehouse space which to be determined by the study recommended above). To implement this system the following basic components for each of the levels must be established:

- a. Stock for a minimum number of months: This is calculated as the period of time needed for resupply under the worst possible conditions, plus an amount for unforeseen events (security inventory).
- b. Minimum amounts: This is the point below which inventories should not fall under normal conditions.
- c. Maximum months of supply: This is calculated on the number of months of stock on hand above which inventory levels should not rise under normal conditions. Routine orders for supplies should carry inventory levels to this point.
- d. Maximum amount: This is calculated on the real amount of contraceptives represented by the maximum number of months of stocks (Example: If a CESAR uses 1000 cycles of pills over a year's time, and deliveries are scheduled for twice a year, the maximum amount equals 500 cycles).
- e. Resupply Interval: This is the amount of time that one service to users requires to be resupplied, with the objective being to maintain the inventory level between minimum and maximum amounts. The resupply interval is the number of months represented times the difference between the maximum months of supply and the minimum.

In a program such as the MOH's, where there are no available reliable historical data, the amounts of inventories should be programmed for all locals by the central level and delivered to them by the central level.

It is recommended that much care be taken to assure that the difference in the concept between amounts of whatever contraceptive method supplied that are sent from the central warehouse to field warehouses and the amounts provided to users, be fully understood at all program levels. The recommended way of doing this is to use different terminology for these transactions. For example, the word "provided" (entrega) for those products given to users and "shipment" (envio) for those products transferred from one level to another.

7. Shipment Planning

It is suggested that a shipping plan be established based on the following:

- a. Amounts for provision to users. (demand)
- b. Amounts desired to maintain availability.
- c. Time required for resupply.

Once the above have been determined, it is recommended that a delivery plan be established based on intervals for deliveries of previously established fixed amounts of contraceptives and by the size of variable requests. Because of the programming capacity of the MOH transport system (it must be shared with other programs) it is easier for the MCH division to set shipment schedules so as to reserve ahead of time availability of vehicles and the varying sizes of the shipment than to have a fixed size of shipment and be obliged to vary the times when they are sent. The latter causes problems for the logistics system, as demonstrated by the conditions of present shipments.

~~The size of the shipment should vary according to the existing inventory at the time. The idea of the shipping plan is to increase stock levels of all methods to the Maximum inventory amount at fixed intervals. The advantage of this system is, as already pointed out, to permit coordination of transportation, and to space deliveries and plan them ahead. Another advantage is that the periods for FIXED ALLOTMENTS to different localities in determined area are also set~~

and hence solves the present problem of different levels of services offered in the same region against inventory levels that are completely different. This way the delivery system is easier to operate and supervise. Maximum and minimum stock levels, as well as dates of deliveries should be, fixed by the central level.

Logistics personnel should understand that emergency shipments should be made only when the minimum stock level of any article is reached before the date of resupply is scheduled. If this should happen frequently, the maximum amounts of the articles in question should be increased.

The person in charge of the central office must review continuously the amounts available as compared with the amounts used or despatched. The maximum and minimum amounts should be reviewed when it becomes necessary to maintain an equilibrium of inventory at all levels.

8. Physical Inventories

Physical inventories should be taken periodically i.e. count all the items and verify if the amounts on hand correspond to the amounts recorded on the inventory kardex. Inventories should be taken every six months, at the least, of all supplies at all levels of the program. More frequent inventories should be taken in those places where constant discrepancies between stock on hand and records are encountered. Receipt and dispatch of materials should also be checked to verify accounts with the indicated records. For this reason, the Inventory Control Card should include the date of the inventory and the amounts encountered.

When taking a physical inventory, supplies in route should be taken into account to avoid reoccurrence of the situation that has developed since March of this year when there was a complete loss of control over inventories because shipments reported in correspondence since the previous July were not taken into account.

The normal procedure is to consider that ownership of property belongs to the receiving party. For example, FP supplies in route, but not yet received at the time of the physical inventory must be counted as part of the inventory of the unit to which they are destined. These goods should be counted as stocks in transit by the people doing the inventory at the national level.

G. Programming and Education

In order to attain improved operationability of this program it is necessary to overhaul the processes of planning, programming and evaluation. It is indispensable that programming be done on the basis of total participation, i.e., with the input of officials of the regions, areas and local service delivery points, accompanied by a careful study and analyses of the real situation in all the area in question with a view to establishing specific goals.

These goals should have certain common characteristics as follows:

- They should relate directly to overall program objectives.
- They should be specific.
- They should be measurable.
- They should be doable and attainable.

After establishing clear goals to be attained it is indispensable that a specific work plan be prepared containing a calendar of activities to be carried out which will serve as a guide for the same.

Service statistics should be adequate enough to permit to periodical evaluation of whether or not objectives and proposed goals have been attained, the quality of the mechanisms used to reach these objectives, and the impact produced by their attainment. For this reason it is recommended that the forms AT-1 and A-2 be modified so that it is possible to obtain information on new users by method, e.g. number of cycles of pills distributed, number of vaginal methods distributed, number of condoms distributed, number of IUD's inserted, number of sterilizations (male and female) done, number of educational activities carried out, etc.

Once these service statistics have been compiled and periodically processed, they should then be carefully analyzed to show the relevant conclusions needed to make decisions. This way, service statistics can be used as program tools, the basis for estimations of CYP and for decision making.

It is also recommended that the forms that are used be accompanied by clear and precise instructions on how to gather data, as well as with a complete definition of the terms used, to avoid misinterpretations and its consequences.

VI. GENERAL CONCLUSIONS

After having developed and finished the evaluation of the Ministry of Health's Family Planning Program the Consultant Group considers that this program already has a basic structure and key personnel in place. We also believe that if modifications outlined in this report all put into effect the efficiency and effectiveness of the program will markedly improve. Additionally, we also think that to achieve significant improvements within a relatively short period of time some of the areas covered by this report should receive priority attention. These are:

- a. Supervision
- b. Logistics
- c. Information, Education and Communications
- d. Evaluation
- e. Institutionalization

We firmly believe that unless the recommendations contained in the report are put in effect Ministry's Family Planning Program will continue at its present low level of effectiveness or even degenerate into even more unacceptable conditions. If the Program's impact upon the prevalence of contraceptive usage will be insignificant.

In the same vein, in order to implement the recommendations put forth it is absolutely necessary that International Donors provide high caliber technical assistance to the program.

Additionally, periodic evaluation should be made of the program's progress toward and achievement of stated goals and objectives with the specific view to implementing corrective action on a timely basis.

A Z Z E X E S

ANNEX 1

DOCUMENTS REVIEWED

1. Standard Operational Definitions.
2. Family Planning Standard and Procedures for the Community.
3. Family Planning Standards and Procedures - CESAR.
4. FP Standards and Procedures for CESAMO/Area Hospitals.
5. Resolution No.141-84 (June 18, 1984) Sterilization.
6. Standard Procedures on Breast Feeding (BF)-CESAR/CESAMO.
7. Standard Procedures on Mother/Child Shared Room and Breast Feeding for Regional and Area Hospitals.
8. Standard Procedures on Teaching Hospital Breast Feeding, MCH Section (Birth Unit).
9. Standard Procedures for Attention at the New-Born Admission Area in the Birth Unit.
10. Standard Procedures for Mother/Child Shared Room and Breast Feeding in Post Partum Ward.
11. Standard Procedures for the Newly Born Service on Breast Feeding.
12. Specific Standards for Breast Milk Bank.
 - I. Selection and Testing of Donors
13. Manual on Standards for Warehousing Contraceptives Provided by the MOHA
14. Action Plan for Implementation of the Family Planning and Breast Feeding Program.
15. Implementation Letter No.113 (August 19, 1986).
16. First Official Report "Institutional and Human Resources Development" Project 522-953, AID Loan 522-U-042.
17. National Population Plan 1982-86 (October 1982).
18. Contraceptive Prevalence Surveys 1984 and 1987.
19. Guidelines for a Strategy for the Development of Operational and Management Capacities in the MOH.
20. Document: Larger Role V/1987.

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21. Participatory Exercises for Applications to FP and BF Courses. MOH/GOH. Survey.
22. Statistical and Information Bulletin on Health. Hospital Statistics Jan-Dec 1986-1987. MOH.
23. Statistical and Information Bulletins. Out-Patient Statistics (1987) MOH - Planning Division.
24. Evaluation of Attack Strategy, Problem: Pregnancy, Birth, Post-Partum. 1983-1987.
25. Report on the II Project (HON85-POI) Tripartite Meeting and Request for Funds for Project HON88-POI V/1988.
26. Training Reports 1984-85-86.
27. Reproductive Risks, Woman and Adolescent Health. Secretariat of Planning, Coordination and Budget (SECPLAN) 1988-91 UNFPA-FNUAP 1.5.
28. Evaluation of the Female Services Division. Jan - Dec. 1986.
29. Health in Numbers 1984-87. Planning Office, Health Statistics Department.
30. Operations Plan - Department of Female Services, 1988.
31. Health in Statistics
31. Honduras in Numbers 1984-86, Central Bank of Honduras; Office of Economic Studies.

ANNEX 2

FUNCIONARIOS ENTREVISTADOS

INSTITUCION	NOMBRE	CARGO
A.I.D.	Dr. Roberto H. Haladay Lic. Enf. Anita Siegal Dr. Roberto Pinto Dra. Ma. del Carmen Miranda	Jefe Ofna. de Salud Población Oficial de Población Asesor Asesora
M.S.H.	Sr. Peter N. Cross Sr. Marijke Velzeboer	Director Ejecutivo Asesora
I.H.S.S.	Dr. Oscar Godoy Arteaga Dr. Elio Sierra	
O.P.S.	Dr. Luis Loya Lic. Maribel Lozano	Representante Regional Asesora Materno Infantil
UNFPA	Lic. Ricardo Agurcia F.	Oficial de Programa
ASHONPLAFA	PM. Alejandro Flores Dr. Joaquín A. Muñoz	Director Ejecutivo Jefe de Servicios Médicos
M.S.P.	Dr. Gustavo Corrales Dr. Yanuario García Dr. Daniel Davila Nolasco Dr. Ricardo Kaffie Dr. José Ochoa Vasquez Dr. Ricardo Ochoa Alcantara Lic. Regina Durón Lic. Ma. del Carmen Ayes Dr. Jeremías Soto Dr. Carlos Pineda Lic. Rodolfo Magaña Dr. Fidel Barahona	Asesor de M.S.P. Director General de Salud Director General de Educación Direc. Gral. Materno Infantil Jefe Depto. Atención a la Mujer Director Hospital Atención a la Mujer Enf. del Depto. de Atención a la Mujer Jefe Departamento Dirección de Estadística Jefe Unidad de Medicamentos Asesor de M.S.P. Jefe de la Unidad de Ciencias y Tecnología

**DIRECTORES REGIONALES,
DIRECTORES AREA.
TECNICAS MATERNO INFANTIL REGIONAL
JEFES DE CESAMOS
JEFES DE CESARES**

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MINISTERIO DE SALUD
 PROYECTO DE EVALUACION DEL PROGRAMA DE PLANIFICACION FAMILIAR
 CUESTIONARIO ESTABLECIMIENTOS DE SALUD

C.1.FFH

I. IDENTIFICACION

1. Region No _____ 2. Area de Salud No _____ Nombre _____
 Unidad _____

3. Tipo establecimiento: 1. Hospital Regional _____
 2. Hospital de Area _____
 3. CESAMO _____
 4. CESAR _____

4. Persona que contesta el Cuestionario:
 Nombre _____ Cargo _____

II. RECURSOS HUMANOS

5. NUMERO DE MEDICOS

5.1 médicos generales _____
 5.2 gineco-obstetras _____
 5.3 otras especializaciones _____
 5.4 médico servicio social _____

5.5 LICENCIADAS EN ENFERMERIA _____

5.6 AUXILIARES DE ENFERMERIA _____

5.7 TRABAJADOR(A) SOCIAL _____

6. RECURSOS FISICOS Y MATERIALES

6.1 NUMERO DE CAMAS EN SERVICIO _____

6.2 NUMERO DE QUIROFANOS EN SERVICIO _____

6.3 TIENEN KITS DE MINILAP si ___ no ___

6.4 TIENEN KITS DE VASECTOMIA si ___ no ___

6.5 TIENEN LAPAROSCOPIO si ___ no ___

6.6 TIENEN ANILLOS DE YOONG si ___ no ___

6.7 TIENEN FARMACIA si ___ no ___

6.8 TIENEN ALMACEN O BÚDEGA si ___ no ___

MS

18. TIENE EL PLAN UN CRONOGRAMA DE ACTIVIDADES si ___ no ___

19. POSEEN MATERIALES O ELEMENTOS EDUCATIVOS DE FF ? si ___ no ___

20. EN CASO AFIRMATIVO, QUE MATERIALES POSEEN ?
1. folletos ----
2. afiches ----
3. rotafolios ----
4. transparencias ----
5. películas ----
6. otros, cual? -----

21. EN CASO NEGATIVO, POR QUE NO EXISTEN ESTOS MATERIALES ?

22. DESDE CUANDO NO EXISTEN ? -----

7. INVENTARIOS

23. PARA CADA UNO DE LOS METODOS SIGUIENTES, EXPLIQUE QUE CANTIDAD DE ELLOS TIENEN EN EL ALMACEN O BODEGA Y LAS FECHAS DE SU MANUFACTURA O VENCIMIENTO:

PRODUCTO	CANTIDAD	FECHA DE MANUFACTURA O VENCIMIENTO (especifique)
LOFEMENAL	----- ciclos	-----
LOFEMENAL	----- ciclos	-----
LOFEMENAL	----- ciclos	-----
FEMENAL	----- ciclos	-----
FEMENAL	----- ciclos	-----
FEMENAL	----- ciclos	-----
DIUS	----- unidades	-----
DIUS	----- unidades	-----
DIUS	----- unidades	-----
SULTAN	----- unidades	-----
SULTAN	----- unidades	-----
TAMITI	----- unidades	-----
CONCEPTROL	----- unidades	-----
CONCEPTROL	----- unidades	-----
NEOSAMPOON	----- unidades	-----

M = fecha de manufactura, V = fecha de vencimiento

24. EN CASO DE QUE NO EXISTAN UNO O VARIOS DE ELLOS, EXPLIQUE LAS RAZONES O CAUSAS

1. pillooras -----
2. condones -----
3. lubricantes -----
4. ... -----

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III. ADMINISTRACION

7. HORARIOS DE CONSULTA EXTERNA

mañana de _____ a _____
tarde de _____ a _____

8. POSEEN MANUAL DE NORMAS DE PLANIFICACION FAMILIAR? si ___ no ___

9. POSEEN MANUAL DE FUNCIONES? si ___ no ___

IV. PRESTACION DE SERVICIOS DE PLANIFICACION FAMILIAR

10. EN ESTE ESTABLECIMIENTO OFRECEN SERVICIOS DE PF ? si ___ no ___

11. EN CASO AFIRMATIVO, CUALES METODOS ?

- 1. píldora _____
- 2. condón _____
- 3. DIU _____
- 4. ester. fem. _____
- 5. ester. masc. _____
- 6. tabletas u óvulos vaginales _____
- 7. ritmo _____
- 8. retiro _____
- 9. otro, cual? _____

12. QUIEN ENTREGA SERVICIOS DE PF ?

- 1. Médico General _____
- 2. Gineco-obstetra _____
- 3. Enfermera _____
- 4. Auxiliar Enfer _____
- 5. Medico Ser. Soc. _____
- 6. Otros _____

13. EN CASO DE NO OFRECER SERVICIOS DE PF, A DONDE REMITE ?

- 1. usuarios de píldora _____
- 2. usuarios de DIU _____
- 3. usuarios de condón _____
- 4. usuarios de ester. fem. _____
- 5. usuarios de ester. masc. _____

14. OFRECEN USTEDES SERVICIOS DE CITOLOGIA VAGINAL ?

si ___ no ___

15. TIENEN UN PLAN DE TRABAJO DE PF ESCRITO ?

si ___ no ___

16. EN CASO AFIRMATIVO, QUIEN LO ELABORO ? _____

17. QUIENES LO CONOCEN (cargos) ? _____

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25. CUANTAS UNIDADES POR ATENCION LE SUMINISTRAN A USUARIAS DE LOS SIGUIENTES PRODUCTOS:

1. píldoras _____
2. condones _____
3. vaginales _____

26. LA PERSONA QUE MANEJA EL ALMACEN, RECIBIO CAPACITACION SOBRE ALMACENAMIENTO DE ANTICONCEPTIVOS ?
si ___ no ___

27. USTEDES SOLICITAN LOS ANTICONCEPTIVOS O SE LOS ASIGNAN ?
solicitan ___ asignan ___

28. COMO ESTIMAN LAS NECESIDADES ?

VII. REGISTRO ESTADISTICO

29. EN EL SISTEMA DE INFORMACION DE PLANIFICACION FAMILIAR QUE USTEDES USAN ACTUALMENTE, SE IDENTIFICAN: formato utilizado

- | | | |
|---|---------------|-------|
| 1. usuarias nuevas | si ___ no ___ | _____ |
| 2. usuarias nuevas por método | si ___ no ___ | _____ |
| 3. controles o subsiguientes | si ___ no ___ | _____ |
| 4. controles o subsiguientes por método | si ___ no ___ | _____ |
| 5. usuarias activas | si ___ no ___ | _____ |
| 6. número de ciclos de píldoras distribuidos | si ___ no ___ | _____ |
| 7. número de unidades de condones distribuidos | si ___ no ___ | _____ |
| 8. número de unidades de vaginales distribuidos | si ___ no ___ | _____ |

30. PREPARAN USTEDES INFORMES DE PLANIFICACION FAMILIAR CON ESTA INFORMACION ?
si ___ no ___

31. EN CASO AFIRMATIVO, CON QUE PERIODICIDAD ?
mensual ___
bimensual ___
trimestral ___
semestral ___
anual ___

32. A QUE OFICINA LO REMITEN ? _____

33. RECIBEN COMENTARIOS O SUGERENCIAS DE LOS INFORMES ?
si ___ no ___

34. DURANTE ESTE AÑO, HAN RECIBIDO VISITAS DE SUPERVISION DEL PROGRAMA DE PLANIFICACION FAMILIAR ?

si ___ no ___

35. EN CASO AFIRMATIVO, QUIENES LA HAN EFECTUADO ? _____

36. DEJARON RECOMENDACIONES Y SUGERENCIAS ?

si ___ no ___

37. EN CASO AFIRMATIVO, SE FUSIERON EN PRACTICA LAS RECOMENDACIONES

si ___ no ___

COMENTARIOS DEL ENTREVISTADO :

COMENTARIOS DEL ENTREVISTADOR :

NOMBRE DEL ENTREVISTADOR _____

FECHA: _____ DE _____ DE 1988.

10. QUE METODOS DE PLANIFICACION FAMILIAR CONOCE USTED ?

- 1. píldoras
- 2. condón
- 3. DIU
- 4. esterilización femenina
- 5. esterilización masculina
- 6. inyección
- 7. tabletas vaginales
- 8. ritmo
- 9. lactancia
- 10. otro, cual
- 11. NINGUNO

14. ESTAN USTED O SU PAREJA USANDO ALGUN METODO DE PLANIFICACION FAMILIAR ?

15. EN CASO AFIRMATIVO, QUE METODO ? _____

III. CONOCIMIENTO DE METODOS DE PLANIFICACION FAMILIAR

16. SABE USTED CUANDO SE COMIENZA A TOMAR LA PILDORA AL INICIAR EL USO DE ESTE METODO ?

- 1. Correcto
- 2. Incorrecto
- 3. No sabe

17. CUANDO UNA SEÑORA TERMINA UN CICLO DE 28 PILDORAS, CUANTOS DIAS DEBE ESPERAR PARA INICIAR UNO NUEVO ?

- 1. Correcto
- 2. Incorrecto
- 3. No sabe

18. CADA CUANTO SE DEBE TOMAR LA PILDORA ?

- 1. Correcto
- 2. Incorrecto
- 3. No sabe

19. SI UNA SEÑORA ESTA DANDO PECHO A UN NIÑO, PUEDE TOMAR PILDORAS ANTICONCEPTIVAS ?

- 1. si
- 2. no
- 3. No sabe

20. UNA SEÑORA QUE NO TIENE RELACIONES SEXUALES DURANTE UNA SEMANA, PUEDE SUSPENDER LAS PILDORAS DURANTE ESTE PERIODO ?

- 1. si
- 2. no
- 3. No sabe

21. UNA SEÑORA CON HIPERTENSION ARTERIAL PUEDE USAR PILDORAS ?

- 1. si
- 2. no
- 3. No sabe

22. USTED RECOMENDARIA EL USO DE LA PILDORA A UNA MUJER DE MAS DE 35 AÑOS DE EDAD ?

- 1. si
- 2. no
- 3. No sabe

23. EN QUE MOMENTO UNA SEÑORA SE DEBE COLOCAR LA TABLETA VAGINAL ?

- 1. Correcto
- 2. Incorrecto
- 3. No sabe

24. PARA CUANTAS RELACIONES SIRVE CADA TABLETA VAGINAL ?
 1. correcto 2. incorrecto 3. No sabe
25. PARA CUANTAS RELACIONES SIRVE CADA CONDON ?
 1. correcto 2. incorrecto 3. No sabe
26. EN QUE CONSISTE LA ESTERILIZACION QUIRURGICA FEMENINA ?
 1. correcto 2. incorrecto 3. No sabe
27. DESPUES DE LA ESTERILIZACION FEMENINA, UNA SEÑORA PUEDE TENER HIJOS ?
 1. si 2. No 3. No sabe
28. DESPUES DE LA ESTERILIZACION FEMENINA, UNA SEÑORA SIGUE TENIENDO SUS REGLAS O MENSTRUACIONES NORMALMENTE ?
 1. si 2. No 3. No sabe
29. EN QUE CONSISTE LA VASECTOMIA O ESTERILIZACION MASCULINA.
 1. correcto 2. incorrecto 3. No sabe
30. VASECTOMIA ES LO MISMO QUE CASTRACION ?
 1. si 2. No 3. No sabe
31. EL HOMBRE CON VASECTOMIA, TIENE EVACULACIONES NORMALMENTE ?
 1. si 2. No 3. No sabe
32. HA RECIBIDO CAPACITACION EN PLANIFICACION FAMILIAR
 1. si 2. No
33. EN CASO AFIRMATIVO, EN QUE AÑO RECIBIO LA ULTIMA CAPACITACION
34. COMO CLASIFICA LAS ENSEANZAS QUE HA RECIBIDO SOBRE PF ?
 1. muy buenas 2. buenas 3. malas 4 muy malas
35. DISPONE USTED DE MATERIALES O ELEMENTOS EDUCATIVOS DE PF ?
 1. si 2. No
36. EN CASO AFIRMATIVO, DE CUALES DISPONE
 1. folletos
 2. afiches
 3. rotafolios
 4. transparencias
 5. películas
 6. otros, cuales
37. ESTA SATISFECHO CON EL USO DE ESOS MATERIALES O ELEMENTOS ?
 1. si 2. No
38. EN CASO NEGATIVO, POR QUE ?

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37. QUE FORMAS DE REGISTRO UTILIZA USTED PARA LAS ACTIVIDADES DE PLANIFICACION FAMILIAR ?

38. ESTA USTED SATISFECHO CON ESAS FORMAS ?

1. Si _____ 2. No _____

39. SI NO ESTA SATISFECHO, POR QUE NO ?

40. DURANTE ESTE AÑO HA RECIBIDO VISITAS DE SUPERVISION EN ACTIVIDADES DE PLANIFICACION FAMILIAR ?

1. Si _____ 2. No _____

41. EN CASO AFIRMATIVO, QUIENES SE LAS HAN PRACTICADO (CARGOS) ?

42. SE ENCUENTRA SATISFECHO CON LAS ACTIVIDADES REALIZADAS POR USTED EN RELACION A PLANIFICACION FAMILIAR ?

1. Si _____ 2. No _____

43. POR QUE ?

44. TIENE ALGUNA SUGERENCIA PARA MEJORAR LOS SERVICIOS DE PLANIFICACION FAMILIAR ?

1. Si _____ 2. No _____

45. EN CASO AFIRMATIVO, CUALES ?

COMENTARIOS DEL ENTREVISTADO :

COMENTARIOS DEL ENTREVISTADOR :

NOMBRE DEL ENTREVISTADOR :

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MINISTERIO DE SALUD
PROYECTO DE EVALUACION DEL PROGRAMA DE PLANIFICACION FAMILIAR
CUESTIONARIO PARA MEDICOS

C.3.PFH

1. IDENTIFICACION

1. REGION NO. _____ 2. AREA DE SALUD NO. _____ NOMBRE _____
UNIDAD _____

3. TIPO DE ESTABLECIMIENTO

1. hospital regional _____
2. hospital de area _____
3. CESAMO _____
4. CESAR _____

4. NOMBRE DEL ENTREVISTADO _____ CARGO _____

11. ACTITUDES

5. TIENE USTED ALGUNA ESPECIALIDAD ?

1. medico general _____
2. gineco-obstetra _____
3. medico de servicio social _____
4. otro _____

6. ESTA USTED EN FAVOR DEL PROGRAMA DE PLANIFICACION FAMILIAR ?

1. si _____
POR QUE ? _____

2. no _____
POR QUE ? _____

3. indiferente _____

7. CUANTOS AÑOS CUMPLIDOS TIENE USTED ? _____

8. CUANTO TIEMPO TIENE EN EL MINISTERIO DE SALUD ? _____

9. CUANTO TIEMPO TIENE EN ESTE CARGO ? _____

10. HA TENIDO ENTRENAMIENTO EN PF ? 1. si _____ 2. no _____

11. HA RECIBIDO ENTRENAMIENTO EN INSERCIÓN DE DIU ? 1. si _____ 2. no _____

12. EN CASO AFIRMATIVO, CUANTOS HA INSERTADO EN EL MINISTERIO EN ESTE AÑO ? _____

13. HA RECIBIDO ENTRENAMIENTO EN ESTERILIZACIÓN QUIRÚRGICA ? 1. si _____ 2. no _____

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14. EN CASO AFIRMATIVO, CUANTAS ESTERILIZACIONES HA HECHO ESTE AÑO EN EL MINISTERIO ?

minilaparatomías..... laparoscopias..... vasectomías.....

15. QUE METODO DE PLANIFICACION FAMILIAR RECOMIENDA USTED CON MAYOR FRECUENCIA ?

COMENTARIOS DEL ENTREVISTADO :

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.....
.....
.....

COMENTARIOS DEL ENTREVISTADOR :

.....
.....
.....
.....

NOMBRE DEL ENTREVISTADOR :

FECHA: DE DE 1983.

ANNEX 5

ABBREVIATIONS USED IN THE TEXT

A.H.	Area Hospitals
AID	Agency for International Development
ASHONPLAFA	Family Planning Association of Honduras
BF	Breast Feeding
CESAMO	Health Center with Medical and Dental Services
CESAR	Rural Heal Center
CYP	Couple Years of Protection
EDENH I	National Demographic Study I
EDENH II	National Demographic Study II
ENESF/87	1987 National Contraceptive Prevalence Survey
ENSMI/84	1984 National Survey of Maternal/Child Health
FP	Family Planning
GOH	Government of Honduras
IHSS	Honduran Social Security Institute
MCH	Maternal and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
N.A.	Nurse Assistant
N.H.	National Hospitals
PAHO	Pan American Health Organization
R.N.	Registered Nurse
R.H.	Regional Hospitals.
UNFPA	United National Fund for Population Activities
UNICEF	United Nations International Fund for Child Education.
USAID/H	AID Mission in Honduras

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MINISTERIO DE SALUD
INSTITUTO DE COORDINACION DEL PROGRAMA DE FAMILIARIZACION FAMILIAR
CUESTIONARIO INDIVIDUAL - PERSONAL DE SALUD NO MEDICO
C.2.FFH

I. IDENTIFICACION

1. REGION NO. _____

2. AREA DE SALUD NO. _____

3. NOMBRE DE LA UNIDAD _____

4. TIPO DE ESTABLECIMIENTO AL CUAL PERTENECE

- 4.1. hospital regional _____
- 4.2. hospital de area _____
- 4.3. CESAP _____
- 4.4. CESAF _____

5. NOMBRE DEL ENTREVISTADO _____

II. CARACTERISTICAS DEL ENTREVISTADO

6. CUANTOS AÑOS CUMPLIDOS TIENE USTED ? _____ años

7. SEXO 1. masculino _____ 2 femenino _____

8. CUAL FUE EL GRADO O AÑO MAS ALTO DE ESCOLARIDAD QUE USTED APROBO

- 1. primaria _____
- 2. secundaria _____
- 3. universitaria o superior _____

9. QUE CARGO TIENE EN ESTE ESTABLECIMIENTO ?

- 1. Profesional de enfermería _____
- 2. Auxiliar de enfermería _____
- 3. Trabajador social _____
- 4. Promotor _____
- 5. Otros _____

10. HACE CUANTOS AÑOS QUE USTED TRABAJA CON EL MINSALUD ? _____ años

11. HA TENIDO USTED HIJOS ALGUNA VEZ ? SI _____ NO _____

12. EN CASO AFIRMATIVO, CUANTOS HIJOS VIVOS TIENE ACTUALMENTE ? _____

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