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AGENCY FOR INTERNATIONAL DEVELOPMENT
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HONDURAS

PROJECT PAPER

HEALTH SECTOR II

AMENDMENT NUMBER 1

AID/LAC/P-898
CR-426

PROJECT NUMBER: 522-0216

UNCLASSIFIED

Agency for International Development
PROJECT DATA SHEET

1. Transaction Code
[C] A = Add
C = Change
D = Delete

Document Code
3

2. Country/Entity
Honduras

3. Project Number
522-0216

4. Bureau/Office
LAC

5. Project Title
Health Sector II

6. Project Assistance Completion Date (PACD)
MM DD YY
09 30 96

7. Estimated Date of Obligation
(Under "B" below, enter 1, 2, 3, or 4)
A. Initial FY | 88 B. Quarter(2) C. Final FY | 9 | 5

8. Costs \$000 or Equivalent \$ 1 =

A. Funding Source	First FY _			Life of Project		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. TOTAL
AID Appropriated Total						
(Grant)				(42,243.3)	(15,009.9)	(57,253.2)
(Loan)						
Other						
U.S.						
Host Country				4,775.9	21,240.5	26,016.4
Other Donor(s)						
TOTALS				47,019.2	36,250.4	83,269.6

9. Schedule of AID Funding (\$000)

A. Appropriation	B. Primary Purpose	C. Primary Tech. Code		D. Obligations to Date		E. Amount Approved This Action		F. Life of Project	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	400			0	0			3,030	-
(2) HE	500							24,000	
(3) CS								30,223.2	
(4)									
TOTALS				0	0			57,253.2	-

10. Secondary Technical Codes (maximum 6 codes of 3 positions each)
510 530

11. Secondary Purpose Code

12. Special Concerns Codes (maximum 7 codes of 4 positions each)

A. Code BR

B. Amount

13. Project Purpose (maximum 400 characters)
The purpose of the Project is to support, strengthen and continue the process of extension of coverage of efficient, sustainable and effective primary health care and rural water and sanitation services, with an emphasis on child survival interventions.

4. Schedule Evaluations
MM YY MM YY
Interim | | | 11 | 89 | Final | 1 | 1 | | 9 | 4 |

15. Source/Origin of Goods and Services
[x] 000 [x] 941 [x] Local [] Other (specify) _____

6. Amendments/Nature of Change Proposed (This is page 1 of a 15 page PP Amendment)
The purpose of this Project Paper amendment is to modify the original project design to: (1) reflect the policy agenda agreed upon with the new national government; (2) incorporate project activities under an expanded STD/AIDS prevention program; (3) reprogram the remaining project budget; and (4) extend the PACD to September 30, 1996.

Approved by
Signature *Marshall D. Brown*
Title: Director USAID/Honduras
Date Signed: 8-26-94

DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

PROJECT AUTHORIZATION

AMENDMENT NO. 1

Name of Country: Honduras
Name of Project: Health Sector II
Number of Project: 522-0216

1. Pursuant to Section 106 of the Foreign Assistance Act of 1961, as amended, the Health Sector II Project for Honduras was authorized by the Assistant Administrator, Latin America and the Caribbean, on May 25, 1988. That authorization is hereby amended to increase the life-of-project period to a new Project Assistance Completion Date of September 30, 1996.
2. Paragraph 3 of Section C, "Special Covenants," is deleted in its entirety and replaced with the following:

The Cooperating Country agrees that all fees and costs recovered as part of any activity described in this Agreement shall be retained by the collecting unit and shall be in addition to any amounts budgeted by the Cooperating Country for that unit. Furthermore, the Cooperating Country agrees to make whatever provisions are necessary, including but limited to the passage of national legislation, to allow the retention of fees and costs at the operational level after the completion of the authorized project.

3. The following paragraphs are added to Section C, "Special Covenants:"

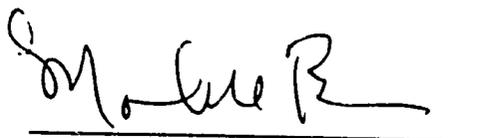
The Cooperating Country agrees that:

- a. The MOH Division of Transportation will provide training and certification services for installing and maintaining inventory control systems for pick-up truck and motorcycle spare parts in each of the MOH sanitary regions before releasing spare parts to them; and
- b. The MOH Division of Transportation in coordination with the HS II Project Coordination Unit will monitor the MOH Sanitary Regions use of the management control systems recommended in USAID/FARS Report No. 92-03. The MOH Division of Transportation shall prepare biannual reports certifying the adequacy of the MOH Sanitary Regions' use of these management control systems.

c. Without prejudicing any and all of the rights of the parties under this Agreement to suspend or terminate project disbursements, all HS II Project disbursements/reimbursements shall be suspended by USAID and the MOH Project Coordination Unit for any MOH Sanitary Region not certified in the biannual reports referred to in item "b" above.

d. The Cooperating Country agrees to make substantial progress in achieving, on a semi-annual basis, the project implementation benchmarks contained in Attachment I to Annex I, "Amplified Project Description" of the Project Agreement, as amended.

4. Except as above amended, all other terms and conditions of the original Project Authorization shall remain in full force and effect.



Marshall D. Brown
Mission Director
USAID/Honduras

Aug 26, 1984
Date



Detailed Implementation Plan
of Assistance for
the National STD/AIDS
Prevention and
Control Program
in Honduras

July 29, 1994

AIDSCAP would like to express its gratitude to the technical staff from the MOH STD/AIDS Division and STD/AIDS Programs in the Health Regions Metro, #2, #3 and #6 and to the personnel from the USAID in Honduras and Washington, D.C. who assisted in the development of this Detailed Implementation Plan of Assistance.

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
AMCHAM	American Honduran Chamber of Commerce
ASHONPLAFA	Asociación Hondureña de Planificación Familiar
BCC	Behavior Change Communication
CBD	Community-based distribution
CCC	Central Coordinating Committee
COHEP	Consejo Hondureño de Empresas Privadas
COCSIDA	Centro de Orientación y Capacitación en SIDA
CPI	Core Prevention Indicators
CSM	Condom Social Marketing
CSW	Commercial Sex Worker
EOIP	End of Implementation Plan
FGD	Focus Group Discussion
FHI	Family Health International
GOH	Government of Honduras
GPA	Global Program on AIDS
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
IA	Implementing Agency
ICC	Interagency Coordinating Committee
IHSS	Instituto Hondureño de Seguridad Social
KABP	Knowledge, Attitude, Beliefs and Practices
LA/C	Latin America and the Caribbean
LOIP	Life of Implementation Plan
MIS	Management Information System
MOH	Ministry of Health
MWM	Men who have sex With Men
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
ODECO	Organización de Desarrollo Comunitario
OFRANEH	Organización Fraternal Negra Hondureña
PAHO	Pan American Health Organization
PIF	Process Indicator Form
PWP	People in the Work Place
RCC	Regional Coordinating Committee
SPS	San Pedro Sula
STD	Sexually Transmitted Disease
USAID	United States Agency for International Development
WHO	World Health Organization
ZIP	Zonas Industriales de Producción

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I. EXECUTIVE SUMMARY

Introduction

This document is the Detailed Implementation Plan (DIP) elaborated by staff from the Ministry of Health (MOH), the USAID mission in Honduras and the AIDS Control and Prevention Project (AIDSCAP) of Family Health International. The purpose of this implementation plan is to delineate the overall Plan design and coordination mechanism between the MOH, USAID, AIDSCAP and the implementing agencies (IAs) of the specific HIV/AIDS/STD prevention and control interventions. The implementation plan also examines administrative and logistical aspects of the Plan, technical assistance requirements and strategies for sustainability. The implementation plan is based on the USAID/Honduras "Mission Strategy for HIV/AIDS Prevention Programming for Honduras," the priorities of the MOH with regards to STD/AIDS prevention and control, input from USAID/W and the combined effort of the technical staff from the MOH, USAID/Honduras and AIDSCAP.

The activities and interventions described in this implementation plan have been carefully selected to complement the programming of the STD/AIDS Division of the MOH and the efforts of other state agencies, non-governmental organizations (NGOs) and donor agencies. The implementation plan focuses on the reduction of sexual transmission of HIV through the utilization of three technical strategies:

- ▶ Improvement in referral, diagnosis and treatment of sexually transmitted diseases (STD).
- ▶ Behavior change communication (BCC).
- ▶ Improvement in the availability and correct and consistent use of condoms.

Goal and Objectives

The primary goal of the program is to provide technical, administrative and financial assistance to institutions in both the public and private sectors in Honduras in order to reduce the growing incidence of HIV/AIDS/STD. The basic objectives of the program are to:

- ▶ increase awareness of the problem of HIV/AIDS/STD at all levels in order to generate support and resources that will allow for sustainable prevention interventions;
- ▶ increase access of target populations to HIV/AIDS/STD prevention services; and
- ▶ strengthen the capacity of the local communities and institutions to carry out HIV/AIDS/STD prevention programs.

One of the principle aims of the implementation plan will be to strengthen the capacity of various institutions and industries to incorporate STD/AIDS prevention activities into existing programs and services. Technical assistance will be provided in all phases of plan design, implementation, monitoring and evaluation. Evaluation activities represent a vital component of the implementation plan, facilitating the monitoring and the adjustment of the interventions to optimize their effectiveness and to measure the general impact of the implementation plan.

Selected Populations and Geographic Areas

To accomplish the stated objectives, the USAID/Honduras "Mission Strategy for HIV/AIDS Prevention Programming for Honduras" identified, in collaboration with experts from the MOH, three target populations concentrated in four specific geographic areas of the eight health regions in Honduras. A series of interventions will be developed to address the needs of these populations in the targetted Health Regions: Metropolitan (Tegucigalpa), #2 (Comayagua), #3 (San Pedro Sula) and #6 (La Ceiba). The selected target populations are the following:

- ▶ People in the Workplace (PWP): adolescents, men and women, including housewives.
- ▶ Core Groups: commercial sex workers (CSWs), their clients and men who have sex with men (MWM).
- ▶ The Garífuna population.

The implementation of interventions for each of the target populations and selected geographic areas will be conducted under subagreements/workplans with IAs, for which the following organizations are being considered:

- ▶ The MOH STD/AIDS Division and STD/AIDS Regional Programs
- ▶ Instituto Hondureño de Seguridad Social (IHSS)
- ▶ Municipal mayorships
- ▶ NGOs such as:
 - a. La Lucha Contra el SIDA
 - b. Centro de Orientación y Capacitación en SIDA (COCSIDA)
 - c. Asociación de Mujeres Contra el SIDA
 - d. Organización Fraternal Negra Hondureña (OFRANEH)
 - e. Organización de Desarrollo Comunitario (ODECO)
 - f. Asociación de Farmacéuticos de Honduras
 - g. Universidad Nacional Autónoma de Honduras
 - h. Councils or representatives of the Catholic and/or Evangelical Churches
 - i. Other institutions identified in accordance with the needs of the implementation plan.

Summary of the Principle Activities of the Implementation Plan

The principle activities of the implementation plan are the following:

- ▶ Support STD programs, clinics and laboratories in (1) training of medical and paramedical personnel, (2) selective purchasing of equipment, and (3) improvement of STD diagnosis and treatment.
- ▶ Provide technical assistance and support for the development of BCC training and/or mass media materials that promote behavior change for the target populations based on quantitative and qualitative research.
- ▶ Develop subprojects for PWP through industrial associations, businesses and zonas industriales de producción (ZIP).
- ▶ Provide technical and financial assistance to NGOs for HIV/AIDS/STD prevention work with high risk groups.
- ▶ Support efforts of policy dialogue at all levels to promote norms, laws and policies that facilitate implementation of HIV/AIDS/STD prevention programs.
- ▶ Develop workshops, conferences and/or seminars with the commercial and industrial sectors and community and religious sector leaders with the purpose of leveraging greater support and resources for prevention programs.
- ▶ Participate with the MOH, IHSS, donor agencies and national and international organizations to assure the availability of a consistent and adequate supply of condoms for the selected target populations.

The implementation plan includes condom programming and logistics management activities in view of the fact that the interventions for target populations depend on the availability of condoms and essential drugs to prevent the spread of HIV/AIDS/STD infection. The specific area of pharmaceuticals will be strengthened by the MOH/World Bank Project. All interventions will be supported and complemented by identifying opportunities for institutional development, initiatives with the private sector and operational research.

Management, Implementation and Coordination

When the implementation plan is approved, subagreements (subprojects) will be developed for the different implementation plan components with selected IAs. These subprojects, which will correspond with specific implementation plans for each of the four geographical regions, will include workplans, timetables and detailed budgets. The MOH and AIDSCAP will jointly be responsible for the development of these subagreements.

The administration, monitoring and evaluation of the implementation plan will be the responsibility of the Central Coordinating Committee (CCC) comprised of the Director of the MOH STD/AIDS Division, a Technical Advisor from the USAID mission, the AIDSCAP/Honduras Resident Advisor and possibly representatives from other involved institutions/IAs. At the regional level, four Regional Coordinating Committees (RCC) will be created which consist of personnel from the respective Health Regions and representatives of other IAs and/or municipalities. Representatives of the National AIDS Control Program (NACP) and the AIDSCAP/Honduras Resident Advisor will attend the regional meetings.

The MOH, AIDSCAP, CCC and RCCs will form part of the organizational and coordination structure of the NACP that includes the National AIDS Commission (NAC) and the Interagency Coordination Committee (ICC). (See APPENDIX A, page 38.) In accordance with the progress, information and feedback from the subprojects, the CCC, in consultation with the AIDSCAP/Honduras Country Office, IAs and RCCs, will refine the management and implementation of the implementation plan allowing for the strengthening and pertinent modification of strategies and interventions. Shifts in the technical or management strategy will be approved by AIDSCAP, USAID/Honduras and the MOH.

This implementation plan to the Honduras NACP has been designed to strengthen the local capacity to prevent and control HIV/AIDS/STD over a four year period beginning in 1994 and ending in 1998. USAID, through AIDSCAP, will implement this implementation plan in collaboration with the Government of Honduras (GOH), the MOH, international donor agencies, NGOs and community groups and associations to mobilize resources and community participation for the implementation of HIV/AIDS/STD prevention projects. The concentration of efforts and resources in selected interventions and limited geographic areas will allow for the development of sustainable models of prevention and control that can be replicated to slow the spread of the HIV/AIDS epidemic among the Honduran population.

II. PRINCIPAL PROGRAM AREAS

The strategy employed by the Detailed implementation plan to reduce the spread of HIV in Honduras addresses the needs of combined interventions with selected target populations. This strategy is based on a number of solid public health principles and lessons already learned in international HIV/AIDS prevention interventions. The use of combined interventions in the areas of improved STD treatment, condom use and behavior change communications has a synergistic effect that produces greater results than when these interventions are used individually. Targeting relies on the principle that intervening with individuals at greatest risk yields greatest results. Hence, HIV/AIDS prevention programs must target populations with the highest HIV incidence and prevalence. The World Bank estimates that targeting can increase the prevention impact as much as eight-fold when compared to programs aimed at the general population. Combined interventions and targeting concentrate limited financial resources and time where the need - and therefore the benefit - is likely to be greatest.

The three following subsections describe the interventions for the selected target groups: PWP, Core Groups and the Garífuna population. In each subsection, the format followed to elaborate each component will be: Description, Objectives, Activities (divided into STD, BCC and Condom Programming), Technical Assistance and Implementing Agencies.

A. PEOPLE IN THE WORK PLACE (PWP)

Description

The MOH STD/AIDS Division estimates an HIV seroprevalence for people 15-49 years old at 4% in San Pedro Sula (SPS) and 1% in Tegucigalpa, and a seroprevalence for the general population at 2% in SPS and 0.5% in Tegucigalpa. Employed people comprise more than 50% of the AIDS case-load in Honduras, particularly in Health Region #3 (SPS), and include working children, youth, men and women. Current health programs for employed persons in Honduras are provided by the IHSS and company-based private health programs, and concentrate mainly on medical care. The fact that HIV/AIDS affects people in their most economically productive years justifies investing in the implementation and institutionalization of effective HIV/AIDS prevention programs in the work place.

It is estimated that women represent the largest working subgroup (70-80%) at the industrial park communities or ZIPs, which enclose many garment factories called "maquiladoras." According to the IHSS and two of the major ZIPs (Municipalities of Choloma and Villanueva), 20% of these women are single with no children, 40% are single mothers who frequently engage in serial monogamy, and 40% are married. Hence, the traditional burden of women as housewives in Honduras is now compounded by working responsibilities outside of their homes.

A focus on PWP affords the opportunity for addressing the needs of women and other working subgroups, and for building private-sector support for HIV/AIDS/STD prevention programs. This component of the implementation plan will initially reach target groups at maquiladoras and other industries (manufacturing, construction and agriculture) through several subprojects in the Municipalities of SPS, Choloma, Villa Nueva and La Lima in Health Region #3, and the Municipalities of Ceiba and Tela in Health Region #6. It is estimated that 60,000 workers (of which approximately 43,000 are women) will be reached, with an indirect impact on an additional 300,000 people who comprise their families.

The implementation plan will integrate interventions in BCC, condom programming and STD referral, diagnosis and treatment services. Interventions for PWP will emphasize technical assistance to enable the IHSS, NGOs and private sector industries to develop and maintain their own prevention programs.

The first phase of the PWP component will be initiated in Health Regions #3 and #6 due to their epidemiological importance. Additional sites and/or private sector businesses in Health Regions #2 and Metropolitan will be phased-in once a methodological experience is gained from the interventions in SPS and La Ceiba and additional resources are leveraged from private sector enterprises and the IHSS. The effectiveness of this program component will be complemented by an active private sector leveraging effort and the policy promotion activities described in Section III, 2.

Objectives

Overall:

- ▶ Reduce the incidence of sexually-transmitted HIV among PWP.

Specific:

- ▶ Improve perception of risk of HIV/AIDS/STD transmission among adolescents, women and men in the work place.
- ▶ Increase demand, access to, availability and use of condoms among PWP.
- ▶ Promote partner reduction as a means of decreasing the risk of HIV/AIDS/STD transmission.

Activities

Activities in support of the above objectives will build upon the IHSS's previous efforts and will be extended to NGOs where feasible. Major activities under the three technical strategies are outlined below.

1. Improve STD referral, diagnosis and treatment services:
 - ▶ Identify clinical sites where STD services can be provided for workers, both at and near work sites.
 - ▶ Train health care providers in the work place (medical and paramedical) in HIV/AIDS, risk assessment, counseling and the algorithmic approach to STD management.
 - ▶ Promote a partner referral system to both work site and external clinical services.
 - ▶ Provide technical assistance to the MOH, IHSS, NGOs and private enterprises to help them incorporate HIV/AIDS/STD prevention and control services within their ongoing activities.

2. Implement BCC interventions:
 - ▶ Develop message, audience and media strategies.
 - ▶ Develop a coordinated BCC implementation plan.
 - ▶ Develop and standardize HIV/AIDS/STD prevention and control BCC materials and/or methods to train both IAs and PWP.
 - ▶ Design and implement BCC interventions at work sites incorporated into social, cultural, recreational and family events.
 - ▶ Develop and/or reproduce BCC and promotional materials for HIV/AIDS/STD prevention and control for targeted audiences.
 - ▶ Train health workers/volunteers and peer leaders to implement interpersonal education programs and peer support for behavior change.
 - ▶ Promote consistent and correct use of condoms, and STD knowledge and services at work sites and in other locations accessible to the target audience.

- ▶ Increase awareness and recognition of the problem and impact of HIV/AIDS/STD among industrial leaders in target sites to facilitate the implementation of prevention programs.
 - ▶ Develop a BCC package/tool to use at workshops for industrial and commerce chambers and for business and community leaders to generate support and resources for HIV/AIDS/STD prevention programs.
3. Improve condom programming and logistics management:
- ▶ Improve MOH and IHSS logistics management systems supplying condoms, pharmaceuticals and other necessary commodities to STD/AIDS programs.
 - ▶ Strengthen the capabilities of industries and NGOs to identify a consistent/affordable source of condoms and to promote condom use among workers.

Technical Assistance

Technical assistance for this component will include STD program development and strengthening, BCC, condom and pharmaceutical programming, logistics management and institutional development. Technical assistance will be provided by:

- ▶ The technical staff of the MOH STD/AIDS Division and Health Region #3 STD/AIDS Program.
- ▶ AIDSCAP/Honduras Country Office technical staff and/or in-country organizations/individuals able to assist the groups that work with PWP.
- ▶ AIDSCAP Headquarters, LAC Regional Office staff, subcontractors and/or independent consultants.

Implementing Agencies

The following entities have been identified as possible implementing agencies for the PWP component of this implementation plan. The design, implementation and monitoring of PWP interventions will be coordinated by each Health Region's STD/AIDS Program with support from the AIDSCAP/Honduras Country Office. In addition to the groups described below, maquiladoras and other industries will participate as co-implementing agencies and partners in all PWP prevention efforts.

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- ▶ The IHSS for interventions in Health Region #3. The IHSS will lead the prevention efforts by strengthening and expanding the intersectoral (MOH, IHSS and Municipality) intervention that is already in place in SPS.
- ▶ The COCSIDA for interventions in Health Region #6 (La Ceiba).
- ▶ The Asociación de Mujeres Contra el SIDA for interventions in Health Region #2 (Comayagua).
- ▶ The IHSS for interventions in the Metropolitan Health Region (Tegucigalpa).

B. INTERVENTIONS FOR CORE GROUPS

Description

This component of the implementation plan will focus on commercial sex workers (CSWs), their clients and men who have sex with men (MWM). The inclusion of core groups who engage in behaviors which put them at increased risk of HIV infection is critical for slowing the HIV/AIDS epidemic. Interventions targeted at such groups and their sexual partners have the potential of slowing the transmission of HIV/STDs to the general population. Reduction of STDs among these populations is one of the most cost-effective interventions, since venereal genital ulcers and other STDs which cause genital tract inflammation increase the risk of sexual transmission of HIV two to three-fold.

CSWs and their clients will be reached at four of the major cities in Honduras - SPS, La Ceiba, Comayagua and Tegucigalpa - where HIV seroprevalence is high and commercial sex work extensive. MWM will be reached in SPS and Tegucigalpa. Interventions will be implemented at MOH clinics and NGO medical facilities serving patient populations which include a large percentage of CSWs, their clients and MWM, as well as through community outreach efforts of NGOs. These will include STD clinics in the four cities and NGOs which work with institution- and non-institution-based CSWs. It is estimated that at least 200 managers of brothels, bars/restaurants, discotheques and hotels where CSWs work, 3,500 CSWs and 300 MWM will be reached through the interventions described below.

Objectives

Overall:

- ▶ Reduce the incidence of sexually-transmitted HIV among CSWs, their clients and MWM.

Specific:

- ▶ Increase the perception of risk of HIV infection among core groups, as well as STD treatment-seeking behavior and negotiation skills for condom use.
- ▶ Increase demand for, access to, and availability and use of condoms among core groups.

Activities

1. Improve STD referrals, diagnosis and treatment:

N.B. The NACP is currently revising the clinical norms to reflect a more syndromatic approach based on the recommendations of PAHO. In the context of the major STD-related activities outlined below, the plan will support this process of revision, validation, dissemination and training, and further evaluation that is already underway.

- ▶ Determine prevalence levels of gonorrhoea, chlamydia and syphilis by conducting annual surveys for high and low risk groups.
- ▶ Determine the antibiotic susceptibility of prevalent strains of N. gonorrhoea from CSWs attending STD clinics in Tegucigalpa by measuring their susceptibility to the antibiotics recommended by the World Health Organization (WHO) for treatment of gonorrhoea.
- ▶ Establish a list of recommended drugs for treatment of gonorrhoea that are scientifically sound and cost-effective, and that can be integrated into the health care system.
- ▶ Provide pharmacies with algorithms (flow charts) listing the syndromic diagnostic aspects of STDs and the recommended treatments for the different STD syndromes.

- ▶ Improve the professional knowledge of physicians, nurses and pharmacists, and the clinical skills of health care providers who are responsible for the clinical management of persons with STDs.
- ▶ Conduct short and intermediate length courses for physicians, nurses, pharmacists and health care providers consisting of lectures and demonstrations for syndromic and laboratory diagnosis of genital lesions and discharges, lower abdominal pain in women and the symptoms and signs of HIV/AIDS.
- ▶ Convene a task force of experts to develop criteria for the clinical and/or laboratory diagnosis for each STD in order to strengthen the national surveillance of these diseases.
- ▶ Update the guidelines for the treatment of STDs and AIDS-related opportunistic infections.
- ▶ Conduct a serosurvey for genital ulcers caused by chancroid and early venereal syphilis among populations at high and low risk for STDs to determine the magnitude of the reservoir of these infections which increase the risk of HIV.
- ▶ Explore the establishment of community-based treatment centers for CSWs as an attempt to overcome some of the obstacles to CSWs attending STD clinics in health centers.

2. Implement BCC interventions:

For CSWs and their clients

- ▶ Assist IAs to develop strategies for working in brothels and leveraging brothel owners' collaboration in prevention programs.
- ▶ Identify peer leaders and involve them in the development of BCC materials.
- ▶ Assist IAs to involve peer leaders in organizing CSWs, in order to optimize the impact of efforts targeted towards this group.
- ▶ Develop and distribute BCC materials appropriate for brothels, hotels, motels and other places used for commercial sex activity.
- ▶ Develop curricula and training strategies for peer educators and outreach workers to promote health care-seeking behaviors of the target population.
- ▶ Assist IAs to implement curricula and training strategies.

- ▶ Design training materials and methodologies for peer educators to provide counseling on avoidance of high-risk sexual practices, inappropriate use of antimicrobial drugs and referrals to STD services if indicated.
- ▶ Develop an educational strategy for locations where male youth (potential CSW clients) congregate and socialize, including bars and recreational areas or activities.

For MWM

- ▶ Develop an educational strategy for locations where MWM congregate and socialize, including bars and recreational areas or activities.
- ▶ Identify the peer leaders from the target group through community outreach.
- ▶ Develop and distribute BCC materials with the participation of the target group.
- ▶ Develop curricula and training strategies for peer educators and outreach workers to motivate health seeking behaviors of the target population.
- ▶ Assist IAs to implement curricula and training strategies.
- ▶ Design training materials and methodologies for peer educators to provide counseling on avoidance of high-risk sexual practices, inappropriate use of antimicrobial drugs and referrals to STD services if indicated.

3. Improve condom programming and logistics management:

- ▶ Assist NGOs to plan for and obtain an adequate condom supply for their programs with the Core Group populations.
- ▶ Improve distribution networks to NGOs.
- ▶ Insure that condoms are available and that their use is recommended in public sector STD clinic services.¹
- ▶ Review, modify and implement guidelines for logistics and proper storage of condoms in public sector facilities treating STD patients.

¹Although there is currently a substantial stock of public sector condoms, the Mission and the NACP remain concerned about the level of supplies beyond FY 95. To resolve the problem, the NACP plans to 1) begin a dialogue with other donor agencies for condom procurements; and 2) create a line item in their budget for 1995 to make an initial small purchase to establish the line item.

- ▶ Help NGOs and STD clinics in designing, testing and implementing innovative schemes for promoting condom use among CSWs and MWM.

Technical Assistance

Technical assistance for this component will include STD program development and strengthening, BCC, condom and pharmaceutical programming, logistics management and institutional development. Technical assistance will be provided by:

- ▶ The technical staff of the MOH STD/AIDS Division and Health Region #3 STD/AIDS Program.
- ▶ AIDSCAP/Honduras Country Office technical staff and/or in-country organizations/individuals able to assist the groups that work with core groups.
- ▶ AIDSCAP Headquarters, LA/C Regional Office staff, subcontractors and/or independent consultants.

Specific technical assistance in BCC will be provided in the following areas:

- a) development of a coordinated interagency implementation plan;
- b) development of message, audience and media strategies;
- c) distribution of responsibilities among participating IAs for the implementation of each strategy's activities;
- d) development of unified messages and standard materials and methodologies to train IAs personnel and peers in HIV/AIDS/STD prevention and control;
- e) preparation of training activities for health workers, volunteers and peer leaders to implement BCC activities.

Implementing Agencies

- ▶ The MOH will be the main IA for interventions with CSWs who are registered with the local health department and/or are brothel-based;
- ▶ Proposed Honduran NGOs who may participate in the implementation of subprojects for unregistered CSWs and MWM, in collaboration with and under the technical guidance of the respective Health Region, are as follows:
 1. Lucha Contra el SIDA for subprojects with CSWs and MWM in SPS and Tegucigalpa;
 2. COCSIDA for subprojects with street CSWs and MWM in La Ceiba.

3. Asociación de Mujeres Contra el SIDA for subprojects with CSWs and MWM in Comayagua;
4. Asociación de Farmacéuticos de Honduras for training pharmacy personnel and distributing educational materials to pharmacists and their customers in the four Health Regions.

C. INTERVENTIONS FOR THE GARIFUNA POPULATION

Description

The Garífunas or "negros caribes" (Caribbean Blacks) are a sizable ethnic group in Honduras. They live throughout the Atlantic coast (litoral) of Honduras and number from 150,000 to 200,000. There are 46 Garífuna communities along the Atlantic coast. This intervention component will be carried out primarily in Health Region #6, where the Garífuna population is concentrated and receive health care through the MOH health centers and ecumenical mission clinics.

There are a number of factors that affect HIV/AIDS prevention and control efforts in the Garífuna communities. A large number of Garífuna men who migrate to the large cities and abroad for economic reasons or who are fishermen return periodically to visit their families. There is minimum commercial sex among the Garífuna population, but early initiation of sexual activity and multiple sexual partners are cultural norms. Polygamy is a culturally accepted practice within the Garífuna communities and alcoholism is a growing concern as a co-factor for high risk behaviors, particularly among male fishermen. Other sociodemographic characteristics of the Garífunas are a high pregnancy rate among adolescents, a tendency of Garífuna women not to communicate openly about sexuality, a larger proportion of women compared to men due to the migration, and the important role of women in small-scale agricultural work and in providing care for their families.

There is a lack of information and knowledge about HIV/AIDS among the Garífuna population, particularly in communities more difficult to access. Compounding this situation, HIV/AIDS prevention BCC materials specifically designed for Garífunas are very limited or non-existent. Hence, the implementation plan will target a population of about 50,000 Garífunas in Health Region # 6 that correspond to MOH health centers and ecumenical mission clinics in the following cities: La Ceiba, Trujillo, Tela, Olanchito, Roatán and Tocoa.

Objectives

Overall:

- ▶ Reduce the incidence of sexually-transmitted HIV among the Garífuna population.

Specific:

- ▶ Increase the perception of risk among the Garífuna population in order to reduce high risk behaviors, particularly unprotected sexual intercourse.
- ▶ Increase health care-seeking behaviors and utilization of MOH and mission clinics among the Garífuna population, particularly for STD referral, diagnosis and treatment services.
- ▶ Increase demand for, access to and availability and use of condoms among the Garífuna population.
- ▶ Create linkages with external Garífuna organizations (e.g., MUGUMA in New York, etc.) to support the Honduran Garífuna population.

Activities

1. Improve STD referral, diagnosis and treatment:
 - ▶ Strengthen the HIV/AIDS/STD services at the MOH clinics in Health Region #6.
 - ▶ Refer the Garífuna population to existing MOH and/or ecumenical mission clinics, where available, for STD diagnosis and treatment as well as HIV counseling and testing.
2. Implement BCC interventions:
 - ▶ Identify peer leaders through community outreach and the current grass-roots groups being formed in select Garífuna communities.
 - ▶ Train peer leaders to implement interpersonal education programs and peer support for behavior change in relation to condom use and STD prevention, diagnosis and treatment. Involve HIV-positive Garífunas and traditional healers as spokespersons/peer educators.
 - ▶ Develop a small-scale assessment in two communities regarding HIV/AIDS/STD knowledge, attitudes, beliefs and practices (KABP).
 - ▶ Develop and distribute age-specific, low-literacy BCC materials for Garífunas. Development and distribution will be accomplished through IAs' outreach workers and peer educators.

- ▶ Design innovative communication strategies that are participatory and reflect real life situations in the Garífuna communities (e.g., improvisational theater, sociodramas, music and small group discussions)².
- ▶ Develop BCC strategies for condom use and partner reduction. Negotiating safer sex and condom demonstrations will be key components of these strategies.
- ▶ Develop and disseminate HIV/AIDS/STD BCC materials to reach Garífuna adolescents in and out of schools in collaboration with the Ministry of Education's regional and national offices.

3. Improve condom programming and logistics management:

- ▶ Assist the MOH and NGOs working in these communities to identify a consistent and affordable supply of condoms to provide to the Garífuna population.
- ▶ Develop and implement a condom distribution strategy at locations where Garífunas socialize.

Technical Assistance

Technical assistance for training peer leaders will continue to be provided by the Health Region #6 personnel. Technical assistance for BCC materials development and condom promotion will be provided to IAs by the MOH STD/AIDS Division. Technical assistance also will be provided by in-country organizations/consultants, AIDSCAP/Honduras, Regional Office and/or Headquarters technical staff, subcontractors and/or external consultant as needed.

Implementing Agencies

All activities that target the Garífuna population will be implemented and or coordinated by the MOH's Health Region # 6 personnel. In addition, the following NGOs have been identified as potential IAs:

- ▶ Centro de Orientación y Capacitación en SIDA, (COCSIDA), an NGO involved in HIV/AIDS peer education training activities, may provide training to other IAs' staff. It is possible that the region may decide to use COCSIDA as an umbrella organization

²Armando Crisanto, a Garífuna leader at the Secretaría de Estado en el Despacho de CULTURA, has been working with a theater group for HIV/AIDS prevention promotion. This effort may serve as a model for further development of culturally relevant theater productions.

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that will provide technical and administrative assistance to and coordinate the efforts of other IAs involved.

- ▶ Organización Fraternal Negra Hondureña (OFRANEH) to facilitate access to their outreach infrastructure of health education community groups known as "grupos sectoriales por barrio" located throughout the Garífuna communities.
- ▶ Organización de Desarrollo Comunitario (ODECO), another NGO representative of the Garífuna community and founded in 1992, to implement HIV/AIDS education community programs.
- ▶ Ecumenical missionary groups working with specific Garífuna communities in the provision of health care.

III. SUPPORTING PROGRAM AREAS

Supporting program areas are those which provide general systems support to (1) improve the availability and supply of essential commodities for HIV/AIDS prevention and control (Condom Programming and Logistics Management), (2) increase the awareness of the problem of HIV/AIDS/STD to generate resources for and facilitate support to policies conducive to HIV/AIDS prevention programs (Policy Promotion and Sustainability, including private sector leveraging activities), and (3) enhance the work and the effectiveness of the major program areas (Evaluation and Monitoring). Each of these supporting program areas will be described following the same format used under the principal program areas with the exception of the Evaluation and Monitoring subsection, which merits a different format due to the nature of the activities it encompasses.

A. CONDOM PROGRAMMING AND LOGISTICS MANAGEMENT

Description

The accomplishment of the interventions proposed in this document depend on the availability of condoms and essential pharmaceuticals to prevent the spread of HIV/AIDS/STD infection. In order to insure this availability both the public and private sectors must be evaluated and strengthened where necessary. This component will cover the public sector supply program and the private sector marketing programs existing and being planned in Honduras.

On the surface, condom availability in Honduras does not seem to be a problem. USAID furnished 5.9 million condoms in 1993: 3.6 million to the MOH, 1.2 million to the IHSS and 1.1 million to ASHONPLAFA. An MOH inventory control system was designed and implemented throughout the country. In addition, a USAID/Honduras team regularly monitors condom presence in medical centers and hospitals with STD services and has found positive results. For instance, summary documents of 1993 monitoring campaigns report that condoms were present in 98% of the hospitals monitored, 98% of the health centers with doctors (CESAMOS), and 84% of the rural health centers (CESARES). There are, however, discrepancies between the findings of the official USAID audit and other recent field observations of STD and health centers. For example, stock outs in important STD centers have been noted, record keeping at the regional level is not always clear, computers at the regional level are most often not used as planned, and records are rarely kept at the area level and almost never kept at the health center level. A serious lack of field supervision has also been noted.

Inadequate drug and condom supplies for free distribution to the poor can seriously impair intervention efforts in Honduras with the populations. The implementation plan does not include resources to directly supply essential commodities. Therefore, intervention efforts, whether NGO, community-based or government-implemented, are primarily dependent on the government health system for an adequate commodity supply. These facts argue for practical,

rapid and targeted technical assistance in logistics management to all of the four major tiers of the MOH distribution system.

A strong logistics management system will maximize the benefit from the upcoming World Bank loan for HIV/AIDS prevention and control, including STD pharmaceutical procurement. In addition, public sector condom distribution should be complemented by private sector commercially marketed and socially marketed condoms.

Private commercial American and Asian condoms are found in ample quantities at prices from 4 to 6 lempiras per condom "3-pack" (from \$0.18 to \$0.27 per condom). Socially marketed condoms are also amply present in traditional pharmacy outlets and at family planning community-based outlets. ASHONPLAFA, the family planning organization presently managing the condom social marketing, distributes three condom brands in their family planning community-based distribution (CBD) network: one generic condom (\$0.07 per condom) and two brand-name condoms, Guardián and Protector (\$0.11 to \$0.16 per condom). The two brand name condoms are also sold at commercial pharmacies at socially marketed prices. These condoms have a family planning image although there is a low key ASHONPLAFA communication program oriented towards HIV/AIDS prevention.

ASHONPLAFA presently claims annual sales from each of their two sales networks (CBD and pharmacies) of around 700,000 pieces each for total annual sales of approximately 1,400,000 pieces for both family planning and HIV/AIDS/STD prevention. The condoms were donated by USAID (1993) as well as other sources. ASHONPLAFA information indicates that they may be responsible for 50% of the pharmacy market sales.

There is currently a substantial stock of public sector condoms on hand and USAID/Honduras plans further procurements for FY 1994 and FY 1995. However, there exists concern for the outgoing years of this implementation plan as well as for afterwards since the Mission has not yet secured funding for purchases beyond these dates. This situation is compounded by the fact that there is, at present, no socially marketed brand name condom directly aimed at the HIV/AIDS prevention market or distributed to non-traditional outlets. The NACP plans to begin dialogue with other donor agencies for condom procurements and to create a line item in their budget for FY 1995, making an initial small purchase to establish the line item as preliminary steps to resolve this situation. 1

Objectives

- ▶ To support planned interventions in Honduras with the selected target populations by improving logistics management systems for condom and STD drug supplies.
- ▶ To assist the MOH in developing improved logistics cycles and management systems for essential commodities for HIV/AIDS prevention and STD control efforts.

- ▶ To assist the MOH in policy dialogue with national or international institutions and donors conducive to condom procurements and/or the establishment of a private social marketing project for HIV/AIDS prevention and control.

Activities

1. Public Sector:

- ▶ Conduct logistics assessments and design a distribution strategy.
- ▶ Ensure essential commodity distribution to planned intervention activities.
- ▶ Conduct an operational field review of overall distribution strategy, warehousing, transportation, supervision, personnel, inventory control, management information system (MIS), stock management, and procurement.

2. Condom Social Marketing (CSM):

- ▶ Explore the feasibility to initiate a private sector driven CSM project during the life of the project with national, bilateral or multilateral funding. A future Honduras CSM program would have to go through the following steps, whether it be a purely national program or as part of a subregional strategy:
- ▶ Create a brand name condom specifically for the HIV/AIDS prevention market.
- ▶ Plan and launch a national CSM effort.
- ▶ Design and implement a social marketing program, through NGOs to sell the new product to the target populations.
- ▶ If the preceding social marketing program has positive results, assist in the preparation of a campaign to launch the new condom on a large scale to the national market, through both traditional and non-traditional outlets.
- ▶ Design and implement an improved system for distributing condoms to CSWs through the public sector and with the eventual use of the brand name condom.
- ▶ Assist NGOs to develop strategies for identifying new markets for condoms, including non-traditional outlets.
- ▶ Develop cost-recovery strategies appropriate for Honduras and provide assistance to NGOs to participate in such activities.

Technical Assistance

Technical assistance in the fields of logistics management, CSM, evaluation methodology and BCC will be provided by in-country organizations/consultants when possible, or by AIDSCAP/Honduras, LA/C Regional Office and/or Headquarters staff, subcontractors and/or external consultants.

B. POLICY PROMOTION AND SUSTAINABILITY

Description

Honduras has a technically sound STD/AIDS Division within the MOH with solid regional offices and an improving surveillance system. The Honduran commercial sector has begun to realize the need to promote HIV/AIDS/STD prevention in the workplace. Honduran churches have developed hospices to specifically address the care of AIDS patients, and are beginning to confront the delicate issue of HIV/AIDS/STD prevention. NGOs such as ASHONPLAFA continue to provide condoms for family planning and HIV/AIDS prevention and control, while La Lucha Contra el SIDA is working in the areas of both prevention and care in Tegucigalpa and SPS. Despite these successes in creating awareness and consolidating human and physical capital to confront HIV/AIDS, the country remains constrained by very limited financial resources.

Therefore, the implementation plan will try to encourage and sustain the positive policy environment which has been created, while encouraging private sector leveraging and the cost-effective use of the country's limited resources.

Policy promotion must maintain HIV/AIDS/STD prevention as a priority among leading policy makers, including those in government, business and the churches. Furthermore, the NACP should recognize the role of the NGOs as complementary to other HIV/AIDS prevention activities.

A number of constraints/obstacles have been identified which continue to prevent the success of HIV/AIDS prevention programs. Some of these obstacles include:

- ▶ Continued differences and inadequate coordination in HIV/AIDS/STD prevention efforts between the NACP, Social Security, municipalities and NGOs;
- ▶ Opposition by some churches to condom distribution and sex education, particularly for adolescents;
- ▶ The unwillingness of some maquiladoras to offer time to their workers to attend HIV/AIDS/STD prevention activities;

- ▶ The harassment of licensed CSWs by the country's police force;
- ▶ The unwillingness of some doctors and health workers to treat patients with HIV/AIDS in hospitals; and
- ▶ The pre-screening of potential employees for HIV by some large-scale employers.

Financial sustainability describes the need to meet the recurrent costs of HIV/AIDS prevention interventions on an ongoing basis after the initial investment in the implementation plan. Given the currently limited resources available for HIV/AIDS/STD prevention in Honduras, it is critical that: (1) opportunities for cost recovery be explored and, where appropriate, implemented (e.g., creating revolving funds for the purchase of STD drugs), (2) the commercial sector be encouraged to contribute their own resources to HIV/AIDS/STD prevention, and (3) ongoing interventions be evaluated to assure that HIV/AIDS/STD interventions are implemented in the most cost-effective manner.

Objectives

The accomplishment of the following objectives is critical to the success of the implementation plan:

- ▶ Promote the passage of national legislation to enhance HIV/AIDS/STD prevention, including the provision of adequate resources, guidelines for workplace policies and programs, and anti-discriminatory treatment of people infected with HIV;
- ▶ Assure that HIV/AIDS/STD prevention remains a priority among leaders in the GOH, commercial sector and NGOs and that appropriate policies are promoted;
- ▶ Encourage the leveraging of additional human, physical and financial resources, especially from the commercial sector; and
- ▶ Assess the recurrent and capital costs and benefits/results of interventions to: (1) guide the design of cost-effective interventions and (2) identify opportunities for financially sustaining these interventions beyond the implementation plan.

Activities

Policy activities will focus on three intermediaries: government policy makers/implementing agencies, business leaders and religious leaders. The following describes how each of these intermediaries will be addressed:

1. Government Policy Makers/Implementing Agencies:

- ▶ Support the STD/AIDS Division to disseminate the results of the Socio-Economic Impact Study of HIV/AIDS in Honduras by developing and presenting slides summarizing the results, along with guides describing how users can present findings from the study. Ten copies of the slides and the guides have already been disseminated to each of the Health Regions by the STD/AIDS Division.³
- ▶ Further disseminate the results from the Socio-Economic Impact Study by reproducing 200 copies of the final report and making this widely available to Honduran policy makers and journalists at the national and regional level.¹
- ▶ Develop and distribute 30 copies of a video tape which summarizes the findings of the Socio-Economic Impact Study and incorporates clips from other AIDS videos.¹
- ▶ Sponsor one annual HIV/AIDS policy dialogue to disseminate information and to promote national policy recommendations. These dialogues will include governmental and non-governmental organizations, including members of the Honduran Congress; Presidential-level policy makers; community leaders; the Honduran Police Force; Ministries of Health, Labor, Finance, Planning and Education; the Armed Forces; business and commercial organizations (e.g., American Honduran Chamber of Commerce (AMCHAM), Consejo Hondureño de Empresas Privadas (COHEP)); labor syndicates; journalists; et cetera. The focus of the dialogues will be on specific policy issues that can be addressed through legislative mechanisms.
- ▶ Sponsor one HIV/AIDS journalist workshop, to assure that appropriate information is disseminated to policy makers and their constituencies and repeat the workshop annually if funding allows.
- ▶ Develop a coordinated cost-effective strategy for HIV/AIDS intervention activities by assessing the recurrent costs and benefits/results, and identifying

³ These activities are a continuation of the "Socio-Economic Impact Study of HIV/AIDS in Honduras." These activities will continue to be funded from the LAC Bureau of USAID/Washington.

opportunities for cost recovery for the following interventions: (1) an AIDS prevention program in the workplace, (2) a targeted condom distribution program with CSWs, and (3) a public health STD clinic.

2. Commercial Sector Leaders

- ▶ Design and reproduce 200 policy guidelines and educational materials for policy makers in the workplace specifically for Honduran businesses.
- ▶ Carry out 36 forums, round tables and workshops over the next 2 years with business leaders to promote HIV/AIDS/STD prevention in the workplace and to assist in developing non-discriminatory workplace policies, discouraging the use of HIV testing without appropriate counseling and leveraging resources for HIV/AIDS/STD prevention interventions.

3. Religious Leaders

- ▶ Bring together leaders from various churches in Honduras for an annual HIV/AIDS/STD and religion workshop to discuss how they can best contribute to the national HIV/AIDS/STD prevention effort.⁴ These workshops would encourage greater investment in HIV/AIDS prevention by churches and collaboration between the churches, NGOs and the GOH while minimizing those obstacles which may hinder future HIV/AIDS/STD prevention efforts.

Technical Assistance

As with other program areas, technical assistance will follow AIDSCAP's procedures and be provided by in-country organizations/consultants when possible, and then by AIDSCAP/Honduras, LA/C Regional Office and Headquarters staff. Specific technical assistance, however, will be provided by the AIDSCAP/Headquarters Policy Unit.

Implementing Agencies

The following represents some preliminary suggestions regarding potential IAs:

- ▶ The MOH STD/AIDS Division for the continued dissemination of the "Socio-Economic Impact Study."

⁴ The Pan American Health Organization (PAHO) is planning to sponsor the "First National HIV/AIDS Prevention and Control Workshop for the Religious Sector" in September of 1994. AIDSCAP will co-sponsor this workshop and/or sponsor follow-up activities to this workshop and subsequent workshops.

- ▶ The IHSS for the implementation of the "AIDS and the Workplace" policy activities.
- ▶ The Universidad Nacional Autónoma de Honduras and the MOH for activities designed to assess the costs of interventions.
- ▶ The MOH for the annual "National AIDS Policy Dialogues" and journalist workshops.
- ▶ Existing religious organizations for the facilitation of workshops with religious organizations.

Evaluation: Policy analysis and dialogue

Evaluation of this component will focus on the sustainability of progress made to date, progress made on private sector leveraging and the cost effective use of resources. As shown in the LogFRAME, these issues will be addressed through the use of process evaluation (i.e. outcome indicators) and will be reported on the process indicator forms (PIFs). The AIDSCAP/Honduras Resident Advisor will also include a policy update section in all reports to the AIDSCAP LA/C Regional Office and Headquarters functioning as a qualitative process measure of changes in policies effecting HIV/AIDS interventions.

C. EVALUATION AND MONITORING

Overview

This plan encompasses measurements of process, outcome and impact, addressed at both the implementation plan level and the subproject or component level, and measured in intervention sites. Both quantitative and qualitative data collection methods will be used during most phases of evaluation. The evaluation plan incorporates "core" measures consistent with the AIDS Core Prevention Indicators (CPI) developed jointly by WHO/Global Program on AIDS (GPA) and USAID. Since the individual activity indicators and the way they will be collected are not rigidly fixed, they will be reviewed at the initiation of the activity in question and monitored regularly.

Each subagreement will be monitored and evaluated according to individual subproject evaluation plans appropriate to the nature and scope of the activity and the objectives of the intervention. Evaluation plans for subproject activities will be included in each subagreement as the subagreement is developed. Country project level indicators will be measured within subprojects where relevant to the activity, along with process and outcome indicators specific to the activity.

Data from the monthly Process Indicator Form (PIF) reports from each subagreement collected along with quarterly summary reports generated at both AIDSCAP Headquarters and

LA/C regional levels will provide feedback through the AIDSCAP/Honduras Resident Advisor to individual subproject IAs.

Within three months after the Resident Advisor has been hired an appropriate in-country IA or individual will be identified to implement this evaluation component of the implementation plan. An evaluation subagreement will be written by the Resident Advisor and the LA/C Regional Office Evaluation Officer working jointly with the identified IA.

Specific evaluation tasks to measure all implementation plan and subproject goals, purposes and outcome indicators will be completed in the evaluation component of the subagreement and will be consistent with this implementation plan evaluation plan once subagreements are written.

Baseline Assessment of HIV/AIDS in Honduras

The evaluation component will produce a project baseline assessment of the HIV/AIDS situation in Honduras, including general information for the whole country, but focusing on the four Health Regions where interventions will occur. This assessment will include:

- ▶ A review of HIV and STD prevalence in the intervention regions;
- ▶ An analysis of the supply, distribution and promotion of condoms in Honduras;
- ▶ The status of STD case management in STD clinics in the intervention regions;
- ▶ The policy environment for HIV/AIDS interventions in Honduras, building on the technical analysis already conducted vis a vis the USAID/Honduras "Mission Strategy for HIV/AIDS Prevention Programming for Honduras," and the "Socio-Economic Impact Study";
- ▶ A literature review of the key HIV/STD quantitative and qualitative behavioral research conducted in Honduras;
- ▶ A review of the equipment available in the targeted STD clinics;
- ▶ A description of significant BCC strategies, campaigns, messages, materials, training efforts and curricula with the targeted populations; and
- ▶ A review of any KABP surveys conducted concerning the targeted population.

The baseline assessment will use existing data whenever possible but also might include collection of new data. The literature review will assess the extent and quality of recent research to enable decisions about the need for further original research at baseline.

Ultimately, this baseline assessment will constitute the "background" for the implementation plan's final evaluation. Activities related to the baseline assessment will set the stage for interventions among the targeted populations. Individual components of the baseline assessment will likely be completed at staggered intervals, but the entire assessment should be completed by December 1994.

Impact and Outcome Evaluation

Impact (biological) of HIV prevention programming: HIV and syphilis seroprevalence

Impact indicators for evaluating the effects of all HIV prevention programming in Honduras include measuring, both at baseline and at the end of the implementation plan (EOIP), the WHO/GPA's CPIs (amended):

- CPI #8. Percent of pregnant women aged 15-24 who have serological evidence of recent infection by venereal syphilis;
- CPI #9. Rate of reported urethritis in men aged 15-49 in the preceding 12 months; and
- CPI #10. Percent of women aged 15-24 seropositive for HIV.

The MOH STD/AIDS Division will provide data from syphilis testing and treatment currently being done at STD clinics serving CSWs. Data will also be captured at HIV sentinel sites in Tegucigalpa, SPS and La Ceiba. In addition, the MOH will implement a sentinel site in Trujillo. Consideration will be given to the provision of assistance to establish an additional site in Comayagua.

Specific activities for the MOH's STD/AIDS Division include:

- ▶ Short-term epidemiological training for clinical staff including doctors, nurses and microbiologists;
- ▶ Review and upgrading of national HIV surveillance guidelines and treatment guidelines;
- ▶ Develop/strengthen four sentinel surveillance sites (one STD clinics in each region);
- ▶ Initiate counseling and outreach services in each of the clinics identified;
- ▶ Make the condom distribution system functional in each of the clinics identified; and
- Address the purchase and use of appropriate STD drugs.

Outcome (behavioral) of HIV prevention programming: BCC

Three basic behavior change CPI's will be measured both at baseline and EOIP. These include:

- CPI #1. Percentage of people in the population aged 15-49 citing at least two acceptable ways of protection from HIV infection;
- CPI #4. percentage of people aged 15-49 who report having been sexually active in the last 12 months who also report having at least one sex partner other than their regular sex partner(s) in the last 12 months; and
- CPI #5. percentage of people aged 15-49 who report sexual intercourse of risk in the last 12 months who also report the use of a condom during the most recent act of sexual intercourse of risk.

Other key remaining questions will be identified that can best be addressed through use of focus group discussions (FGDs), in-depth individual interviews or rapid ethnographic assessments. Subagreements developed will address developing and/or strengthening peer counseling, BCC messages, and outreach and BCC messages in the workplace among the target groups in order to measure the extent to which CPIs 1, 4 and 5 have been addressed.

Outcome indicators: Condom distribution and availability

The two CPIs that need to be measured at baseline and at follow-up include:

- CPI #2. Percentage of total number of condoms available for distribution during the preceding 12 months in the population aged 15-49; and
- CPI #3. Percentage of number of people who acquire a condom in the population aged 15-49.

In addressing these CPI's the implementation plan will:

- ▶ Improve the condom logistics distribution program in reaching the target populations;
- ▶ Assist the MOH in developing improved logistics cycles and management systems for essential commodities for HIV/AIDS prevention and STD control efforts;
- ▶ Conduct a brand name needs assessment on the creation and launching of new CSM condoms for use by the private sector; and
- ▶ Conduct distribution strategy and logistics assessments.

Outcome indicators: Facility-based STD case management

STD prevention and control interventions for targeted populations will incorporate measures of appropriate levels of diagnosis and treatment in accordance with national standards. A brief baseline assessment of appropriate management will be performed, but a more thorough evaluation will not be done until some progress has been made in upgrading STD services. A follow-up evaluation will be conducted yearly in the context of routine facility supervision. The CPI's to be measured with this methodology include:

- CPI #6. Percent of individuals presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards); and
- CPI #7. Percent of individuals seeking STD care in health facilities who received appropriate advice on condom and on partner notification.

For the purpose of the implementation plan evaluation, the total number of patients seen at the four STD clinics in which project interventions occur will be aggregated at baseline, yearly and at EOIP, by gender, diagnosis and age in the target populations.

Other aggregate process data will include the total number of STD clinic providers trained in proper diagnosis and treatment of STDs (both clinic and laboratory personnel), and the total number training sessions held for STD clinic health care providers.

Policy analysis and dialogue

The AIDSCAP Headquarters' Policy Unit will attempt to stimulate and support the policy environment which has already been created, and will promote private sector leveraging and the cost-effective use of limited resources. AIDSCAP's technical assistance in policy involves facilitating the process of developing rational and appropriate policies in the public and the private sectors. While it is expected that this facilitation will lead to appropriate changes in specific policies, ultimately it is the responsibility of the national policy makers, not AIDSCAP, to determine specifically how their country will confront the issue of HIV/AIDS. Thus, the evaluation of this component will principally measure to what extent the activities have been completed in addressing the following process indicators.

- ▶ Distribution of the Socio-Economic Impact Study report to 200 Honduran policy makers and journalists;
- ▶ Circulation of thirty copies of a Socio-Economic Impact Study video;
- ▶ Analysis of the projected costs of three HIV/AIDS projects;
- ▶ Development and distribution of 200 copies of workplace policy guidelines and educational materials;

- ▶ 36 forums, round tables, and workshops held with different business leaders;
- ▶ Workshops held for 50 religious leaders;
- ▶ Distribution of ten copies of slides and guides of the Socio-Economic Impact Study;
- ▶ Sponsor four HIV/AIDS policy dialogues; and
- ▶ Sponsor one HIV/AIDS journalist workshop.

As shown in the LogFRAME these issues will be addressed through the use of process evaluation (i.e., outcome indicators) and will be reported on the LogFRAME PIF. The AIDSCAP/Honduras Resident Advisor will also include a policy update section in all reports to AIDSCAP LA/C Regional Office and Headquarters functioning as a qualitative process measure of changes in policies effecting HIV/AIDS interventions.

Monitoring

Each subagreement will have a Project Manager from the IA who is responsible for directing project activities. The Project Manager will monitor implementation of his or her respective subproject and submit monthly LogFRAME PIFs to the AIDSCAP/Honduras Resident Advisor. Indicators on the PIF are from the output level "measurable indicator" column of each subproject LogFRAME and are specific to each subproject. The Resident Advisor will review the completed PIF with the CCC and discuss questions and concerns with each Project Manager before signing the PIF and sending it to the AIDSCAP LA/C Regional Office. Regular meetings between the Resident Advisor and each Project Manager will also aid in monitoring progress, identifying and resolving problems, and adjusting implementation as appropriate.

Each Project Manager will also provide quarterly narrative summaries describing in text format the accomplishments and constraints encountered in implementation during the period, and next steps foreseen for the following period. Quarterly reports will also be submitted to the AIDSCAP/Honduras Resident Advisor and the CCC no later than two weeks after the end of the quarter. Each Project Manager will keep the Resident Advisor informed on all developments and implementation of their respective project. Copies of all BCC materials produced or reproduced will be submitted to the Resident Advisor for technical review, two copies of which will be forwarded to the AIDSCAP LA/C Regional Office.

Annual Implementation Plan review

During each year of the implementation plan, the LA/C Regional Office Evaluation Officer with the local evaluation IA will assess the Plan's current level of implementation, as well as the detailed plans for the following year. This is not an external evaluation, but rather a

formal formative internal evaluation procedure to critically assess the progress of the implementation plan to date and to provide feedback to the CCC which will make the appropriate decision regarding refunding or new funding of IAs.

Final evaluation

The implementation plan will undergo a final evaluation which will be completed by NACP, USAID and AIDSCAP evaluators. The purpose of the evaluation will be to measure the success, both quantitatively and qualitatively, of the interventions funded by the implementation plan. Each of the goals, purposes and outputs will be evaluated.

IV. MANAGEMENT OF THE IMPLEMENTATION PLAN

In-Country Management

The general coordination and supervision of the implementation plan will be the responsibility of a Central Coordinating Committee (CCC) represented by the Director of the MOH STD/AIDS Division, a Technical Advisor from the USAID mission, the AIDSCAP/Honduras Resident Advisor, and possibly representatives from other involved institutions/IAs. Four Regional Coordinating Committees (RCCs) will be created to plan and monitor the progress of interventions and subprojects at the regional and local levels. The RCCs will consist of personnel from the respective Health Regions and representatives from IAs and/or municipalities. Representatives of the NACP and the AIDSCAP/Honduras Resident Advisor will attend the regional meetings.

The plan of activities will be approved by the CCC. The day-to-day administration, monitoring and evaluation of the implementation plan will be conducted through an AIDSCAP/Honduras Country Office based in Tegucigalpa in coordination with the CCC. The Country Office will be managed by a Resident Advisor and supported by a Program Officer, an BCC Advisor, a Finance Officer and a Bilingual Executive Secretary. All AIDSCAP/Honduras Country Office staff will be nationals with extensive background and experience in national development planning, particularly in health programs design, implementation and/or monitoring and evaluation. The Country Office staff shall be proficient in the working languages of the field office (Spanish-English), and will be appointed by a Selection Committee comprised by representatives from the MOH STD/AIDS Division, USAID/Honduras and AIDSCAP. (Please refer to APPENDIX A, page 38 for the Organigram of Coordination Mechanisms.)

In-Country Technical Monitoring

The Resident Advisor, in conjunction with the Director of the MOH STD/AIDS Division, will be responsible for developing and monitoring all USAID/AIDSCAP-funded subprojects. For each subproject, a subagreement will be developed with the implementing agency or agencies. Subagreements are contractual documents that incorporate the subproject plan and obligate funds and technical assistance. All subagreements will be reviewed and approved by AIDSCAP's LA/C Regional Office and presented to USAID/Honduras for concurrence and for preparing periodic reports for the ICC and COMSIDA.

All subagreements will delineate the progress reporting and the monitoring and evaluation data collection requirements of the IAs. IAs will collaborate with AIDSCAP and the MOH to facilitate the baseline, process and outcome/impact evaluation of subprojects and, if applicable, the financial/management assessments during the life of the subagreements. Once subagreements are approved, the Resident Advisor is responsible for monitoring subproject activities, identifying additional technical assistance needs, and mobilizing resources to ensure that IAs receive proper guidance to implement their activities.

All communications from the AIDSCAP/Honduras Country Office will be handled through the Resident Advisor to the AIDSCAP LA/C Regional Office. Administrative and logistical communications between USAID/Washington to AIDSCAP/Honduras will be channeled through the AIDSCAP LA/C Regional Office. The Resident Advisor will be the principal liaison officer between USAID/Honduras, the MOH STD/AIDS Division and Regional Programs and the AIDSCAP LA/C Regional Office. Communications about Assistance Plan policy decisions will be cleared by the CCC before being channeled to Washington.

- In-Country Financial Management

An AIDSCAP/Honduras Country Office Finance Officer will be hired to monitor the disbursement of funds to the subprojects and the transaction of accounts. The Finance Officer will ensure that financial reports are prepared regularly and that all required documentation is submitted. The Finance Officer, supported by the AIDSCAP LA/C Regional Office, will conduct a financial review and assessment of IAs in Honduras to assure financial management capabilities prior to the authorization of subagreements. He/she will also strengthen IAs' accounting systems if necessary. The overall responsibility for Country Office expenditures and subproject activities will be the responsibility of the Resident Advisor.

AIDSCAP LA/C Regional Office Management

The Resident Advisor reports to the AIDSCAP LA/C Regional Office Director. The Regional Director reports to the Office of the Director at AIDSCAP Headquarters. The LA/C Regional Office will monitor all implementation plan activities through monthly reports and close

communication with AIDSCAP/Honduras. The LA/C Regional Office, together with the AIDSCAP/Honduras Country Office and in consultation with the NACP and USAID/Honduras and USAID/Washington, will review subproject monitoring and evaluation reports to decide on subproject modifications to ensure that implementation plan activities fulfill the USAID/Honduras Strategic Plan for HIV/AIDS Prevention and this implementation plan elaborated with the MOH.

AIDSCAP LA/C Regional Office Technical Monitoring

The Resident Advisor will identify technical assistance needs through periodic monitoring of subprojects with the assistance of the MOH STD/AIDS Division and Programs and/or the USAID/Honduras Technical Advisor. He/she will channel requests for technical assistance which cannot be met locally to the AIDSCAP LA/C Regional Office.

The LA/C Regional Office will identify and recruit technical assistance in response to unmet local needs. In order to build the in-country technical capacity to conduct HIV/AIDS prevention projects, technical support will first be sought locally. If appropriate technical support is not available locally, assistance will be provided in the following order: (1) AIDSCAP LA/C Regional Office technical staff, (2) AIDSCAP Headquarters technical staff, (3) AIDSCAP subcontractors, and (4) independent consultants.

AIDSCAP LA/C Regional Office Financial Management

Subagreement budgeting and expense reporting is guided by AIDSCAP Headquarters' Finance and Administration Division, which provides templates and report forms to facilitate financial planning and reporting. The overall financial oversight of the implementation plan ; expenditures will be the responsibility of the AIDSCAP LA/C Regional Office.

V. LOGFRAME FOR USAID/HONDURAS HIV/AIDS PREVENTION PROGRAM

The following LogFRAME for the implementation plan is based on WHO/GPA Core Prevention Indicators (CPIs) developed to measure process, outcome and impact indicators. Detailed activities are provided in APPENDIX B: TIMELINE OF ACTIVITIES.

Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Goal: Reduce the rate of sexually transmitted HIV in four Health Regions in Honduras.</p>	<p>1. HIV prevalence maintained at 0.3% or less in Region 1; 1.5% or less in Region 2; 3.6% or less in Region 3; and 1.4% or less in Region 6 by EOIP. [CPI 10]</p> <p>2. Syphilis prevalence maintained at 15% or less by EOIP. [CPI 8]</p> <p>3. HIV prevalence maintained at 5.5% or less in Metro Tegucigalpa; and 19.8% or less in SPS in CSWs during LOIP.</p>	<p>1. HIV sentinel surveillance.</p> <p>2. Syphilis sentinel surveillance</p>	<p>(Goal to supergoal) Sexual intercourse is the primary mode of HIV transmission.</p>
<p>Purpose: To reduce high risk sexual behavior among PWP, Core Groups and the Garífuna populations in Metro Tegucigalpa, Comagua, SPS and La Ceiba.</p>	<p>1.1 Increase from baseline target population reports condom use in the most recent sexual intercourse of risk (with a non-regular partner) by EOIP. [CPI 5]</p> <p>1.2 Decrease from baseline target population report one or more non-regular sexual partners in the last 12 months by EOIP. [CPI 4]</p> <p>1.3 Increase from baseline target population can identify at least 2 correct preventive strategies by EOIP. [CPI 1]</p> <p>1.4 Increase in population (aged 15-49) who can acquire a condom * [CPI 3]</p>	<p>1.1 Project narrative reports of major findings from target population-based surveys complemented by FGDs and/or key informant interviews.</p>	<p>(Purpose to goal)</p> <p>1. Reducing the number of sexual partners and reducing STDs have an impact on HIV transmission.</p> <p>2. Condoms are available and accessible to the target population.</p> <p>3. STD diagnosis and treatment services targeted by the project are the primary providers of STD care for target populations.</p>
<p>Outputs: 1. Increase access of target populations to HIV/AIDS/STD prevention services.</p>	<p>1.1 80% of target population with STDs receives treatment according to standard STD diagnosis and treatment protocols. [CPI 6]</p>	<p>1.1-1.3 Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>1.1 Target population(s) will feel empowered to access STD diagnosis and preventive services.</p>

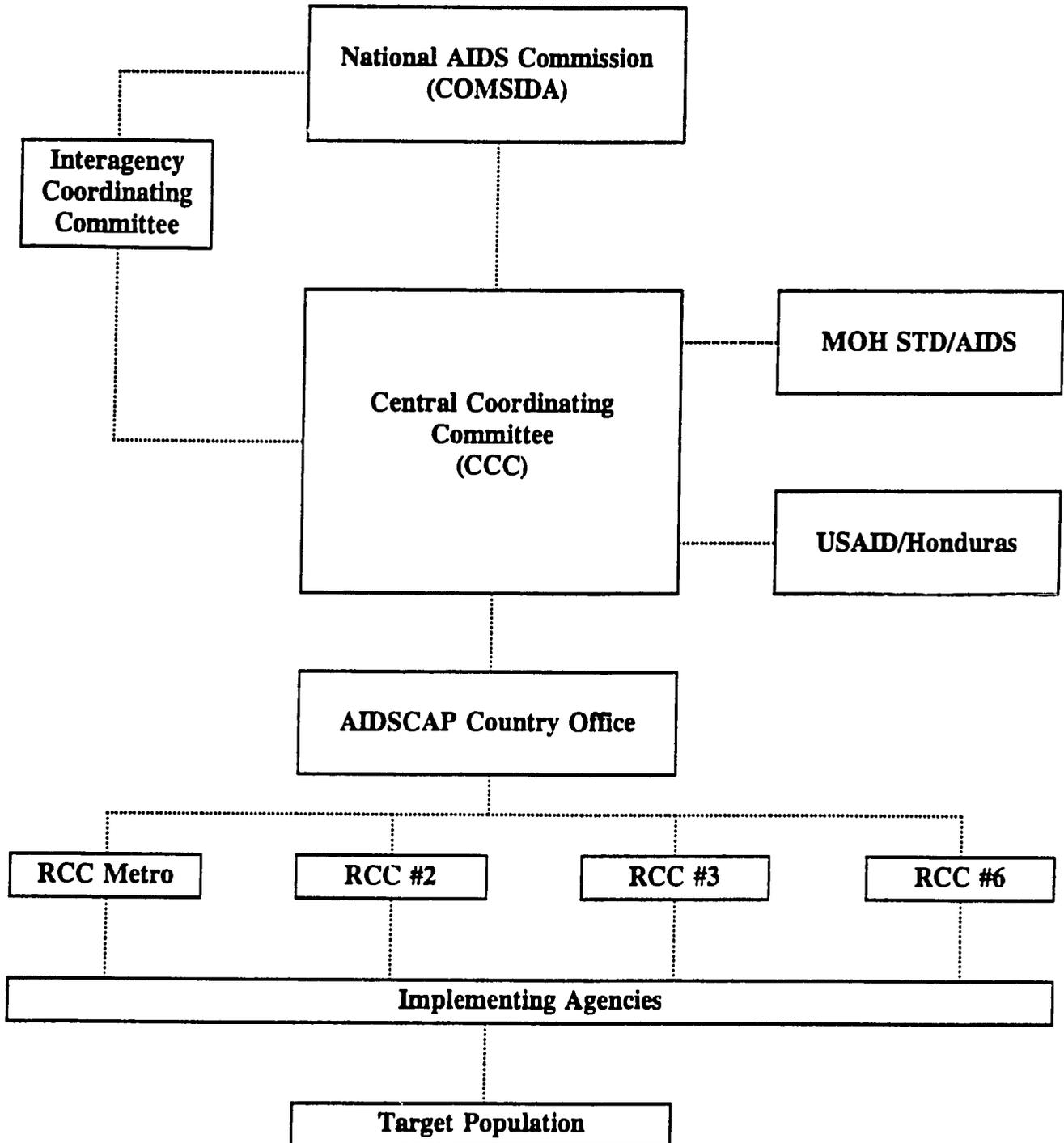
Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
	<p>1.2 50% of target population with STDs receive appropriate preventive education, including advice about partner notification and condoms by EOAP. *[CPI 7]</p> <p>1.3 80% target population aware of/has access to [improved/high-quality] STD services by EOAP.</p> <p>1.4 At least 25,000 condoms distributed in each of four STD facilities participating in project activities per month by end of year 2.</p> <p>1.5 One training session per month conducted for each of the four clinic personnel/number of people trained (by gender and type) by start of year 2.</p> <p>1.7 At least 25% of STD diagnosed clients participate in partner referral system by EOAP.</p> <p>1.8 Establish a National STD Committee by end of year 1.</p>	<p>1.4-1.8 Monthly performance indicator reports (PIFs).</p>	<p>1.2 Laboratory and technical capabilities to manage effectively with increase demand on STD diagnosis and treatment services.</p> <p>1.3 STD service providers will want to work with target population(s).</p> <p>1.4 Target populations are easily identified.</p> <p>1.5 Physical, human and financial resources will be available throughout LOIP.</p>
<p>2. Implement targeted BCC interventions to reduce high-risk behavior in target populations.</p>	<p>2.1 5,000 brochures, 80 training manuals for CSWs; 1,000 posters, 30,000 brochures, 100 training manuals for PWP; and 1,000 posters, 20,000 brochures, 120 training manuals, 50 information kits for schools, 12 radio spots for Garifunas produced and distributed by EOIP.</p> <p>2.2 50 CSWs, 100 PWP and 100 Garifunas trained as peer health educators by EOIP.</p> <p>2.3 10 CSWs, 20 PWP and 20 Garifuna training sessions conducted by EOIP.</p> <p>2.4 60,000 PWP, 3,500 CSWs, 200 brothel/restaurant managers, 300 MWM and 50,000 Garifunas reached by communication activities by EOIP.</p>	<p>2.1 Project process data.</p> <p>2.2 Project narrative reports of major findings from FGDs and/or key informant interviews.</p>	<p>2.1 Accurate mobilization of target population to participate in project activities.</p> <p>2.2 Communication activities lead to behavior change.</p> <p>2.3 Communication strategies will be consistent with social, cultural, and religious norms for various segments of society.</p>

Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>3. Strengthen condom programming and logistics management in four Health Regions.</p>	<p>3.1 The plan for strengthening the logistics system developed by the end of year 1.</p> <p>3.2 Consistent supply of condoms (no stockouts) reported by participating NGOs by EOAP.</p> <p>3.3 NGO logistics management system designed and linked to the public distribution system by EOAP.</p> <p>3.4 30% increase in population (aged 15-49) who can acquire a condom.</p> <p>3.5 Explore the feasibility of initiating a private sector CSM project during LOP.</p>	<p>3.1 Process data/logistic reports/surveys.</p>	<p>3.1 Condom logistics infrastructure exists.</p> <p>3.2 Constant and consistent supply of quality condoms is secure.</p> <p>3.3 Accessibility is major barrier to condom use.</p> <p>3.4 Pricing structure allows purchase by target population.</p>
<p>4. Strengthen the capacity of the local communities and institutions to carry out HIV/AIDS/STD prevention programs.</p>	<p>4.1 Participating IAs receive on going technical assistance throughout LOIP.</p> <p>4.2 IAs receive technical and managerial training through LOIP.</p> <p>4.3 80% of IAs trained implement quality AIDS interventions by EOAP.</p> <p>4.4 50% of IAs establish collaborative relationships with other relevant organizations by EOAP.</p>	<p>4.1 Pre- and post- institutional assessments that include both quantitative and qualitative methodologies.</p> <p>4.2 Consultant trip reports.</p> <p>4.3 Project reports.</p> <p>4.4 Process indicator reports.</p>	<p>4.1 Institutions with appropriate mission statement/philosophy exist to implement AIDSCAP mandates.</p> <p>4.2 Sociopolitical support for capacity building is constant throughout LOIP.</p>

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Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>5. Increase awareness of the problem of HIV/AIDS/STD at all levels in order to generate support and resources that will allow for sustainable prevention interventions.</p>	<p>5.1 Distribution of copies of Socio-economic Impact Study to 200 different Honduran policymakers and journalists by end of year 1.</p> <p>5.2 Distribution of 30 copies of Socio-Economic Impact Study video by end of first year.</p> <p>5.3 Analysis of the projected costs of three HIV/AIDS projects by EOIP.</p> <p>5.4 Develop/distribute 200 copies of workplace policy guidelines and education materials by EOIP.</p> <p>5.5 Hold 36 forums, roundtables, and workshops with different business leaders by EOIP.</p> <p>5.6 Hold workshops for 50 religious leaders by EOIP.</p> <p>5.7 Distribute ten copies of slides and guides of the Socio-Economic Impact Study by end of year 1.</p> <p>5.8 Sponsor four HIV/AIDS policy dialogues by EOIP.</p> <p>5.9 Sponsor one HIV/AIDS journalist workshop by EOIP.</p>	<p>5.1-5.9 Process indicator reports.</p>	<p>5.1 Multi-sectoral policy environment that is conducive to the development and implementation of comprehensive AIDS prevention activities is created.</p> <p>5.2 Government policies strongly influence effectiveness of intervention strategies.</p>

APPENDIX A. ORGANIGRAM OF COORDINATION MECHANISMS



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APPENDIX B. TIMELINE OF ACTIVITIES

ACTIVITY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
I. PERSONNEL IN POSITION																
Country Office set up	X															
Resident Advisor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Technical Support (BCC)	X	X	X	X	X	X	X	X								
Community/health workers/peer educators			X	X	X	X	X	X	X	X	X	X	X	X	X	X
2. DETAILED IMPLEMENTATION PLAN OF ASSISTANCE																
Design/planning/preparation of general implementation plan	X															
Preparation of 4 regional implementation plans	X	X														
Preparation of subagreements		X	X													
Implementation of subprojects			X	X	X	X	X	X	X	X	X	X	X	X	X	X
3. SERVICES DELIVERY INITIATED (SPECIFIC)																
PWP ACTIVITIES																
Assess previous/ongoing activities	X	X														
Develop subagreements		X	X													
Training of trainers and on-site leaders, educators, volunteers and health care providers in work place.			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identify clinical sites where STD services can be provided for PWP	X	X			X				X				X			
Develop/validate/reproduce BCC material		X	X		X	X			X	X			X	X		
Leverage private sector support	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CORE GROUP ACTIVITIES																
Assess ongoing activities/redefine BCC strategies	X	X														

of

ACTIVITY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Develop subagreements		X	X													
Select/train personnel/educators/community workers		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identify/train peer leaders			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop/validate/reproduce BCC material		X	X		X	X			X	X			X	X		
GARIFUNA ACTIVITIES																
Conduct KABP survey	X	X														
Develop subagreements		X	X													
Train/retrain personnel		X	X	X	X				X				X			
Identify/train peer community leaders			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop/validate/reproduce BCC material		X	X		X	X			X	X			X	X		
4. SERVICE DELIVERY INITIATED (GENERAL)																
STDs																
Inventory of STD clinic laboratory and equipment needs		X	X													
Conduct courses for physicians, pharmacists and health care providers (four 3 day training on syndromic and laboratory diagnosis)			X	X		X		X		X		X				
Conduct seroprevalance survey for syphilis, gonorrhea, chlamydia, chancroid, and herpes in target populations			X	X												
Test anti-microbiological susceptibility on gonococci to antibodies	X	X														
Establish list of recommended drugs for treatment of gonorrhea that can be integrated into health system		X														
Formulate national STD treatment guidelines; establish dependable sources for STD clinics and diagnostics.			X	X												

ACTIVITY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
CONDOMS																
Conduct an operational field review of overall distribution strategy, warehousing, transportation, supervision, personnel, inventory control, MIS, stock management and procurement		X														
Assist MOH in developing improved logistics cycles and management systems for essential commodities for HIV/AIDS/STD prevention and control efforts		X	X													
Improve logistics systems, condom supplies and STD drug supplies for targeted programs			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Explore the feasibility of initiating a private sector driven CSM project with national, bilateral or multilateral funding					X	X	X	X	X	X	X	X	X	X	X	X
Assist NGOs to develop strategies for identifying new markets for condoms, including non-traditional outlets					X	X	X	X	X	X	X	X	X	X	X	X
Develop cost-recovery strategies appropriate for Honduras and provide assistance to NGOs to participate in such activities					X	X	X	X	X	X	X	X				
5. POLICY PROMOTION																
Dissemination of Socio-Economic Impact Study and video.		X	X	X	X				X				X			
Annual HIV/AIDS Policy Dialogues			X				X				X				X	
Workshops with religious organizations			X		X		X		X		X		X		X	
Workshops with work place policy makers			X	X			X	X			X	X			X	X
Forums and workshops with business leaders			X		X		X		X		X		X		X	
Analysis of costs for targeted condom distribution project with CSWs									X							
Analysis of costs for AIDS prevention in the work place program and public health STD clinic project										X						
6. TECHNICAL ASSISTANCE																
HQ/Regional Office visits	X	X			X		X		X		X		X		X	X

ACTIVITY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Local consultants			X		X		X		X		X		X		X	
External technical assistance				X				X				X				
7. PROCUREMENT OF SUPPLIES	X		X		X		X		X		X		X			
8. PROGRESS REPORTS/EVALUATION																
Contract evaluation component		X	X													
Complete baseline assessment			X	X												
Annual reports				X				X				X				X
Midterm program review								X								
Final evaluation/report																X

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APPENDIX C. ADDITIONAL POTENTIAL ACTIVITIES

The following represent potential activities that could be implemented should additional funding become available in the future.

I. Assessing Needed Support of Families Affected by AIDS

Since the major mode of HIV transmission is sexual contact, AIDS is predominantly affecting those in the years of prime economic productivity, and the periods when individuals are most likely to build and support families. Consequently, those who are becoming ill and dying of AIDS are often precisely those responsible for supporting, or contributing to the support of a household. They are the laborers producing income or food for families, caretakers of children and the elderly, and the managers of family farms and households.

Families in which one or more members are HIV-positive or have AIDS are likely to experience a reduction in income and productivity precisely as their expenses increase to care for the sick. Income and productivity decrease because neither ill family members nor their caretakers are able to work sufficiently to provide for the household. Furthermore, school-age children often must interrupt their educations to become caretakers for ill parents or siblings, to become income or food producers, or simply because the family can no longer afford school fees.

Because of the likelihood that HIV has been transmitted between husbands and wives within a household, the phenomena of 'AIDS orphans' is increasing throughout Honduras. Grandparents, other extended family, and communities are taking responsibility for the care of these children, although in some cases, orphaned siblings must adapt to taking care of themselves and managing their own households.

The ongoing NACP/AIDSCAP Socio-Economic Impact Study has focused predominantly on the costs of treating patients with AIDS and assessing the impact of AIDS on productivity. However, this study has provided no insight into the issue of how AIDS affects families or how greater support might be provided to families which have an ill family member. This information is critical both in terms of promoting further HIV/AIDS prevention efforts and in developing appropriate responses by the government, churches and NGOs to support afflicted families.

A household impact assessment would serve to gather the data that Honduran policy makers can then use to develop targeted policies and programs to provide support and relief for families, households and communities affected by AIDS. It is hoped that the information gathered through the study, and the conclusions drawn, would stimulate the formulation of appropriate and useful social policies that would improve the functioning of household economies of families impacted by the epidemic.

Specifically, such a study would address the resource needs of families as related to:

- ▶ basic needs such as food, clothing and shelter due to income changes resulting from family member's illness;
- ▶ caretaking for young children or orphans whose caretaker is ill or has died;
- ▶ health care; and
- ▶ payment of school and other fees, and general living expenses.

The purpose of AIDSCAP's collaboration in the Honduran study would involve: (1) training Honduran collaborators in a household impact methodology that focuses on AIDS and socio-economics, (2) assisting collaborators in promoting a policy dialogue among Hondurans about programs likely to be needed by Honduran families, and (3) promoting the development of recommendations for NGOs and the GOH regarding methods to alleviate the impact of AIDS on families and communities.

The data for the household impact assessment would be gathered through case studies and surveys conducted with individual households in AIDSCAP's target regions.

II. Simulation Modeling

Introduction

Honduras is experiencing a growing HIV/AIDS epidemic. In response, a variety of AIDS intervention programs have been planned and/or implemented with the assistance of international donors including USAID, the World Bank, the World Health Organization, and so forth. Such intervention programs include: (1) enhanced STD treatment for at risk populations, (2) promotion and distribution of condoms, (3) communications programs to reduce the number of sexual partners, (4) school based AIDS education, (5) work place AIDS education, and (6) policy reform programs.

Given the scope of the HIV/AIDS epidemic in Honduras, and the significant financial expenditures allocated to AIDS prevention, it is imperative that a coordinated cost effective strategy for HIV/AIDS intervention activities be developed. To accomplish this, it is proposed that, if funding allows, an analysis of the projected efficacy of HIV/AIDS prevention programs be conducted in Honduras. This analysis would help policy makers make better decisions about how to effectively allocate scarce funds.

This analysis would be conducted using simulations models. The analysis, together with cost estimates of prevention programs, would be used to generate projections of: (1) epidemiologic

impacts of various prevention programs by population group, and (2) comparisons of cost effectiveness across prevention programs and targeting strategies.

Goals

- (1) To identify how behavioral changes found to occur through HIV/AIDS prevention programs impact the scope and distribution of HIV and AIDS in Honduras by type of program, geographic region, age, gender and sexual behavior.
- (2) Given that AIDS intervention programs will have varying levels of efficacy in changing behavior across groups with different HIV serostatus, gender, region and age, the modeling would seek to identify the best targeting strategies for each intervention program.
- (3) Identify goal levels for coverage and effectiveness of behavioral interventions that would lead to significant reduction in the incidence of HIV on a population level.
- (4) Compare the cost-effectiveness of various prevention programs.
- (5) Examine how the promotion and distribution of condoms affects HIV prevalence and incidence in various settings.

Method

Analysis would be conducted with simulation models and associated Honduras data files. When modeling data are coupled with cost data it will be possible to calculate the cost-effectiveness ratio of various intervention approaches, with results disaggregated by independent variables. It is proposed to simulate projections through the year 2010 using this advanced technology.

The modeling would develop a baseline dataset for SPS with behavioral and demographic data. This dataset would be developed from extensive literature review and country level studies, and could be modified as needed for specific country level analysis.

Having a dataset available for SPS would allow for the most sophisticated modeling analysis of interventions, cost-effectiveness, targeting and impact assessment. Results from analysis of the dataset could be used by policy makers in both SPS and Honduras as a whole.

Impact projections would be coupled with cost estimates to generate population specific evaluations of the comparative impact and cost of various intervention programs. The following intervention programs would be examined:

- (1) STD treatment programs;
- (2) Behavior change/reduction of number of sex partners; and
- (3) Condom promotion and distribution programs/socially marketed and targeted programs.

Findings generated from this analysis would be used to facilitate decision making by policy makers and international donors. A detailed report of the findings would be distributed in appropriate forms to various target groups of policy makers including: (1) politicians and government workers, (2) private sector business owners and managers, (3) church leaders, and (4) international donors. Data generated from these analyses could be used with ongoing AIDS Impact Model (AIM) activities. These findings would also be used in policy maker workshops in Honduras.

It is estimated that it would take approximately 1 year to compile the baseline dataset for analysis. Cost data would also be collected during this period, and would likely be available for analysis within 1 to 1.5 years. Modeling analysis would be ongoing, and would be initiated once the baseline datafiles were available.

APPENDIX D. SOCIO-ECONOMIC IMPACT STUDY

In November of 1992, a study was jointly initiated by the MOH and AIDSCAP with funding from the LAC Bureau of USAID. This study was designed to assess the social and economic impact of HIV/AIDS in Honduras. This was accomplished by developing projections of the epidemic and the corresponding economic impact in SPS and Tegucigalpa. By August of 1993, the results from the study had been presented to over 400 people in both cities at 2 national workshops attended by the President and the First Lady.

The next steps are to assure that there is sufficient distribution of the study. This is to be accomplished by completing the following activities:

- | | |
|----------------|--|
| April 1994 | A copy of the Socio-Economic Impact Study was delivered to AIDSCAP by the MOH. |
| April 1994 | AIDSCAP will approve a revised field budget which includes funds for the production of a video tape. |
| May 1994 | Comments on the Socio-Economic Impact Study will be sent to the MOH and will be copied to USAID/Honduras. |
| May 1994 | A copy of the final report (including graphics) will be sent to AIDSCAP by the MOH. |
| June 1994 | AIDSCAP will reproduce 200 copies of the final report in Spanish and 50 copies in English. All Spanish copies will be sent to the MOH and USAID/Honduras for distribution. |
| September 1994 | A copy of the Socio-Economic Impact Study videotape will be finalized. |

Altogether AIDSCAP provided 13 weeks of technical assistance for this study. In addition to the production of the actual study, a transfer of technology occurred in that MOH personnel were trained in how to perform socio-economic impact assessments. The seven individuals trained include an epidemiologist, an economist, the head of the NACP and four data collectors. The epidemiologist and the head of the NACP were trained in the use of modeling software (EPIMODEL, DemProj and AIM); and the economist was trained in performing direct cost assessments, indirect cost assessments and sectoral analyses. All three were also trained to perform socio-economic impact assessments and lead policy dialogues. The data collectors received specific training on how to review hospital records and identify the cost of providing hospital care. In addition, AIDSCAP provided the MOH with a computer, an overhead projector and a projection panel to facilitate future modeling presentations.

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

FROM: L.S. Waskin, DF 
E. Leonard, HRD 

DATE: August 24, 1994

SUBJECT: Amendment of the Health Sector II Project (522-0216)

ACTION REQUESTED: Your approval of this Action Memorandum is requested, thus indicating your concurrence with the modified design of the Health Sector II Project. This Action Memorandum, which has been drafted to serve as a Project Paper Supplement as described in USAID Handbook No. 3, will serve as the basis for the amendment of the: (1) Project Authorization extending the PACD to September 30, 1996; (2) Project Data Sheet; and (3) Project Agreement: (a) reflecting the policy agenda agreed upon with the new national government; (b) incorporating activities to be implemented under the AIDSCAP program; (c) revising selected project outputs; (d) reprogramming the project budget; and (e) extending the PACD to September 30, 1996.

BACKGROUND:

- I. **Project Purpose and Major Outputs:** The purpose of the Health Sector II project is to support, strengthen and continue the process of extending coverage of efficient, sustainable and effective primary health care and rural water and sanitation (RW&S) services, with an emphasis on child survival interventions. The project purpose will not change under the proposed project amendment.

Indicators of the project's contribution to the Mission Strategic Objective of "Improved Family Health" include reduced infant mortality, a reduced level of malnutrition among children 12-23 months of age, and reduced reproductive risk. The project contributes to all three of this Strategic Objective's program outcomes:

- o Increased Percentage of Hondurans Who Practice Effective Family Planning;
- o More Effective Child Survival Interventions; and
- o Increased Use of STD/AIDS Prevention Practices.

Under the proposed amendment, substantially increased resources will be directed, through participation in the AIDSCAP program, to the last of these outcomes.

An updated project logical framework (Attachment 1) comprises a complete list of project outputs and their indicators under the Amendment. Some original indicators have been dropped for various reasons: accomplishment of the output, e.g., polio eradication; the project is no longer addressing a particular health problem, e.g., infection by Chagas, and malaria control; and outputs for which indicator monitoring is not feasible, e.g., monthly monitoring of educational/promotional messages on radio and T.V. Ten indicators measured under the Project are also used in conjunction with the Program Outcomes cited in USAID/Honduras' FY 1995-96 Action Plan, and some have been modestly revised to match the indicators developed for use with these Program Outcomes. Finally, a new project output and associated indicators have been added in the logical framework in conjunction with the increased emphasis on STD/AIDS prevention.

- II. Achievements to Date: There have been a number of achievements in the health field in Honduras since the inception of the Health Sector II Project in 1988. Infant mortality dropped 12% between 1989 (50 infant deaths per 1000 live births) and 1993 (estimated at 44). This is one of the fastest rates of decline in all Latin America. Immunization rates in the less than 1 year old population exceed 90% for all of the antigens (polio, DPT, BCG and Measles). Polio was officially declared to be eradicated in Honduras in April of this year, and there has not been a measles fatality in over two years. Both measures exceed LOP targets.

Diarrheal diseases no longer represent the same health problem to children under 5 that they did at the beginning of the project; in fact, they are no longer the leading cause of infant and child mortality. The proportion of outpatient visits for children under 5 years old due to diarrheal diseases dropped from more than 17% during the period 1988-90, to less than 13% in 1992 and 1993. The use of ORS in diarrhea cases involving children under 5 years old jumped from 17.5% in 1987, to 29.5% in 1991/92. Both measures are on track relative to their LOP targets.

The health infrastructure has been improved, and health services are beginning to be decentralized through the development and implementation of a number of inventory, management and supervision systems. There are over 100 microcomputers processing and analyzing data at the central and regional levels. The Project has constructed three new regional administrative centers, and renovated and/or repaired over 500 health centers, well above the original LOP target of 426. Financial sustainability of primary health care services has been enhanced by a system of fee retention in the health centers, which has increased in participation and amount every year of the Project.

In the human resource development area, the Project has sent approximately 30 health professionals for Masters Degrees, has set up a system of self-instructional manuals for auxiliary nurses to update their training without closing health centers, and has provided training for thousands of community personnel in the management of various illnesses. The Project is in the process of establishing two national training centers for community counselors in breastfeeding, which will contribute to improved food security and sustainable child survival efforts.

The capacity for doing formative research for the appropriate design of health education campaigns and materials has been installed at the central and regional levels. The central level now has the capacity for video and radio production, and a project-assisted desktop publishing facility has improved the MOH capacity to design print materials, achieving the Logical Framework's health education/promotion verifiable indicators.

In water and sanitation, major efforts have been made to enhance SANAA's (the National Water Authority) capability to expand accessibility of potable water and excreta disposal services to rural areas lacking these services. SANAA has not only strengthened its own capability to deliver services, but has worked closely with private voluntary organizations (PVOs) in helping them provide the services. The MOH Division of Environmental Health (DEH) has also provided similar services in communities with less than 200 inhabitants. To date 488 rural water systems, 741 wells, and 68,870 latrines have been constructed serving approximately 237,000 rural Hondurans. All of these efforts have included a significant health education component to encourage changes in behavior, and a community organization component to assure that water systems will continue to function in a sustainable manner. These accomplishments are ahead of schedule relative to the rate planned as contained in the original project logical framework.

In the area of family planning/birth spacing, the Project supported the renovation and development of the country's first women's health clinic, located in San Pedro Sula. This clinic offers family planning services, including IUD insertion, counseling, distribution of oral contraceptives, voluntary sterilization, and education/information services. Project financing to the La Leche League community peer counselor program will increase the prevalence of exclusive breastfeeding in the first six months of life, thereby achieving, among other benefits to the children, the postponement of pregnancy through amenorrhea. To date, the project has contributed to an increase of the total (modern and traditional methods) contraceptive prevalence rate from 40.6% (33.0% modern methods) in 1987 to 46.7% (34.7% modern methods) in 1991-2. This rate of increase is consistent with that foreseen in the Mission's Action Plan, in which "Increased Contraceptive Prevalance" is an indicator at the Program Outcome level.

A total of ten PVOs have been funded to make available primary health care in areas where the MOH has not been able to provide these services. To date, these PVOs are working in 245 rural communities with a total population of approximately 127,000. A successful workshop involving the PVOs and the MOH was carried out in 1993 for the purpose of improving coordination in the delivery of child survival and maternal health services. This PVO participation well exceeds that planned.

- III. Recent Dialogue on Health Sector and Institutional Policy Changes, January – July 1994: The inauguration of a new government in January 1994 triggered an intensification of the policy dialogue between the MOH and USAID. The Mission and the Ministry identified five priority policy areas to be addressed under the planned project amendment (see "Policy Matrix," Attachment 3). The majority of the new short-term technical assistance planned under the Amendment will support efforts in these policy areas. These efforts are described below (Section II, "Planned Activities," on page 7).

The first priority policy area involves local programming and human resources. Strategies for improving this area that will be supported by technical assistance under the Amendment include formalizing a MOH policy concerning local administration, and reorienting the MOH Human Resources Division under a policy of decentralized health services.

The second area addresses finances and rationalizing the budgetary process. The MOH has recognized the need for reform in this area. To help rationalize the budgetary process, for example, the Vice Ministers have requested Mission assistance in establishing a management information system within the MOH to provide timely financial and budgetary data to decision makers. In addition, the MOH has taken steps to allocate its own resources to carry out the physical renovations, including considerations of security and adequate electrical installations needed to accommodate a bank of computers. The Mission in turn will provide technical assistance, hardware and training to MOH staff in the operation of a management/financial software package such as MUNIS. Remaining TA over the course of the Amendment will ensure that the Project Output of "Health Financing Analysis and Planning Capability in Place" is achieved. In the area of local retention of fees, the GOH has – provisionally – begun to address the problem. Under Health Sector II, the MOH is authorized to collect and retain fees for services at the health center level. A percentage of these fees remain in the centers themselves, to be used by the local health support committee for local needs, including physical improvements of the building and emergency purchases of medicines. Once the project terminates, however, these funds may revert to the Ministry of Finance. It is necessary to modify the law to permit the permanent retention and management of these funds at the local level. The MOH, with project-funded technical assistance if requested, will prepare a draft of legislation and submit it for consideration by the Congress. Submission of this legislation will be included as a covenant under this Project Amendment.

The third policy area involves improved logistics, such as the implementation of an open and efficient purchasing system for supplies, equipment and personal services. The MOH is working towards this end; for example, it is creating a new procurement division within the MOH, with responsibilities for procurement and distribution of supplies, equipment, materials, and services. Over the next several months, with project-funded technical assistance, the division will "routinize" its procedures to achieve a transparent logistical system. This will improve, for example, the MOH's ability to restock medicines and other supplies from within other units of the Ministry, and will reduce stock losses due to pilferage.

The fourth priority area concerns the development of general information systems required to manage both human and financial resources effectively. Such systems are currently lacking and constrain the MOH's ability to adequately formulate, manage, execute and control its budget. Lack of modern information systems also constitute a serious roadblock in efforts to institutionally decentralize.

The last broad policy area involves the need for improvements in a variety of health technologies, including ARIs, AIDS, birthspacing/reproductive health, and expanding potable water and sanitation services in rural areas. Major policy improvements will be sought in several of these areas through continued policy dialogue and technical assistance. For example, the Project will assist MOH to develop a formal policy promoting birthspacing as a prime means of reducing reproductive risk. Health personnel from several institutions and at a number of levels will be involved. Under the Amendment, a reproductive health communication program targeted at both health providers and the general population will be developed and implemented. Policy dialogue at all levels that promote norms, laws and policies that facilitate implementation of HIV/AIDS/STD prevention programs will be supported by the AIDSCAP program under the Amendment. In terms of water and sanitation, major restructuring of both the MOH's Environmental Health Division and SANAA, will be supported by the Amendment.

In addition to these five policy areas, one overarching area in which the need for improvement was identified was that of establishing a clearer definition of responsibilities and lines of authority for each entity of the MOH. In response, the new government has delineated responsibilities among the three Vice Ministers (responsible respectively for the areas of populations at risk, service networks, and international relations and sectoral policy) and three Director Generals (in the areas of environmental health, populations at risk, and hospitals.) This has led to a more rational organization of the Ministry, and has improved communication at the technical level. The Mission also identified the urgent need to improve the coordination, execution and control of the Health Sector II Project. The MOH accepted the need for improved coordination, established a project committee of the Vice Ministers and Director Generals, and has been meeting on a biweekly basis with the Mission

Technical Office. No further dialogue or technical assistance is required in these areas.

With the sectoral policy agenda as a basis, and with the termination of the long-term technical assistance contract, the Mission has worked with the MOH to prepare a plan for technical assistance needed over the remainder of the Project (revised PACD 9/30/96) in both technical and management support areas (see Attachment 4). The emphasis will be short-term, task-specific assistance, which, in close collaboration with MOH counterparts, will address key aspects of each policy area. Based on the identified TA requirements, plans for project implementation and procurement have been developed for the remaining life of project. These plans, in turn, have had a direct bearing on the reprogramming and budgeting of remaining Project funds (see Attachments 5, "Implementation Plan and Schedule," and 6, "Procurement Plan"). Thus, under the Amendment, there is a consistent link running from the policy agenda to project inputs, implementation and budgeting.

DISCUSSION:

- I. Rationale for the Amendment: This amendment is required in response to a number of conditions not contemplated in the Project Paper that must be addressed to ensure continued successful project implementation and achievement of desired project outputs. For example, the long-term technical assistance (TA) contract with Management Sciences for Health (MSH) was terminated on December 31, 1993, and future project related technical assistance will be contracted on a short-term basis with specific and more focused interventions and products. The majority of this TA is intended to assist the MOH in implementing the policy agenda described above on which the MOH and the Mission have been engaged over the past months.

A second key change involves the incorporation of the AIDSCAP Program into the project. When the Project Paper was prepared in early 1988, AIDS in Honduras was not the overwhelming public health problem that it is today. With over 50% of the AIDS cases in Central America located in Honduras, and over 50% of those numbers concentrated on the North Coast area, the reduction of the rate of HIV seroprevalence is a major priority of the MOH. Accordingly, Honduras has been named an AIDS emphasis country by USAID, and the Mission will program approximately \$800,000 of both FY 95 and FY 96 obligations to the project for enhanced STD/AIDS control and prevention, contraceptive social marketing, and behavior change communication. This significant investment of project resources was not contemplated during the initial project design. (See Attachment 8 for further information on AIDS prevention activities.)

Two additional important changes, resulting from those mentioned above, involve a revision of selected project outputs and indicators in the logical framework, and the reprogramming of the Project budget. The former was discussed above in the section of this Action memorandum entitled, "Background;" suffice it to say that the revision reflects changes in those project outputs which have been reached (e.g., immunopreventable diseases), those which will be modified or added (e.g., HIV seroprevalence), and those which are no longer supported by Project funding (e.g., vector control). The revised Logical framework is presented in Attachment 1. The reprogramming of Project resources is an obvious and natural result of this exercise. The revised Project budget is presented on page 13, and further financial information is contained in Attachment 2 to this memorandum.

This amendment will also "bridge" the Health Sector II project to a more substantial project amendment proposed for next year. The FY95 amendment would add at least \$7.1 million in additional authorized LOP funding, narrow the focus of the Project to maternal and reproductive health, family planning and infant health, and the reduction of AIDS transmission, and extend the life of project to a new PACD of May 24, 1998, i.e., to the allowable ten year maximum duration.

- II. Planned Activities Under the Amendment: Each of the existing Project components, Sustainable Support Systems, Health Technologies, Rural Water and Sanitation, and Private Sector activities will continue under the Amendment. Unless noted otherwise below, activities under each component will be implemented in accordance with the original Project design. It should be noted that several continued activities are "gender sensitive." Areas in which gender may play an important role are public health education, the reproductive health communication program, education in improved sanitary practices in conjunction with RW&S activities, STD/AIDS prevention efforts, and attitudinal surveys *vis-a-vis* local MOH health services. Where appropriate, project supported research, e.g., under the AIDSCAP program, will examine the role gender plays in affecting improved family health.

Estimated funding for each component includes, under the original authorized LOP level of \$57.3 million, funding obligated to date, but not expended; that which will be obligated under this FY94 amendment; and that which will be obligated in FY95 within the present authorized level. The estimates below do not include additional LOP funds anticipated under the FY95 amendment, which is expected to raise the authorized level to at least \$64.4 million.

Attachment 5, "Implementation Plan and Schedule," describes the timing and level of effort through the revised PACD of September 30, 1996, as well as the mechanisms for acquiring Project inputs in a timely and efficient manner.

A) Sustainable Support Systems: Activities under this component will continue to strengthen the MOH capability to expand and improve primary health care services nationwide. As noted in the previous section, many activities will directly support the agreed upon policy agenda. Specific project elements which will be emphasized under the Amendment, and examples of the planned technical assistance to address them, include:

- o Expanding local programming, involving the community level in the provision of adequate and appropriate health care through the local health center. Planned TA: Regional surveys will be undertaken, with assistance from the Project, to learn more about the attitudes of users towards MOH health services. A report of the findings will then be produced and used as one basis for drafting a MOH local programming policy. Finally, TA will be offered to develop and implement a detailed implementation plan corresponding to the policy.
- o Improving logistics, involving the implementation of an improved distribution system for materials, supplies, and services. Planned TA: Design and establish an integrated procurement/distribution system. TA will develop a computerized system of warehouse entry and exit control, and train personnel in its use, in order to stem material losses.
- o Strengthening management information systems, which will provide timely information on the management of human and financial resources to decision makers. Planned TA: The MUNIS financial management program will be installed in a network of computers at the central level and personnel trained in its use and maintenance. TA will help to improve local level decision-making through strengthening the gathering and analysis of health statistics.
- o Strengthening human resources development, which will develop and implement a system of training the required human resources to support the decentralization of health services. Planned TA: Assist in the formation of regional and local level teams to provide the desired training involving primary health care.
- o Improving health finances, with the goal of rationalizing the budgeting and expenditure process to achieve maximum impact of the available financial resources. This will include assistance in modifying GOH legislation to authorize, on a permanent basis, the local collection and retention of fees. Planned TA: Assistance in improving cost recovery and cost control at the regional and local levels, and investigation of the use and possible expansion of pharmacy rotating funds.

An estimated \$2.90 million will be expended on this project component in FYs 95-96.

B) Health Technologies: This project component supports specific health interventions, most of which correspond to the areas of child survival/reproductive health. The main thrust of these activities will be to impact on the remaining leading causes of infant mortality: perinatal mortality, acute respiratory infections (ARIs), diarrheal diseases (including cholera), and reproductive health risks, involving improper birthspacing and exposure to STDS, including HIV/AIDS (discussed in more detail below). Work under one element, Vector Control, has been discontinued due to its success in reducing the prevalence of malaria. Work under the other elements (immunization, breastfeeding and growth monitoring) will continue according to the original project design.

An objective of the Amendment is to maintain the gains achieved in the area of control of diarrheal diseases through strengthening the efforts of Community Oral Rehydration Units, expanding the coverage of potable water, and continuing efforts involving sanitary education. The Amendment will work toward developing a similar community case management protocol for ARIs, currently the main cause of infant mortality in Honduras. The project will continue to support efforts to reduce immunopreventable diseases by improving the cold chain. The birthspacing element will increase the provision of family planning information, counseling and choices in contraceptives to individuals and couples who wish to determine the frequency of pregnancies. Planned TA: Diarrheal disease control will be assisted through training in institutional case management, and through improving and expanding the work of community-based ORS units. TA will also be directed at improving the marketing of ORS to adults. Birthspacing activities will be assisted through training in IUD insertions, and of birth attendants. TA will help develop a birthspacing/maternal health curriculum for medical schools in Honduras. TA will also help to improve the logistics of contraceptive distribution, so that rural health centers have a more reliable supply. ARI activities will be assisted through strengthening and expanding community treatment programs, and by training institutional personnel in improved treatment techniques (the Amendment will finance medical supplies and equipment for institutional ARI treatment).

An estimated \$3.71 million will be expended between FYs 95-96 on the diarrhea control, immunopreventable diseases, ARIs, birthspacing, TB control, and STD/HIV prevention and control (see below) project elements.

STD/AIDS Prevention and Control Element: This element of the Health Technologies component will be implemented through the project's participation in the AIDSCAP program. HIV/AIDS was not a major health problem in Honduras at the time of development of the Project Paper. However, as of November 30, 1993, 3,234 cases of AIDS were reported to the MOH. This figure represents 57 percent of the total reported AIDS cases in Central America, even though only 17 percent of the region's population lives in Honduras (5.3 million inhabitants).

Early in 1992, USAID's Latin America and the Caribbean Bureau (LAC) declared Honduras to be an AIDS emphasis country. During that year, the Mission concluded negotiations with LAC, with what is now the AIDS Office of the USAID Global Bureau, and with the AIDSCAP Program to undertake an evaluation of the socioeconomic impact of the epidemic in Honduras (financed by the LAC Bureau). An AIDSCAP team presented the final report of their recommendations to the Mission in May 1993, and the MOH presented the results of the study the following August to an interinstitutional and interagency audience. The Mission sent its proposed HIV/AIDS strategy, based on the recommendations in the AIDSCAP report, to the LAC Bureau in December 1993. The Bureau and the AIDS Office of the USAID Global Bureau reviewed the strategy and authorized an AIDSCAP detailed implementation visit which took place in April, 1994. The final version of the detailed implementation plan (DIP) is under review; however, its substance is reflected in the text of this PP Supplement, and its expected accomplishments set forth in the attached logical framework.

The goal of proposed AIDSCAP activities under the Amendment is to reduce the growing incidence of HIV/AIDS/STDs in Honduras. Three populations will be targeted: "people in the workplace," "core groups," including commercial sex workers, their clients, and men who have sex with men, and the Garífuna. Four geographic areas will be targeted, corresponding to MOH Health Regions covering Tegucigalpa, Comayagua, San Pedro Sula, and La Ceiba. The AIDSCAP program will utilize three technical strategies to achieve a reduction in the incidence of HIV/AIDS/STD:

- Improvement in referral, diagnosis and treatment of sexually transmitted diseases (STDs);
- Behavior change communication (BCC); and,
- Improvement in the availability and correct use of condoms.

The principal activities covered by the AIDSCAP DIP (see Attachment 8) will include:

- a) Support STD programs, clinics and laboratories in (1) training of medical and paramedical personnel, (2) selective purchasing of equipment, and (3) improvement of STD diagnosis and treatment;
- b) Provide technical assistance and support for the development of BCC training and/or mass media materials that promote behavior change for the target populations based on quantitative and qualitative research;
- c) Develop subprojects for "people in the workplace" through industrial associations, businesses and zonas industriales de producción (ZIPs);

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- d) Provide technical and financial assistance to NGOs for HIV/AIDS/STD prevention work with high risk groups;
- e) Support policy dialogue efforts at all levels to promote norms, laws and policies that facilitate implementation of HIV/AIDS/STD prevention programs;
- f) Develop workshops, conferences, and/or seminars with leaders from the commercial, industrial, community and religious sectors, to leverage greater support and resources for prevention programs; and,
- g) Participate with the MOH, IHSS, donor agencies, and national and international organizations to assure the availability of a consistent and adequate supply of condoms for the selected target populations.

The day-to-day administration of the DIP will be conducted through an AIDSCAP/Honduras Country Office based in Tegucigalpa. The work will be conducted in close coordination with a Central Coordinating Committee (CCC) represented by the Director of the MOH STD/AIDS Division, a Technical Advisor from the Mission, the AIDSCAP/Honduras Chief of Party (COP), and possibly representatives from other involved public and private sector institutions. In addition to the COP, the AIDSCAP Country Office will be staffed by a Program Officer, an BCC Advisor, a Finance Officer and support staff. The level of effort for professional staff will be 180 person months. All will be Honduran nationals.

An estimated \$2.0 million will be expended between FYs 95-96.

C) Rural Water and Sanitation: Under the Amendment, RW&S activities will continue the construction of water supply and sanitation systems throughout rural Honduras in line with the original project design. SANAA, the national water authority, will construct approximately 80% of the systems, and the six PVOs already participating in the project will construct the remaining 20%. The project will include as principal components community organization and participation to ensure sustainability, and health education to ensure behavioral changes. An estimated \$3.4 million will be expended in FYs 95-96 on the construction of approximately 200 water systems. This will increase the LOP total to 700 – or nearly 200 more than the original design called for.

D) Private Sector: Private sector activities implemented by PVOs will continue under the Amendment according to the original project design. The activities will be implemented through six PVOs engaged in RW&S (discussed above) and ten engaged in child survival activities involving the provision of primary health care services in 245 communities. Approximately 127,000 rural residents will benefit from these services and it is expected that infant mortality will drop dramatically in these communities. PVO-implemented RW&S services will benefit a rural population of

approximately 113,000 residing in 312 communities. It is expected that the incidence of diarrheal disease will be reduced in these areas. The project's child survival emphasis will continue to justify the support of the La Liga de la Lactancia Materna's community peer breastfeeding counselors program. An estimated \$1.7 million will be expended in FYs 95-96 on all PVO work.

- III. Amended Project Budget: An amended project budget table illustrating USAID's contribution to the Project is located below. The GOH cash contribution to the project remains \$26 million, i.e., 52 million lempiras as calculated at the original exchange rate on the date of signature of the Project Agreement of L.2.0=\$1. Additional financial information, including a budget indicating the reprogramming of the GOH's project contribution, can be found in Attachment 2.

The budget table indicates variances between the original (design) and amended budgets in terms of obligations by project component and element. At the component level, the large variances for the Rural Water and Sanitation, Private Sector, and Project Administration items, +19%, +22%, and -49%, respectively, are a consequence of distributing the "Contingency" line item in the Project Administration component of the original budget. Over the course of project implementation to date, the contingency was allocated to the two of the most successful components of the project, RW&S and Private Sector.

Variances at the element level are in some cases substantial. The reason underlying the very large variance in AIDS Control (+847%) is evident. The drop in Breastfeeding and Growth Monitoring (-31%) is explained by the method of accounting. The project's support for breastfeeding has been provided through a PVO, and funding is attributed to the Private Sector component. Likewise, the apparent drop in birthspacing funding is explained by the fact that \$435,000 of the originally estimated funding was accounted for through other project elements. In fact, the originally estimated \$3.03 million have, or will be, devoted to population activities. Further information is contained in Attachment 2.

SUMMARY PROJECT BUDGET

(USAID Contribution)

PROJECT COMPONENT/ ELEMENT	ORIGINAL PLANNED EXPENDITURES	REVISED PLANNED EXPENDITURES	VARIANCE (ABSOLUTE)	VARIANCE (RELATIVE)
A. SUSTAINABLE SUPPORT SYSTEMS	20,215,600	18,851,774	(1,363,826)	-6.75%
1. Local Programming	6,268,900	7,322,986	1,054,086	16.81%
2. Logistics & Admin.	3,132,200	2,877,144	(255,056)	-8.14%
3. Maintenance Systems	604,000	720,984	116,984	19.37%
4. Mgmt. Info. Systems	3,461,000	2,068,591	(392,409)	-40.23%
5. Human Resources Development	3,648,900	2,750,349	(898,511)	-24.63%
6. Health Finance	1,215,000	909,722	(305,278)	-25.13%
7. Educ./Promotional Programs	1,885,600	2,201,998	316,398	16.78%
B. HEALTH TECHNOLOGIES	8,804,800	10,294,632	1,489,832	16.92%
8. Diarrhea Control	315,500	330,930	(15,430)	-4.89%
9. Imuno. Descases	790,500	799,786	(9,286)	-1.17%
10. ARIs	638,500	1,009,499	370,999	58.10%
11. Birthspacing	3,000,800	2,812,379	(188,421)	-6.28%
12. Breastfeeding & Growth Monitoring	522,500	358,090	(164,410)	-31.47%
13. Vector Control	3,099,300	1,603,502	(1,496,248)	-48.28%
18. TB Control	100,100	183,276	83,176	83.09%
19. AIDS Control	337,600	3,197,620	2,860,020	847.16%
C. RURAL WATER AND SANITATION	13,463,700	16,078,733	2,615,033	19.42%
14. RWS&S: SANAA	9,618,700	12,899,003	3,280,303	34.10%
15. RWS&S: MOH	3,845,000	3,179,730	(665,270)	-17.30%
D. PRIVATE SECTOR	6,392,000	7,798,702	1,406,702	22.01%
16. Private Sector	6,392,000	7,798,702	1,406,702	22.01%
E. PROJECT ADMINISTRATION	8,423,900	4,276,199	(4,147,741)	-49.24%
17. Project Administration & Contin.	8,423,900	4,276,199	(4,147,741)	-49.24%
TOTALS	57,300,000	57,300,000	0	0.00%

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- IV. **Project Covenants:** The original Project Agreement contains eight covenants, seven of which will remain "as is" in the amended Agreement. The eighth original covenant is entitled, "Retention of Fees and Costs at the Operational Level," with which the GOH complied through passage of national legislation. A revised covenant in the amended Project Agreement will support the permanent retention and management of locally generated funds at the local level after the end of the Project. Another covenant, "Grantee Commitment to Provide Counterpart Funds," was added during a previous amendment of the Project Agreement.

There will be two new covenants added to the amended Project Agreement, bringing the total to eleven (11). The first of the covenants deals with MOH regional management systems and has two parts: (a) a requirement that the MOH develop and implement an inventory control system in each Health Region, prior to releasing spare parts for vehicles to them; and (b) to continue compliance with USAID/FARS Report No. 92-03, concerning use of vehicle management control systems, the MOH will be required to prepare biannual reports certifying the Health regions' adequate use of the management control system now in place.

The second new covenant will require that the MOH make "substantial progress" in achieving, on a semi-annual basis, project implementation benchmarks which are linked to the Amendment policy agenda. A table indicating these benchmarks will be attached to Annex I, "Amplified Project Description," of the Project Agreement.

ISSUES: No issues were identified.

AUTHORITY: The AA/LAC has delegated to all LAC Mission Directors, under revised Delegation of Authority No. 752, dated September 14, 1992, the authority to negotiate, execute and implement project amendments, including Project Authorizations executed by any USAID official, if the amendment: does not result in total LOP funding in excess of \$100 million, and does not cause the LOP to exceed ten (10) years; does not present any significant policy issues; and does not require issuance of a waiver that may only be approved by the Administrator or Assistant Administrator. Therefore, you have the authority to amend the Project Authorization and Project Agreement for the Health Sector II project.

RECOMMENDATION: This memorandum has presented a justification for, and description of, the proposed project amendment. The project analyses (financial, technical, social soundness, and administrative) contained in the original Project Paper remain valid and require no modification due to the proposed activities. The original economic analysis has been augmented by a recent study which examined the socio-economic impact of AIDS in Honduras (see Project files), the results of which clearly justify the proposed increase in project expenditures for HIV/AIDS prevention.

In November 1993, the Mission submitted a Technical Notification for the Health Sector II at a level of \$8.5 million. Obligations could be incurred after November 23, 1993, and indeed the Mission has obligated funds against the Health Sector II notification earlier this fiscal year.

The Project Committee recommends that you approve the amended design of the Health Sector II Project to reflect the policy agenda agreed upon with the new national government, incorporate activities to be implemented under the AIDSCAP program, revise selected project outputs, reprogram the project budget, and extend the PACD to September 30, 1996. Your approval of these changes will be certified by your signature of the attached: (1) Amendment No. 1 to the Project Authorization; (2) Amendment No. 1 to the Project Data Sheet; and (3) Project Agreement Amendment No. 19.*

* To be signed on August 26, 1994 in a ceremony with the GOH.

ATTACHMENTS:

Attachment 1: Revised Logical Framework

Attachment 2: LOP Budget Analysis

Summary Cost Estimate and Illustrative Financial Plan (FY95-96)

Funding Schedule

Financial Implementation Schedule for Mission Earmarking of Funds

FY95 Directives Compliance

Attachment 3: Policy Matrix

Attachment 4: Technical Assistance Plan

Attachment 5: Implementation Plan and Schedule

Attachment 6: Procurement Plan

Attachment 7: Monitoring and Evaluation Plan

Attachment 8: AIDSCAP Detailed Implementation Plan (DIP)

(522-0216)
LOGICAL FRAMEWORK

Project Title & Number: Health Sector II

Life of Project:
From FY 88 to FY 96
Total U.S. Funding: \$57,300,000

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
GOAL:			
A. Improve the health status of the Honduran people, especially children under the age of five years and women, 15-45 years of age.	1.1 Reduction of the infant mortality rate from 61/1000 in 1985 to 41/1000 in 1996.	1.1.1 EFHS Survey	1. Continuation of current health policies of future governments.
	1.2 Decrease the maternal mortality rate from 221/100,000 in 1989 to 145/100,000 in 1996.	1.2.1 EFHS Survey	2. A better national budget allotment for M.O.H. 3. Favorable measures from the Executive Branch for the Ministry of Health Budget.
PROJECT PURPOSE:			
B. Support, strengthen and continue the process of extension of coverage of efficient, sustainable, and effective primary health care and rural water and sanitation (RW&S) services, with an emphasis on child survival(cs) interventions.	1.1 40% reduction of the child mortality rate (1-4 years) from 4.3/1000 to 2.6/1000.	1.1.1 EFHS Survey	1. The M.O.H. budget will remain at 8-12% of GDP.
	1.2 Reduced level of malnutrition among children 12-23 months of age from 21.6 in 1987 to 17.0 in 1996 (percent at 2 or more std. deviations below the int'l. reference level).	1.2.1 EFHS Survey	2. The primary health care portion of M.O.H. budget will not decrease over the life of project.

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	1.3 An 80% decrease in the morbidity rate of the following diseases: Measles (13.4 cases/100,000), Whooping cough (7.4/100,000), Tetanus (1.6/100,000), maintain Diphtheria at 0 ('87 baseline)	1.3.1 Epidemiology Supervision Report 1.3.2 Surveys 1.3.3 Operations Research	3. Child Survival interventions will remain a GOH priority.
	1.4 70% of the rural population in Health Regions 3, 5 and 6 in communities with 2,000 or fewer people have access to potable water and latrines.	1.4.1 MOH and SANAA Reports 1.4.2 Sample Surveys	
	1.5 Decrease acute respiratory infections as the principal cause of mortality in the country's hospitals between 1988 and 1996 by 30%.	1.5.1 MOH Statistical Annual Reports	
	1.6 Reduce total fertility rates of Women of 15-44 years of age from 5.6 in 1987 to 4.6 in 1996.	1.6.1 EFHS Survey	
	1.7 Increase the percentage of rural women who had a prenatal visit at a health center during her last pregnancy from 67.1 percent in 1991 to 80.1 percent in 1996.	1.7.1 EFHS Survey	
	1.8 Reduce the cholera fatality rate to less than one percent of reported cholera cases.	1.8.1 MOH Annual Reports	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
I. <u>CHILD SURVIVAL</u> <u>SUSTAINABLE SUPPORT</u> <u>SYSTEMS</u> <u>OUTPUTS:</u> 1. Local programming model implemented.	1.9 Reduce percentage of outpatient visits of children under five to health centers due to diarrhea from 17.5 percent in 1990 to 13.0 percent in 1996.	1.9.1 MOH Annual Reports	
	1.10 HIV prevalence maintained at 0.3% or less in Region 1; 1.5% or less in Region 2; 3.6% or less in Region 3; and 1.4% or less in Region 6.	1.10.1 MOH Survey	
	1.1 Three regions have fully implemented the model, having done an inventory of personnel and financial resources, conducted a family census and prepared annual plans, including drug and medical supply needs; the other 5 regions have partially implemented the model.	1.1.1 Project's Monitoring Reports	
	1.2 In three regions, the supervision system is fully implemented, with:		

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	1.2.1 80% of Nurse Aides from CESARs and CESAMOs supervise the health volunteers under their program responsibility four times a year.	1.2.1 Monitoring Reports of Local Programming	Achieved
	1.2.2 80% of CESARs and CESAMOs receive area supervision visits three times a year (30% in 1987).	1.2.2 Area Supervision Reports	Achieved
	1.2.3 80% of area level establishments receive supervision visits by regional staff three times a year.	1.2.3 Region's Supervision Reports	(30% in 1987)
	1.2.4 80% of region level establishments receive supervision visits from central staff three times a year.	1.2.4 Supervision Reports on Central Level	(40% in 1987)
	1.3 All (8) regions have in operation computerized Management Information Systems (MIS) and have increased discretionary expenditure authority to 25% of their operating expenses.	1.3.1 Analysis of MOH Budget	(Non-personnel budgets from a baseline maximum of about 10%)

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS	
2. Improved logistics system in place	1.4 426 CESARs (80% of total) are renovated and/or repaired. (POSSS)	1.4.1 Project's Monitoring 1.4.2 MOH's Supervision and Evaluation Reports		
	1.5 All Regions have staff with on-the-job training in supervision, administration and use of information systems. (POSSS & POSSE)	1.5.1 MOH Reports 1.5.2 Project's Monitoring Reports 1.5.3 Contractors' Reports		
	2.1 Special procurement office or system is established within MOII.	2.1.1 Project Reports		
	2.2 Simplified inventory control systems for medical equipment, supplies, and pharmaceuticals are in use at regional, area and local levels. (POSSS)	2.2.1 Monitoring Reports 2.2.2 Administration Division Records		
	2.3 Computerized inventory controls are operating in central and regional warehouses.	2.3.1 Monitoring Reports 2.3.2 Contractor Reports		
	2.4 24 area level storage facilities are established.	2.4.1 Monitoring Reports		
	2.5 Three integrated centers for regional staff with training and laboratory facilities are established.	2.5.1 Engineering Inspector's Reports		

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
3. Maintenance systems strengthened	3.1 80% of cold chain system is adequately working. 3.2 90% of the operational levels will have trained maintenance personnel provided with basic tools.	3.1.1 Maintenance Reports 3.1.2 Immunization Reports	
4. Management and health information systems being used	4.1 An integrated series of health and management information networks at the central level will be in place, capable of providing reliable and timely information for decision-making and planning at the top administrative levels of the MOH. 4.2 These systems will be linked with the regional level systems, data processing will be decentralized to the regional level under the local programming model, and the specific components of the information system mentioned in previous sections will be integrated into this generalized system.	4.1.1 Monitoring Visits	(65% in 1987)
5. Training capability strengthened	5.1 Eleven self-instruction modules on TB, EPI, control of diarrhea disease, ARI, cold chain, MCH and others are being used.	5.1.1 Monitoring Reports	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	5.2 Staff Resource Register is operational and being used to program training.	5.2.1 Human Resources Development Division Reports	
	5.3 40 MOH professionals have received Master's degrees.	5.3.1 USAID Records (PIO/Ps)	Reduced from 50
6. Health financing analysis and planning capability in place at central, regional and community levels.	6.1 MOH Planning Division doing expenditure analyses and budget preparations; quarterly reports submitted to MOH policy level.	6.1.1 Planning Division Records	
	6.2 Evaluation done on feasibility of expanding medicine sale rotating funds at community levels; follow-on workshop.	6.2.1 Workshop and evaluation completed; pilot project begun, if evaluation deems feasible	
	6.3 Cost recovery by hospitals at 25% of non-personnel operational costs.	6.3.1 Hospital financial records	(Baseline: 12%)
7. Educational/promotional activities being supported through mass media and community efforts.	6.4 Cost recovery systems implemented by 75% of CESARs.	6.4.1 Special Study	
	7.1 A radio and T.V. stations contract system in operation, which includes audience research, setting up of selection criteria and broadcast monitoring.	7.1.1 Copy of contracts signed	Achieved

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	7.2 Regional Health Teams Trained in Health Education Methodologies and are producing material at the regional level.	7.2.1 Communication plans and implementation programming 7.2.2 Formative evaluation reports 7.2.3 Production reports, including listing of programs produced 7.2.4 Station monitoring reports and broadcast	
	7.3 One MOII radio production studio in full operation.	7.3.1 200 radio programs and spots produced yearly	Achieved
	7.4 A systematic and permanent communications planning systems being directed by the Division of Health Education.	7.4.1 Written plans for each MCH program or major child survival activity approved and funded at the beginning of each calendar year	Achieved
II. <u>CHILD SURVIVAL</u> <u>MATERNAL HEALTH</u> <u>STDS/HIV/AIDS HEALTH</u> <u>TECHNOLOGIES</u>			
<u>OUTPUTS:</u>			
1. Activities expanded for treatment against childhood dehydration caused by diarrheal diseases.	1.1 40% of children under five with diarrhea in last three days who were treated with ORS.	1.1.1 EFHS	(Baseline 17%)

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	1.2 90% of the Health Centers have adequate supplies of ORS in stock.	1.2.1 Project's monitoring reports	
2. Immunization coverage of basic vaccines increased.	2.1 95% percent of children under one vaccinated for selected diseases (DPT, Measles, Polio, and TB).	2.1.1 MOH Annual Reports	(Baseline in 1990: DPT (84); M(90); P(87); TB(71)) (Are children still being vaccinated for polio?)
3. Home treatment of mild ARI being done according to program standards.	3.1 40% of families adequately treat mild ARI in households.	3.1.1 Operations Research 3.1.2 Surveys	(Benchmark: 10%)
4. Strength technical capability of health services to treat moderate-to-severe ARI.	4.1 90% of CESAMOs and 50% of CESARs have vaporizer/humidifiers.	4.1.1 Surveys 4.1.2 Investigations 4.1.3 Reports	(None presently)
5. Prenatal care, childbirth, and postnatal care, activities expanded.	5.1 80% of pregnant women that visit health facilities (CESAR and CESAMO) will receive attention in compliance with program norms.	5.1.1 Statistical Reports 5.1.2 Survey	(Baseline: 12%)
	5.2 90% of pregnant women detected in high risk group are attended to by health system.	5.2.1 Survey 5.2.2 Reference Reports 5.2.3 Project Monitoring Reports	(40% in 1986)
	5.3 60% of beneficiaries of the maternal care programs will have vaginal cytologies performed at intervals prescribed by MOH norms.	5.3.1 Ministry Reports	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	5.4 100% of women aged 12-49 vaccinated with a second dose of tetanus toxoid within the last three years.	5.4.1 MOH Annual Reports	(Baseline: 25%)
6. Child spacing - family planning practices expanded.	6.1 90% of CESAR's will be distributing temporary contraceptive methods.	6.1.1 Survey	(40% in 1986)
	6.2 60% of the voluntary personnel (Traditional Midwives and Health Guardians) will be distributing oral contraceptives and condoms.	6.2.1 Survey	Baseline: None
	6.3 100% of health providers and 50% of women of fertile age are aware of health risks of short intervals (under 2 years) between pregnancies.	6.3.1 KAP Surveys (Ep. Survey)	
7. Promotion of breastfeeding increased.	7.1 40% of children 2-3.99 months who were only breastfed during the previous 24 hours.	7.1.1 EFHS	(Baseline: 19.8%)
8. Growth monitoring activities for children under five years to detect and treat malnutrition expanded health system.	8.1 80% of CESARES, CESAMOS, CHA have anthropometric equipment.	8.1.1 Program Reports on Monitory and Supervision	(40% in 1986)
	8.2 80% of mothers with children under 1 year know appropriate feeding practices.	8.2.1 Surveys	(20% in 1986)

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
9. Tuberculosis detection and control activities made more efficient.	8.3 Improved growth monitoring will be established by assuring that 80% of children under the age of five who visit a health center have growth and development charts. 9.1 90% of diagnosed cases being treated.	9.1.1 Program Evaluation Report 9.1.2 Statistical Reports of MOH	(80% in 1986)
10. Increased use of STD/HIV prevention practices.	9.2 A reduction in rate of abandonment of treatment to 10%. 10.1 Increased total number of condoms distributed (sold and handed out) from 2,600,000 in 1990 to 6,200,000 in 1996.	10.1.1 MOH and USAID procurement and distribution records.	(20% in 1986) 1. Private Sector Population II project will also contribute to this output
III. <u>RURAL WATER AND SANITATION</u>			
<u>OUTPUTS:</u>			
1. Expanded access to and use of safe water systems and human waste disposal system in rural Honduras.	1.1 550,000 rural residents benefitting from USAID-supported water and sanitation systems. 1.2 700 aqueducts constructed by SANAA and 80 by MOH in project area and supported by POV's.	1.1.1 Population Census and Surveys 1.2.1 Field Visits 1.2.2 SANAA and MOH Reports	Increased from 530 SANAA, and 30 MOH aqueducts.

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
	1.3 1000 wells with handpumps built and 400 wells improved by MOH.		
	1.4 57,000 water seal latrines built (37,000 SANAA and 20,000 MOH).		
	1.5 20,000 pit latrines built by MOH.		
	1.6 73 septic tanks installed (50 SANAA and 23 MOH).		
2. SANAA's maintenance capability for rural areas upgraded and further institutionalized.	2.1 TOM maintenance technicians functioning and supported by SANAA field office.	2.1.1 Project Data and Field Verification	
3. SANAA's promotional/educational capability for rural areas is upgraded and further institutionalized.	3.1 36 additional promoters are hired, trained and placed by SANAA.	3.1.1 Project Data and Field Verification	Achieved
	3.2 6 personnel of SANAA trained in sanitary engineering.	3.1.2 Evaluation of impact of health education component.	Achieved
		3.2.1 Project Data	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS/ COMMENTS
4. Water quality practices institutionalized in SAN/AA and standards approved by MOH.	4.1 Water sources for systems exceeding safe bacteriological standards and equipped with water treatment apparatus.	4.1.1 Field, Visits, Surveys	
IV. PRIVATE SECTOR			
<u>OUTPUTS:</u>			
1 Participation by PVOs in supporting Child Survival and Rural Water and Sanitation activities.	1.1 A minimum of 9 and a maximum of 12 Private Voluntary Organizations will be receiving OPG support from the Project for Child Survival and RW&S activities.	1.1.1 PVO progress reports	Achieved
2 Packaging and distribution capacity for commercialization of oral rehydration salts established.	2.1 Local private company has included ORS in its retail product line.	2.1.1 Survey of Commercial outlets	Achieved

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INPUTS (FY95-FY96)	APPROX. LOE	(\$000) USAID FUNDS		(L.000) GOH FUNDS	(\$000) PROJECT TOTAL		(\$000) GRAND TOTAL
		FX	LC	LC	FX	LC	
Project Components:							
1. Sustainable Support Systems		<u>1,800</u>	<u>1,100</u>	<u>3,000</u>	<u>1,800</u>	<u>2,600</u>	<u>4,400</u>
TA	52	325	177.5				
Training		150	-				
Commodities		825	270				
Local Costs			264				
Other (Salaries)		500	388.5				
2. Health Technologies		<u>3,000</u>	<u>711</u>	<u>6,000</u>	<u>3,000</u>	<u>3,711</u>	<u>6,711</u>
TA	93.5	1,807	13				
Training		-	-				
Commodities		1,147	-				
Local Costs		-	-				
Other (Salaries)		46	698				
3. Rural Water & Sanitation		<u>2,400</u>	<u>1,000</u>	<u>12,000</u>	<u>2,400</u>	<u>7,000</u>	<u>9,400</u>
TA	26	-	129				
Commodities		2,400	200				
Other (Salaries)			671				
4. Private Sector		<u>700</u>	<u>1,000</u>	<u>0</u>	<u>700</u>	<u>1,000</u>	<u>1,700</u>
Other (Grants)		700	1,000				
5. Project Admin.		<u>1,300</u>	<u>200</u>	<u>0</u>	<u>1,300</u>	<u>200</u>	<u>1,500</u>
Local Costs		1,050	150				
Other (Salaries)		150					
Eval./Audits		100	50				
TOTAL		9,200	4,011	21,000	9,200	14,511	23,711

NOTE: Level of Effort (LOE) estimates are for person-months of short term technical assistance.

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ATTACHMENT II, CHART 1: LOP BUDGET ANALYSIS

PROJECT COMPONENT/ELEMENT	OBLIGATIONS TO DATE	REMAINING FY 94 OBLIGATIONS	FY 95 OBLIGATIONS	TOTAL OBLIGATIONS	DESIGN TOTALS	VARIANCE (ABSOLUTE)	VARIANCE (RELATIVE)
A. SUSTAINABLE SUPPORT SYSTEMS	16,990,961	758,813	1,102,000	18,851,774	20,215,600	(1,363,826)	-6.75%
1. LOCAL PROGRAMMING	6,621,988	478,998	222,000	7,322,986	6,268,900	1,054,086	16.81%
2. LOGISTICS & ADMIN	2,870,901	6,243	0	2,877,144	3,132,200	(255,056)	-8.14%
3. MAINTENANCE SYSTEMS	456,635	65,349	199,000	720,984	604,000	116,984	19.37%
4. MGMT. INFO. SYSTEMS	1,625,657	157,934	285,000	2,068,591	3,461,000	(1,392,409)	-40.23%
5. HUMAN RESOURCES DEVELOPMENT	2,447,123	8,226	295,000	2,750,349	3,648,900	(898,551)	-24.63%
6. HEALTH FINANCE	874,722	25,000	10,000	909,722	1,215,000	(305,278)	-25.13%
7. EDUC./PROMOTIONAL PROGRAMS	2,093,935	17,063	91,000	2,201,998	1,885,600	316,398	16.78%
B. HEALTH TECHNOLOGIES	7,249,446	1,942,641	1,102,545	10,294,632	8,804,800	1,489,832	16.92%
8. DIARRHEA CONTROL	286,821	41,109	3,000	330,930	315,500	15,430	4.89%
9. IMMUNO. DISEASES	735,947	14,839	49,000	799,786	790,500	9,286	1.17%
10. ACUTE RESPIRATORY INFECTIONS	307,275	702,224	0	1,009,499	638,500	370,999	58.10%
11. BIRTHSPACING	2,550,056	0	262,323	2,812,379	3,000,800	(188,421)	-6.28%
12. BREASTFEEDING & GROWTH MONITORING	309,621	48,469	0	358,090	522,500	(164,410)	-31.47%
13. VECTOR CONTROL	1,603,052	0	0	1,603,052	3,099,300	(1,496,248)	-48.28%
18. TB CONTROL	182,054	0	1,222	183,276	100,100	83,176	83.09%
19. AIDS CONTROL	1,274,620	1,136,000	787,000	3,197,620	337,600	2,860,020	847.16%
C. RURAL WATER AND SANITATION	15,411,533	61,200	606,000	16,078,733	13,463,700	2,615,033	19.42%
14. RWS&S: SANAA	12,448,430	54,573	336,000	12,839,003	9,618,700	3,220,303	34.10%
15. RWS&S: MOH	2,963,103	6,627	210,000	3,179,730	3,845,000	(665,270)	-17.30%
17. PRIVATE SECTOR	7,798,702	0	0	7,798,702	6,392,000	1,406,702	22.01%
16. PRIVATE SECTOR	7,798,702	0	0	7,798,702	6,392,000	1,406,702	22.01%
1. PROJECT ADMINISTRATION	3,836,358	49,346	330,455	4,216,159	8,423,900	(4,147,741)	-49.24%
17. PROJECT ADMINISTRATION & CONTIN.	3,836,358	49,346	330,455	4,216,159	8,423,900	(4,147,741)	-49.24%
TOTALS	51,347,000	2,812,000	3,141,000	57,300,000	57,300,000	0	0.00%
AMEND 19 WQ1							

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ATTACHMENT II, CHART 2

**SUMMARY COST ESTIMATE AND ILLUSTRATIVE FINANCIAL PLAN, FY 95 THRU FY 96
(RESUMEN DEL COSTO ESTIMADO Y PLAN ILUSTRATIVO, FY 95 Y FY 96)**

PROJECT COMPONENTS (COMPONENTES DEL PROYECTO)	USAID (\$000)			GOH (L.000)
	FX	LC	TOTAL	
SUSTAINABLE SUPPORT SYSTEMS (SISTEMAS DE APOLLO SOSTENIBLES)	1,800	1,100	2,900	3,000
HEALTH TECHNOLOGIES (TECNOLOGIAS EN SALUD)	3,000	711	3,711	6,000
RURAL WATER AND SANITATION (AGUA Y SANEAMIENTO RURAL)	2,400	1,000	3,400	12,000
PRIVATE SECTOR (SECTOR PRIVADO)	700	1,000	1,700	0
PROJECT ADMINISTRATION (ADMINISTRACION DEL PROYECTO)	1,300	200	1,500	0
TOTAL USAID GRANT (TOTAL DE LA DONACION USAID)	9,200	4,011	13,211	
TOTAL GOH CONTRIBUTION (TOTAL DE LA CONTRIBUCION DEL GdeH)				21,000
TOTAL PROJECT (TOTAL DEL PROYECTO)	23,711			
GOH COUNTERPART CONVERTED AT 2 TO 1 (CONTRIBUCION DEL GdeH CONVERTIDO AL 2 POR 1)				

NET ACCRUED EXPENDITURES ESTIMATED AT \$44,089,000 FOR THE END OF FY 94.

(GASTOS NETOS ESTIMADOS A SER \$44,089,000 AL FIN DE FY 94)

COMMITTED AND/OR EARMARKED ACTIVITIES ESTIMATED AT \$6,152,000 FOR THE END OF FY 94.

(ACTIVIDADES CON FONDOS YA COMPROMETIDOS Y/O RESERVADOS ESTIMADOS A SER \$6,152,000 AL FIN DE FY 94)

ATTACHMENT II, CHART 3: FUNDS SCHEDULER

PROJECT COMPONENT/ELEMENT	UNEARMARKED BALANCE	UNEARMARKED LESS PENDING 1994 ACTIVITIES	DISTRIBUTION OF REMAINING FY 94 OBLIGATIONS	DISTRIBUTION OF FY 95 OBLIGATIONS (TO REACH \$57.3)	TOTAL REMAINING DISTRIBUTIONS (TO REACH \$57.3)
A. SUSTAINABLE SUPPORT SYSTEMS	586,187	(758,813)	758,813	1,102,000	2,447,000
1. LOCAL PROGRAMMING	351,002	(478,998)	478,998	222,000	1,052,000
2. LOGISTICS & ADMIN.	23,757	(6,243)	6,243	0	30,000
3. MAINTENANCE SYSTEMS	9,651	(65,349)	65,349	199,000	274,000
4. MGMT. INFO. SYSTEMS	27,066	(157,934)	157,934	285,000	470,000
5. HUMAN RESOURCES DEVELOPMENT	145,774	(8,226)	8,226	295,000	449,000
6. HEALTH FINANCE	0	(25,000)	25,000	10,000	35,000
7. EDUC./PROMOTIONAL PROGRAMS	28,937	(17,063)	17,063	91,000	137,000
B. HEALTH TECHNOLOGIES	443,562	(1,286,363)	1,942,641	1,102,545	3,488,748
8. DIARRHEA CONTROL	3,291	(41,109)	41,109	3,000	47,400
9. IMMUNO. DISEASES	20,161	(14,839)	14,839	49,000	84,000
10. ACUTE RESPIRATORY INFECTIONS	1,601	(702,224)	702,224	0	703,825
11. BIRTHSPACING	261,677	168,677	0	262,323	524,000
12. BREASTFEEDING & GROWTH MONITORING	1,531	(48,469)	48,469	0	50,000
13. VECTOR CONTROL	0	0	0	0	0
18. TB CONTROL	7,878	4,778	0	1,222	9,100
19. AIDS CONTROL*****	147,423	(653,177)	1,136,000	787,000	2,070,423
C. RURAL WATER AND SANITATION	278,503	78,503	61,200	606,000	945,703
14. RWS&S: SANAA	235,130	85,130	54,573	396,000	685,703
15. RWS&S: MOH	43,373	(6,627)	6,627	210,000	260,000
D. PRIVATE SECTOR	0	0	0	0	0
16. PRIVATE SECTOR	0	0	0	0	0
E. PROJECT ADMINISTRATION	75,654	(49,346)	49,346	330,455	455,455
17. PROJECT ADMINISTRATION & CONTIN.	75,654	(49,346)	49,346	330,455	455,455
TOTALS	1,383,906	(2,016,019)	2,812,000	3,141,000	7,336,906

***** P.E. 19 (AIDS) PIPELINE = \$277,823 AT END OF 1995. TOTAL FUNDS SCHEDULED IN THIS CHART WILL NOT BALANCE WITH THE TOTAL FUNDS PLANNED FOR MISSION EARMARKING IN CHART 4 BECAUSE OF THIS PIPELINE.

ATTACHMENT II, CHART 4:

FINANCIAL IMPLEMENTATION SCHEDULE FOR MISSION EARMARKING OF PLANNED ACTIVITIES

PROJECT ELEMENT/ MECHANISM/ACTIVITY PENDING FUNDING	1994	1995	TOTAL
1. LOCAL PROGRAMMING	830,000	222,000	1,052,000
A. MOH ROTATING FUNDS			
1. Per diem	60,000	132,000	192,000
2. Materials	40,000	80,000	120,000
3. Equipment	5,000	10,000	15,000
(Local costs for implementation of DOFUPS)			
B. USAID DIRECT			
1. Motorcycle Spare Parts	325,000	0	325,000
2. Vehicle Spare Parts	400,000	0	400,000
2. LOGISTICS & ADMIN.	30,000	0	30,000
A. USAID			
1. TA Warehouse MIS	30,000	0	30,000
3. MAINTENANCE SYSTEMS	75,000	199,000	274,000
A. MOH ROTATING FUNDS			
1. Repair of Health Centers	47,000	88,000	135,000
2. Repair of Vehicles	28,000	111,000	139,000
4. MGMT. INFO. SYSTEMS	185,000	285,000	470,000
A. USAID			
1. TA For DIP For Financial MIS	5,000	0	5,000
2. TA For Execution Of MIS DIP	20,000	20,000	40,000
3. TA For Equip. Installation/Maintenance	0	5,000	5,000
4. Computer Equipment & Software	0	100,000	100,000
5. TA For EFHS Survey	60,000	60,000	120,000
6. Decentralized MIS Training TA	100,000	100,000	200,000
5. HUMAN RESOURCES DEV.	154,000	295,000	449,000
A. MOH ROTATING FUNDS			
1. Training for community volunteers	64,000	137,000	201,000
2. Training For Institutional Employees	10,000	8,000	18,000
B. USAID			
1. Scholarships for MPH	75,000	75,000	150,000
2. TA Assessment of Regional Needs	5,000	0	5,000
3. TA/ Other Expenses Meet Regional Needs	0	75,000	75,000
6. HEALTH FINANCE	25,000	10,000	35,000
A. USAID			
1. TA Community Pharmacies	15,000	0	15,000
2. FONREC Software	5,000	0	5,000
3. TA Retained Revenues	5,000	10,000	15,000
7. EDUC./PROMOT. PROGS.	46,000	91,000	137,000
A. MOH ROTATING FUNDS			
1. Printing Materials	45,000	80,000	125,000
2. Per Diem	0	11,000	11,000
B. USAID			
1. Social Communications TA	1,000	0	1,000

ATTACHMENT II. CHART 4 CONTINUED

PROJECT ELEMENT/ MECHANISM/ACTIVITY PENDING FUNDING	1994	1995	TOTAL
8. DIARRHEA CONTROL	44,400	3,000	47,400
A. MOH ROTATING FUNDS			
1. Fuel (rapid response: cholera)	1,400	3,000	4,400
B. USAID			
1. TA: BASICS	43,000	0	43,000
9. IMUNO. DISEASES	35,000	49,000	84,000
A. MOH ROTATING FUNDS			
1. Spare parts (refrigerators)	0	21,000	21,000
2. Maintenance of Regional Cold Storage	10,000	3,000	13,000
B. USAID			
1. Refrigerators	25,000	25,000	50,000
10. ARIs	703,825	0	703,825
A. USAID			
1. TA: BASICS	18,000	0	18,000
2. Clinical Equip. (7 area hospitals)	651,825	0	651,825
3. Nebulizers	34,000	0	34,000
11. BIRTHSPACING	93,000	431,000	524,000
A. MOH ROTATING FUNDS			
1. Per diem (Reg. Meetings)	0	4,000	4,000
2. In-country Training	0	5,000	5,000
3. Remodeling of Women's Clinics	0	160,000	160,000
B. USAID			
1. Contraceptives	0	222,000	222,000
2. Clinical Equip.	0	40,000	40,000
3. Contraceptives Logistics TA	13,000	0	13,000
4. University Curriculum TA	40,000	0	40,000
5. Hospital Protocol TA	40,000	0	40,000
12. BREASTFEEDING AND GROWTH MONITO	50,000	0	50,000
A. USAID			
1. POSAIN Commun. Strategy	20,000	0	20,000
2. POSAIN Training Manual & Eval.	30,000	0	30,000
18. TB CONTROL	3,100	6,000	9,100
A. MOH ROTATING FUNDS			
1. Per Diem (Reg. Meetings)	2,500	5,000	7,500
2. Materials (Lab)	600	1,000	1,600
19. AIDS CONTROL	800,600	992,000	1,792,600
A. MOH ROTATING FUNDS			
1. Per diem (supervision)	600	1,000	1,600
B. USAID			
1. Condoms	0	191,000	191,000
2. AIDSCAP TA	800,000	800,000	1,600,000
14. RWS&S: SANAA	150,000	535,703	685,703
A. SANAA/AID ROTATING FUNDS	0	535,703	535,703
B. USAID			
1. Vehicle Spare Parts	150,000	0	150,000
15. RWS&S: MOH	50,000	210,000	260,000
A. MOH ROTATING FUNDS	50,000	81,000	131,000
(local costs to install hand pumps)			
B. USAID			
1. TA: Environmental Health Information System	0	9,000	9,000
2. TA: MOH Emergency Response Capability	0	72,000	72,000
3. TA: Consolidate Environmental Health Activities	0	48,000	48,000
16. PRIVATE SECTOR	0	0	0
17. PROJECT ADMIN.	125,000	330,455	455,455
A. MOH ROTATING FUNDS	25,000	89,000	114,000
B. USAID			
1. Personnel	0	150,000	150,000
2. Evaluation	100,000	0	100,000
C. CONTINGENCY	0	91,455	91,455
TOTALS	3,399,925	3,659,158	7,059,083

THE TOTAL FOR THE TWO YEARS IN THIS CHART IS OUT OF BALANCE WITH CHART 3 BY \$277,823 BECAUSE OF THE AIDS PIPELINE.

ATTACHMENT II, CHART 5: FY 95 DIRECTIVES COMPLIANCE			
DIRECTIVE	LOP= \$57.3	LOP > \$57.3	TOTAL
CHILD SURVIVAL	1,485,677	1,955,323	3,441,000
AIDS	787,000	0	787,000
POPULATION	262,323	960,677	1,223,000
UNRESTRICTED	606,000	0	606,000
TOTAL	3,141,000	2,916,000	6,057,000

ACCORDING TO THE ABS, THE MISSION IS SCHEDULED TO OBLIGATE \$6,057,000 IN FY 95 FOR HEALTH PROJECT ACTIVITIES. THE ABS ASCI CODES INDICATE HOW THE MISSION WILL OBLIGATE THESE FUNDS IN ACCORDANCE WITH DIRECTIVES. HOWEVER, THE CURRENT AUTHORIZED LOP BUDGET FOR THE HS II PROJECT, \$57.3 MILLION, WILL ONLY ACCOMODATE A PORTION OF THE DIRECTIVES TO BE MET IN FY 95. THE ABOVE CHART DISTRIBUTES MISSION COMPLIANCE WITH THE FY 95 DIRECTIVES BETWEEN PLANNED OBLIGATIONS TO REACH THE CURRENT LOP AUTHORIZED BUDGET AND PLANNED OBLIGATIONS OCCURING UNDER EITHER A HS II PROJECT WITH AN INCREASED LOP AUTHORIZED BUDGET OR A NEW PROJECT.

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<u>Política- Administrativa</u>	La falta de una claridad de responsabilidades y autoridad en el Ministerio.	<ol style="list-style-type: none"><li data-bbox="1345 419 1961 528">1. Establecer las líneas de responsabilidad y <u>comunicación</u> entre las instancias del Ministerio.<li data-bbox="1345 568 1961 724">2. Elaborar una programación del trabajo (con metas) de acuerdo con la política de salud, respetar la programación por niveles, y evaluar lo ejecutado contra lo programado.

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<p>I. <u>Programación Local</u> <u>y Recursos Humanos</u></p>	<p>I.A. No existe una ejecución adecuada (en cantidad y calidad) de los sistemas y servicios de salud a nivel local.</p>	<p>I.A.1 Formalizar una política sobre la administración local.</p> <p>I.A.2 Ejecutar el Plan Detallado de Implementación (ver Plan Detallado de Implementación para el Desarrollo del Nivel Local y los manuales de los sistemas DOFUPS).</p> <p>I.A.3 Reconfirmar y fortalecer la supervisión a todos los niveles como herramienta clave de la administración local.</p> <p>I.A.4 Monitorear y evaluar la ejecución de la supervisión.</p>
	<p>I.B. Falta de dirección y de coordinación en el proceso de capacitación en apoyo a la administración local.</p>	<p>I.B.1 Reorientar la División de Recursos Humanos bajo una política de descentralización de los servicios de salud (ver informe "Adecuación Organizacional de la División de Recursos Humanos").</p> <p>I.B.2 Implementar el plan de capacitación con enfoque en tres áreas para mejorar la calidad de los servicios: a) supervisión <u>capacitante</u>, b) epidemiología, y c) gerencia (ver informe "Plan de Capacitación y Desarrollo de los Recursos Humanos" y el documento del CDC "Data for Decision Making, Honduras, Country Assessment").</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
II. <u>Finanzas</u>	II. A. Existe escasez de recursos a todos los niveles.	<p>II.A.1 Formular y ejecutar una política, con las modificaciones legales necesarias, sobre las fuentes alternativas de financiamiento del nivel local.</p> <p>II.A.2 Conocer y evaluar las experiencias actualmente vigentes (como la farmacia popular en el CESAMO de Catacamas y la cuota de recuperación de los CESARES manejados por PREDISAN en la Región 7) (ver informe "Para Fuentes Alternativas de Financiamiento al Nivel Local").</p>
	II.B. El manejo actual de los recursos no permite su uso eficiente y adecuado.	<p>II.B.1. Racionalizar el proceso del desarrollo del presupuesto (tomando en cuenta las cuotas trimestrales asignadas por el Ministerio de Hacienda) y el control de su ejecución (ver informe "Propuesta para la estructuración de un proceso de planificación/presupuestación que responda a las necesidades del Ministerio de Salud").</p> <p>II.B.2 Incluir un componente de finanzas que comprenda su búsqueda y manejo en el "Plan de Educación" mencionado en I.B.2 arriba.</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<p>III. <u>Logística</u></p>	<p>III.A. Existe una deficiencia en la cantidad, calidad y oportunidad de los insumos críticos en la producción de los servicios.</p>	<p>III.A.1 Establecer un sistema que permita el abastecimiento continuo y permanente de los insumos críticos incluyendo:</p> <ul style="list-style-type: none"> - una estructura que permita la adquisición de medicamentos de calidad y su disponibilidad oportuna (ver documento "Estructura Organizativa, División de Suministros"), y - un listado de proveedores precalificados (ver "Documento de Precalificación, Medicamentos y Materiales Medico-Quirurgicos").
	<p>III.B. Los sistemas actuales no permiten el control eficiente y oportuno de los insumos.</p>	<p>III.B.1 Implementar y fortalecer los sistemas necesarios. (ver documento "Definición de los Sistemas de Registro de Entradas, Salidas y Existencias a Nivel Regional y de Areas").</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<p>IV. <u>Sistemas de Información Gerencial</u></p>	<p>IV.A. La información gerencial para el manejo adecuado de los recursos humanos y financieros no es oportuna ni de calidad suficiente.</p>	<p>IV.A.1 Revisar, normatizar, documentar y comprobar la utilidad de los procedimientos administrativos para pagaduría, contabilidad, y personal en el contexto de las nuevas leyes de "Modernización del Estado".</p> <p>IV.A.2 Definir y producir los informes gerenciales que se requieren para racionalizar el manejo de los recursos humanos y financieros.</p> <p>(Ver el documento, "Diagnóstico de Tecnología Informática", por Pedro Herrera, y objetivos específicos nos. 10 y 11 de la DIP, "Estructurar Presupuesto Y Establecer Sistema Para Vigilar Su Ejecución Y Control", por Samuel Dickerman.)</p>
	<p>IV.B. No existe una capacidad para mantener los equipos y para capacitar personal a nivel central y regional en el uso de los equipos y paquetes básicos.</p>	<p>IV.B.1 Identificar la entidad responsable para realizar estas funciones.</p> <p>IV.B.2 Crear los puestos necesarios y nombrar el personal calificado para llevar a cabo estas funciones. (ver documentos "Capacidades y Funciones del MSP en Informática" y "Perfiles del Personal Necesario en el MSP en Informática").</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<p>V. <u>Tecnologías en Salud</u></p>	<p>V.A. Altas tasas de mortalidad por IRAs.</p>	<p>V.A.1 Apoyar el Tratamiento Comunitario de las Neumonias por personal comunitario capacitado (ver informe Plan para la Implementación a Nivel Nacional del Tratamiento de la Neumonias por Personal Comunitario).</p> <p>V.A.2 Ejecutar el plan de comunicación existente al nivel local.</p> <p>V.A.3 Seguir apoyando la participación comunitaria en la vigilancia de su salud (ver informe "Vigilancia Comunitaria de los Niños Menores de Cinco Años y de las Mujeres en Edad Fértil).</p>
	<p>V.B. Altas tasas de mortalidad por enfermedades diarreicas.</p>	<p>V.B.1 Apoyar y fortalecer el proceso de las Unidades de Rehidratación Oral Comunitarias (UROCs).</p> <p>V.B.2 Continuar ampliando la cobertura poblacional de acceso a agua potable.</p> <p>V.B.3. Continuar la educación sanitaria poblacional a través de medios masivos.</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
	<p>V.C. Altas tasas de transmisión del VIH.</p>	<p>V.C.1 Implantar una estrategia de prevención que abarca:</p> <ul style="list-style-type: none"> - El control y prevención de las ETS; - Mercadeo Social del Condón; - Comunicación para efectuar cambios de comportamiento sexual en la población. <p>(Ver documento "Síntesis en Español de las Recomendaciones del Proyecto AIDSCAP a la Misión de la USAID/Honduras y "El Estudio del Impacto Socio-económico del VIH/SIDA en Tegucigalpa y San Pedro Sula").</p>

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HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
	<p>V.D. Altas tasas de mortalidad materna y fecundidad; patrones culturales que promueven familias grandes.</p>	<p>V.D.1 Formular una política del MSP de espaciamiento de embarazos dentro de un marco de salud reproductiva.</p> <p>V.D.2 Promover la participación multi-institucional en este proceso.</p> <p>V.D.3 Desarrollar y ejecutar un plan de comunicación en la salud reproductiva dirigido al personal institucional y a la población en general.</p> <p>V.D.4 Ejecutar las recomendaciones de la "Propuesta para la Incorporación del Espaciamiento de Embarazos bajo el Enfoque de Riesgo Reproductivo en la Curricula de las Escuelas Formadoras de Recursos en Salud".</p>

HEALTH SECTOR II
Issues Matrix

AREA DE ACCION	SITUACION	ESTRATEGIAS
<p>VI. <u>Agua Potable y Saneamiento</u></p>	<p>A. Los programas de Salud Ambiental del Ministerio de Salud no están trabajando con la efectividad deseada. Hay duplicidad de esfuerzo y recursos mal utilizados.</p>	<p>A.1 Consolidación de los programas de Salud Ambiental del MSP.</p> <p>A.2 Establecer una dirección más formal entre los niveles centrales, regionales, y de área en salud ambiental.</p> <p>A.3 Creación del Técnico de Salud Ambiental</p>
	<p>B. El SANAA labora de una forma ineficiente y mezcla sus dos funciones de "empresa de agua" y "ente normativo rector del sector agua y saneamiento".</p>	<p>B.1 Re-estructuración del SANAA para crear una subgerencia de ente rector y otra de operación de acueductos.</p> <p>B.2 Creación de Oficinas Regionales.</p> <p>B.3 Re-definir el papel de OMUR (Operación y Mantenimiento Urbano Rural/SANAA) para asegurar la buena operación y mantenimiento de los acueductos rurales y apoyar las Juntas de Agua.</p>

USAID/HONDURAS
MEMORANDUM



DATE : August 5, 1994
TO : Elena Brineman, DMD
FROM : Laurie Loux, HRD/POP *LL*
SUBJECT : TA Plans of the MOH
THROUGH : Emily Leonard, HRD *EL*

Attached is the latest draft of the TA plans for the MOH. We have received reports from all pertinent areas, and have translated these reports into the attached format in order to clearly delineate what each department wishes to accomplish with TA.

cc: ELeonard, HRD
DLosk, HRD/HPN
STerrell, HRD/HPN
RHicks, HRD/HPN
TJohnson, DF

epf

August 10, 1994, 9:30am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>Salud Ambiental</u>	Capacidad del Ministerio de reaccionar a emergencias causadas por fenomenos ambientales es limitada.	Formación de comisiones regionales de emergencia.	Se requieren 2 asesores durante 12 meses. Los asesores desarrollarán dos talleres a nivel central y uno por región para: 1) Establecer metodologías de trabajo para enfrentar emergencias ambientales (brotes de cólera, malaria, inundaciones, etc.) 2) Establecer comisiones regionales permanentes con responsabilidad específica de responder a emergencias. <u>Contraparte</u> Dr. Alejandro Melara, Dirección Atención al Medio

August 10, 1994, 9:30am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>Salud Ambiental</u>	Los servicios de salud ambiental del Ministerio estan disgregados causando una enorme duplicación de esfuerzos. Se requiere una integración de los servicios de salud ambiental.	Creación de una estructura integrada de salud ambiental tanto a nivel central como a nivel regional. Creación de un perfil de funciones del nuevo técnico de salud ambiental.	Se requiere 1 asesor durante 6 meses, y 1 asesor que realice tres visitas de dos semanas cada una. Se elaborará el esquema institucional de Atención al Medio tanto a nivel central como a nivel regional. Se elaborará un perfil de funciones del nuevo técnico de salud ambiental, y se desarrollará el curriculum de una serie de cursos para re-capacitar a personal del Ministerio que actualmente labora en las distintas esferas de salud ambiental. <u>Contraparte</u> Dr. Alejandro Melara, Dirección Atención al Medio

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August 10, 1994, 9:30am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>Salud Ambiental</u>	El Ministerio carece de un sistema de información epidemiológica ambiental para permitir decisiones oportunas.	Se elaborará un esquema básico que indique a) la información a ser recogida, b) el procesamiento y distribución de la información	Se requiere una asesoría de 1 persona por tres meses El asesor analizará la información ambiental que actualmente se está recogiendo y determinará que otra se requiere. Elaborará metodologías para la recolección de información, procesamiento de la misma, y distribución a los niveles de decisión. <u>Contraparte</u> Dr. Alejandro Melara, Dirección Atención al Medio

August 5, 1994, 9:31am

EL PLAN DE COOPERACION TECNICA
 POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>CONTROL DE LAS ENFERMEDADES DIARREICAS</u> (incluyendo cólera)</p>	<p>Alta incidencia de diarreas debido a la contaminación del agua doméstica.</p>	<p>Un estudio de mercadeo para identificar el potencial para el mercadeo social de cloro y jabón para la prevención del cólera y otras enfermedades diarreicas.</p>	<p>2 semanas para revisar datos existentes (cuantitativos y cualitativos) y entrevistar a los productores.</p> <p>4 semanas para realizar investigaciones formativas sobre los comportamientos esenciales para una estrategia de mercadeo.</p> <p>4 semanas para identificar y ensayar materiales promocionales.</p> <p>4 semanas para elaborar estrategias de mercadeo.</p> <p><u>Contraparte</u> Dra. Rosa Kafati Dra. Fanny Mejía</p>

August 5, 1994, 9:43am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>CONTROL DE LAS ENFERMEDADES DIARREICAS</u> (incluyendo cólera)</p>	<p>Alta tasa de letalidad del cólera en las comunidades de difícil acceso a los centros de salud.</p>	<p>Diseño de una estrategia para el establecimiento exitoso de Unidades de Rehidratación Orales Comunitarias (UROC's) en las comunidades de difícil acceso, incluyendo la metodología de la evaluación del mismo.</p>	<p>3 semanas para evaluar la información existente y hacer visitas al campo. (Del 15 de agosto al 15 de septiembre de 1994).</p> <p>1 semana para la preparación de una guía. (Del 15 al 30 de agosto de 1994).</p> <p>2 semanas para una visita de seguimiento del proceso. (6-8 meses después).</p> <p><u>Contraparte</u> Dra. R. Kafati</p>

August 5, 1994, 9:35am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>INFECCIONES RESPIRATORIAS AGUDAS</u>	Alta mortalidad por IRAs debido a la respuesta inadecuada por parte del personal institucional.	Evaluación con análisis detallado del impacto de la capacitación institucional en el manejo de casos, incluyendo recomendaciones para mejorar las destrezas y conocimientos relevantes.	2 Semanas para analizar datos del "post-test" con la contraparte nacional y preparar un informe para discutir con las regiones. 2 semanas para visitar las regiones para discutir los resultados y organizar un taller inter-regional. 1 semana para preparar el informe final conteniendo las recomendaciones y compromisos adaptados por las regiones. 2 semanas (6 meses después) para una visita de seguimiento de la implantación de las recomendaciones. <u>Contraparte</u> Dr. Jorge Melendez

August 5, 1994, 9:41am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>INFECCIONES RESPIRATORIAS AGUDAS</u></p>	<p>Alta mortalidad por IRAs en la comunidad, especialmente en las áreas de difícil acceso a los centros de salud.</p>	<p>Evaluación del estudio piloto del manejo comunitario de las neumonías con recomendaciones para su replicación en otras áreas remotas del país.</p>	<p>2 semanas para evaluar el desempeño de los supervisores y personal comunitario</p> <p>2 semanas (4 meses después) para revisar lo mismo y: 1) hacer un análisis preliminar del impacto en la mortalidad, y 2) hacer recomendaciones escritas específicas para modificar la metodología para ser aplicada en otras áreas.</p> <p>3 semanas (meses después) para hacer un análisis final de los resultados incluyendo el impacto en la mortalidad. Discutir los resultados con personal nacional en un taller del "Estado del Arte" con expertos internacionales.</p> <p>2. semanas (6 meses después) para evaluar la sostenibilidad de la estrategia.</p>

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August 9, 1994, 8:31am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>ATENCION A LA MUJER</u>	Altas tasas de mortalidad materna y perinatal.	Diseñar un Protocolo de Anticoncepción post-parto a nivel hospitalario incluyendo una metodología de monitoreo y evaluación de la actividad.	<ul style="list-style-type: none">- Una semana para el diseño del Protocolo. (5-9 de septiembre de 1994).- Dos semanas para la capacitación del personal. (12-23 de septiembre de 1994).- Dos semanas para el diseño del sistema de monitoreo y evaluación de la actividad incluyendo los requisitos para un programa para el manejo computarizado de la información. (26-30 de septiembre de 1994).- Dos semanas para una visita de seguimiento para evaluar la actividad con el equipo nacional. <p><u>Contraparte</u> Dra. Mirtha Lorena Ponce de Ponce</p>

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**EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II**

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>ATENCION A LA MUJER</u>	Falta de coherencia entre las escuelas formadores profesionales y la practica y necesidades del MSP en Planificación Familiar.	Nuevas curriculas en la practica de planificación familiar bajo el enfoque del riesgo reproductivo en las escuelas formadores de profesionales en salud y medicina (Ver inform: "Propuesta para la Incorporación del Espaciamiento de Embarazos Bajo el Enfoque de Riesgo Reproductivo en la Curricula de las Escuelas Formadoras de Recursos en Salud").	<p>Una visita de 2 semanas para visitar las escuelas y conocer sus curriculas y personas responsables.</p> <p>Una visita de 4 semanas para trabajar con los técnicos nacionales en la revisión de las curriculas.</p> <p>Una visita de 2 semanas 8-12 meses después para evaluar las nuevas curriculas.</p> <p><u>Contraparte</u> Dra. Mirtha Lorena Ponce de Ponce, DMI Dr. Jorge Medina, Recursos Humanos</p>

August 4, 1994, 11:40am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>ATENCION INTEGRAL DEL NIÑO (POSAIN)</u> COMUNICACION SOCIAL</p>	<p>Falta de un plan de comunicación sobre atención integral del niño que apoye el desarrollo de la Propuesta de Capacitación para personal institucional y comunitario.</p>	<p>Desarrollo de un plan de comunicación sobre atención integral del niño para personal institucional y comunitario, que mejore los conocimientos, aptitudes y prácticas para un adecuado crecimiento y desarrollo del niño.</p>	<p>2 semanas (1 en el campo hablando con el personal de las regiones, áreas y CESARes donde se ha ejecutado el POSAIN y una con el equipo nacional), para elaborar un borrador de la propuesta junto con la DES. (Agosto, 1994).</p> <p>20 semanas para observar el proceso en el campo, identificar comportamiento, variables, audiencia blanca e identificar necesidades para evaluación formativa. (1o. de febrero de 1995)</p> <p>8 semanas para revisar evaluaciones formativas y otra información, diseñar estrategia, mensajes y medios. (1o. de junio de 1995).</p> <p>10 semanas para participar en la elaboración y validación de materiales. (1o. de agosto de 1995).</p> <p><u>Contraparte</u> Dr. Carlos Villalobos Dra. Fanny Mejía</p>

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>ATENCION INTEGRAL DEL NIÑO (POSAIN)</u></p> <p>Capacitación.</p>	<p>Desconocimiento de la Propuesta de Atención Integral del Niño Menor de 5 Años a Nivel Nacional</p>	<p>Elaboración e implementación de una guía de capacitación sobre atención integral del niño para el personal institucional y comunitario.</p>	<p>2 semanas para revisar materiales y realizar visitas al campo (septiembre, 1994).</p> <p>4 semanas para elaborar una estrategia de capacitación con guías para el personal. Tal estrategia incluirá la metodología para su evaluación (octubre, 1994)</p> <p>3 semanas (10-12 meses después) para participar en la evaluación y revisión de las guías (julio, 1995).</p> <p><u>Contraparte</u> Dr. Carlos Villalobos Lic. Alba Lidia Sánchez</p>

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August 1, 1994, 5:49pm

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>COMUNICACION EN SALUD</u>	Falta de una política clara del rol de la Comunicación en Salud en la estructura y los programas del MSP.	Una política de la Comunicación en Salud ampliamente discutida y aprobada por el nivel político.	2 semanas para: - preparación de los documentos de discusión; - realizar un taller de un día con el nivel político; - preparar los documentos finales. <u>Contraparte</u> Dra. Fanny Mejía

August 5, 1994, 8:31am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DEL TRABAJO
<u>COMUNICACION SOCIAL</u>	Existe una idea equivocada de que SRO/TRO sólo es apropiado para niños, por lo cual adultos con cólera no lo utilizan	Una revisión de la estrategia actual de comunicación para el programa ampliado de diarrea/cólera, que identifica mensajes y medios para promover SRO/TRO entre adultos con cólera	Una semana con el equipo nacional para revisar plan, analizar comportamientos para modificar, identificar mensajes y sugerir medios para comunicarlos. <u>Contraparte</u> Dra. Fanny Mejía Dra. Rosa Kaffati

August 1, 1994, 5:49pm

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>VIH/SIDA</u>	Alta transmisión sexual del VIH.	Ver Plan Detallado de Implementación del AIDSCAP.	Ver Plan Detallado de Implementación del AIDSCAP. <u>Contraparte</u> Dr. Jorge Fernandez

August 1, 1994, 5:51pm

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>SISTEMA DE INFORMACION GERENCIAL</u></p>	<p>Un control inadecuado de la ejecución del presupuesto y desarrollo incompleto del Sistema de Información Financiera.</p>	<p>Implantación del Programa MUNIS instalado en una red de computadoras en el nivel central con personal técnico capacitado en su uso.</p> <p>Apoyo del Plan de Implementación de Adquisición de equipo y capacitación del recurso humano.</p>	<p>Asesoría Técnica Nacional para la elaboración de un Estudio de Factibilidad para emitir la propuesta final.</p> <p>Licitación y contratación de una(s) entidad(es) para realizar: 1) la instalación de la red, y 2) la instalación del sistema MUNIS.</p> <p>Taller o cursos de capacitación del recurso humano en técnicas computarizadas y de mantenimiento preventivo del equipo.</p> <p><u>Contraparte</u> Roberto Rivera, Admin.</p>

August 5, 1994, 9:53am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>SISTEMA DE INFORMACION GERENCIAL</u>	Un sistema de información que esta subutilizada en la toma de decisiones.	Un análisis de las necesidades para información en la toma de decisiones a cada nivel. Una adecuación de los subsistemas de; 1) Atenciones, 2) Vigilancia Epidemiológica y 3) Estadísticas de Población. Un proceso para balancear las necesidades de los programas para información con la capacidad para recolectarla del nivel local.	Ver propuesta para una actividad bajo el proyecto "Data for Decision Making". <u>Contraparte</u> Div. de Epidemiología Depto. de Estadística

August 5, 1994, 9:58am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>SISTEMA DE INFORMACION GERENCIAL</u>	La necesidad de tener datos del impacto en la población (fecundidad, mortalidad, etc.) que solamente se realiza a través de encuestas periódicas.	Informes de la encuesta.	Visitas periódicas para apoyar el equipo nacional en: <ul style="list-style-type: none">- selección de la muestra- definición de necesidades para información- diseño del cuestionario- control de calidad- análisis de los datos- preparación de los informes <u>Contraparte</u> Dr. Enrique Zelaya

August 5, 1994, 10:00am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>LOGISTICA</u>	Un control inadecuado de las entradas y salidas de los almacenes.	Un sistema computarizado de control de entradas y salidas instalado con personal capacitado en su uso.	Contratar una compana nacional para adoptar un paquete comercial a las necesidades del MSP, según los lineamientos en el informe "Definición de los Sistemas de Registro de Entradas, Salidas y Existencias a Nivel Regional y de Areas". <u>Contraparte</u> Lic. Geraldina Sanchez Dra. Daisy Ramos

August 5, 1994, 10:02am

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>LOGISTICA</u>	Necesidad de un monitoreo continuo del proceso de la administración de suministros para detectar y corregir fallas.	Un sistema de monitoreo del proceso implantado, incluyendo normas de evaluación y control y sus mecanismos de implementación.	Contratar una entidad local para realizar, con el contraparte, un análisis de las etapas del proceso y la elaboración de un sistema de información y control. El contratista realizará una evaluación de la implementación del proceso después de una plaza de 8-10 meses. <u>Contraparte</u> Lic. Geraldina Sanchez Dra. Daisy Ramos

August 1, 1994, 5:47pm

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>FINANZAS:</u> Alternativas de financiamiento a través de farmacias populares</p>	<p>Insuficiente abastecimiento de medicamentos oportunamente y a bajo costo y la necesidad de ingresos a nivel local.</p>	<p>Evaluación a través de un informe de la experiencia nacional con farmacias populares y fondos comunales de medicamentos. Evaluación escrita de la experiencia nacional con fondos comunales de medicamentos.</p> <p>Un taller nacional para discutir los hallazgos y recomendaciones de la evaluación con informe final.</p>	<p>1 semana con el equipo nacional para planificar la metodología.</p> <p>4 semanas para el trabajo de campo con el contraparte y para escribir el informe.</p> <p>2 semanas para planificar y realizar el taller y para escribir el informe final.</p> <p>2 jornadas de 2 semanas cada una para seguir la implantación de las recomendaciones finales acordados en el taller.</p> <p><u>Contraparte</u> Lic. Lilian Fúnez Lic. Jorge Cano Lic. Roberto Rivera Lic. Adán Barahona</p>

August 1, 1994, 5:47pm

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>FINANZAS:</u> Fondos Recuperados</p>	<p>Necesidad de implantar un sistema de Fondos Recuperados incluyendo el control del gasto.</p> <p>Falta de seguimiento a la revisión de información de la implantación de cuotas del estudio del sistema de Fondos Recuperados.</p>	<p>Realizar un taller con las regiones sanitarias y centros hospitalarios que se han determinado como Areas Experimentales del Proceso del Sistema de Fondos Recuperados (3 ó 4 días).</p> <p>Elaboración del informe de los resultados de una investigación del campo del funcionamiento del sistema de fondos recuperados incluyendo su funcionamiento y su contribución al sistema de salud.</p>	<p>Contratación de una entidad local para planificar y como apoyo logístico y de seguimiento en la aplicación de metodologías y compromisos antes, durante y después del taller.</p> <p>Realizar una evaluación de campo por un grupo de trabajo conformado por la División de Finanzas y de Planificación y la Dirección Administrativa.</p> <p><u>Contraparte</u> R. Rivera, Admin. J. Cano, Fondos Recuperados</p>

EL PLAN DE COOPERACION TECNICA
 POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<p><u>RECURSOS HUMANOS</u></p>	<p>Falta de conocimiento y apreciación por parte del personal de salud, sobre las actitudes de la población hacia los servicios.</p>	<p>Un estudio del mercado realizado en cada región sobre las actitudes de los usuarios hacia los servicios de salud.</p> <p>Un informe resumen de los resultados de los estudios con recomendaciones específicas para mejorar la relación entre el MSP y la comunidad a nivel local.</p>	<p>1 semana para orientar a los facilitadores del MSP en estudios del mercado.</p> <p>1 semana para realizar un taller con los equipos regionales y los facilitadores para diseñar los estudios regionales.</p> <p>2 semanas para realizar un taller de análisis de los resultados de los estudios regionales y para elaborar una síntesis de los resultados con recomendaciones para ser discutidos en un taller nacional.</p> <p><u>Contraparte</u> Dirección de Planificación División de Recursos Humanos</p>

EL PLAN DE COOPERACION TECNICA
POR PARTE DEL PROYECTO SECTOR SALUD II

AREA DE ACCION	SITUACION	RESULTADO(S) Y/O PRODUCTO(S) ESPERADO DE LA COOPERACION	RESUMEN DE LA METODOLOGIA DE TRABAJO
<u>RECURSOS HUMANOS</u>	<p>Accesibilidad limitada de los grupos más postergados en la atención a la salud debido a:</p> <p>1) Falta de ejecución adecuada de los sistemas de salud a nivel local; y</p> <p>2) Falta de dirección y coordinación en el proceso de capacitación en apoyo a la administración local.</p>	Planes regionales de la adecuación de los recursos humanos a nivel local.	<p>2 semanas/región para realizar la logística para 9 talleres regionales para elaborar los planes e identificar las necesidades para poder brindar asistencia y cooperación técnica a cada región.</p> <p>2 semanas/región (3 meses después) para monitorear la ejecución de los planes y preparar informes con recomendaciones.</p> <p>3 semanas para realizar un taller nacional (Ver 4.3 adjunto).</p> <p>4 semanas/región para proporcionar la asistencia técnica identificada en el taller nacional.</p> <p><u>Contraparte</u> Dir. de Planificación Div. de Recursos Humanos</p>

IMPLEMENTATION PLAN AND SCHEDULE

AREA OF ACTION	TASK/ PRODUCT	DESCRIPTION OF WORK	APPROX. START DATE	TIME REQ'D.	ESTIMATED COST	SOURCE/MEANS OF PROCUREMENT	COMMENTS
Environmental Health	Design of Environmental Health Information System	Analysis of existing environmental health epidemiological information. Design of collection, analysis, and distribution of environmental health data.	12/1/94	3 months	\$9,000	Local P.O.	
Environmental Health	Design of Quick Response System for Environmental Health Emergencies	Establishment of work methodologies for responding to environmental health emergencies. Creation of emergency committees in each health region.	12/1/94	12 months	\$72,000	Local P.O.	
Environmental Health	Design of Environmental Health Organizational Structure Within the MOH	Review of existing organizational structure of all environmental health activities within the MOH. Design of a functional Office of Environmental Health. Define scope of work and training curriculum for environmental health technician.	11/1/94	6 months	\$48,000	Local P.O. and PASA	Local consultant will work with organizational structure. PASA consultant will develop scope of work and training curriculum for environmental health technician.

1/1/94

AREA OF ACTION	TASK/PRODUCT	DESCRIPTION OF WORK	APPROX. START DATE	TIME REQ'D.	ESTIMATED COST	SOURCE/MEANS OF PROCUREMENT	COMMENTS
Diarrhea Control		Design strategy to improve success of community ORT units	10/15/94	7 weeks	36,000	BASICS	Review implementation of strategy 6-8 months later
Diarrhea Control	Study and resulting strategy	Marketing study to identify potential of social marketing of chlorine and soap; develop strategy	10/15/94	14 weeks	25,000	BASICS	Basics will contract local personnel to do bulk of work
Reproductive Health	Curriculum	Develop Curriculum	01/15/94	2 months	40,000	Buy-in	
Reproductive Health	Logistics	Control	11/15/94	10 weeks	13,000	Local P.O.	
Reproductive Health	Protocol	Protocol	11/15/94	2 months	40,000	Buy-in	

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AREA OF ACTION	TASK/ PRODUCT	DESCRIPTION OF WORK	APPROX. START DATE	TIME REQ'D.	ESTIMATED COST	SOURCE/MEANS OF PROCUREMENT	COMMENTS
Human Resource Development	HRD plans; workshops to elaborate plans; technical assistance	Develop regional plans for the strengthening of human resources at the local level	1) 11/15/94	1 month	5,000	Local P.O.	
			2) 01/15/94	66 weeks	75,000		
Health Education and Promotion	Analysis; workshop; final report	Prepare health communication policy	02/15/94	1 week	2,500	BASICS	
Breastfeeding Growth Monitoring	Analysis; trng. strategy; evaluate results and revise training program	Train personnel responsible for imp. of POSAIN program	10/15/94	6 weeks	7,500	BASICS	Evaluation 10-12 months after initial training
Health Education	SRO/TRO Strategy for Adults	Design Strategy	11/15/94	1 week	2,500	BASICS	
Breastfeeding Growth Monitoring		Develop a communication strategy to strengthen/expand POSAIN	01/15/94	8 weeks	9,500	BASICS	
ARIs	Report of evaluation findings	Evaluate institutional training program for managing ARI cases	10/15/94	7 weeks	18,000	BASICS	Review implementation of evaluation finding six months later
ARIs		Evaluate community management pilot program	10/15/94	9 weeks	40,000	BASICS	Review implementation of evaluation finding six months later

AREA OF ACTION	TASK/ PRODUCT	DESCRIPTION OF WORK	APPROX. START DATE	TIME REQ'D.	ESTIMATED COST	SOURCE/MEANS OF PROCUREMENT	COMMENTS
Finances	Written Eva. and Workshop	Eval. of alts. for financing of low cost medicines	11/15/94	11 Weeks	\$15,000	Local P.O.	
Finances	Workshop and Written Report	Study of revolving funds	10/15/94	6 Weeks	5,000	Local P.O.	
Logistics	Adapt commercial computer software	Develop logistics control system and train personnel	11/1/94	1 Year	20,000	Local P.O.	In line with report, "Def. of Systems of Entry & Departure Registration"
Logistics	Develop system of information and control and evaluate system after use	Develop monitoring system	11/15/94	8 Weeks	10,000	Local P.O.	Evaluate system after period of 8-10 months
HIV/AIDS	See DIP	See DIP	10/1/94	2 Years	1,600,000	Contract with AIDSCAP Project	
MIS		Analyze info. needs; develop program to strengthen MIS capabilities	12/1/94	1 Years	200,000	DDM Buy-in	See, "Data for Decision Making Proposal" and "Analysis of Information Technology"
MIS	EFHS	Develop survey instruments; improve data analysis and report preparation	10/15/94	6	120,000	Buy-in or PASA	Periodic visits to assist MOH team
MIS	Feasibility study; install system; acquire equipment; train personnel	Install MUNIS program and train personnel	9/15/94; 11/15/94	1 month 15 months	5,000 140,000	Local P.O. Local P.O. and Equipment	Includes commodity procurement (\$100,000)

10/15/94

HEALTH SECTOR II PROCUREMENT PLAN (FY 95)

ELEMENT	DESCRIPTION	ESTIMATED COST	SOURCE/ ORIGIN	TYPE OF PROCUREMENT	DATE PIO IN O/CM OR AID/W	DATE ACTION CONTRACTED	PURCHASE AGENT (CURRENCY)
I. HOST COUNTRY							
A. COMMODITIES							
1	OFFICE SUPPLIES AND FILING CABINETS FOR HEALTH CENTER MANAGEMENT SYSTEMS	\$135,000	CACM/000	HOST COUNTRY	N/A	VARIOUS	MOH SANITARY REGIONS (ROTATING FUNDS; LEMPIRAS)
3	MATERIALS & SUPPLIES FOR REPAIRING MOH HEALTH CENTERS	\$135,000	CACM/000	HOST COUNTRY	N/A	VARIOUS	MOH SANITARY REGIONS (MOH ROTATING FUNDS; LEMPIRAS)
9	SPARE PARTS FOR REFRIGERATORS USED IN MOH COLD CHAIN	\$21,000	CACM/941 (SWEDEN)	HOST COUNTRY	N/A	VARIOUS	MOH SANITARY REGIONS (MOH ROTATING FUNDS; LEMPIRAS)
15	CONSTRUCTION MATERIALS FOR SANAA/AID RURAL WATER & SANITATION PROGRAM	\$200,000	CACM/000	HOST COUNTRY	N/A	VARIOUS	SANAA/AID (ROTATING FUND; LEMPIRAS)
I. HOST COUNTRY							
B. SERVICES							
3	REPAIR & PREVENTITIVE MAINTENANCE OF PROJECT VEHICLES	\$139,000	CACM/000	HOST COUNTRY	N/A	VARIOUS	MOH SANITARY REGIONS (MOH ROTATING FUNDS; LEMPIRAS)
7	PRINTING CONTRACTS FOR EDUCATIONAL/ PROMOTIONAL MATERIALS	\$125,000	CACM	HOST COUNTRY	N/A	VARIOUS	MOH (MOF ROTATING FUND; LEMPIRAS)
17	PROJECT ADMINISTRATIVE PERSONNEL (MOH)	\$50,000	CACM	HOST COUNTRY	N/A	VARIOUS	MOH (MOF ROTATING FUND; LEMPIRAS)

ELEMENT	DESCRIPTION	ESTIMATED COST	SOURCE/ ORIGIN	TYPE OF PROCUREMENT	DATE PIO IN O/CM OR AID/W	DATE ACTION CONTRACTED	PURCHASE AGENT (CURRENCY) NOTES
	II. USAID/II (O/CM)						
	B. SERVICES						
	I. MANAGEMENT INFO. SYSTEMS (ONE ACTION)	\$92,000					
2	a. TA FOR WAREHOUSE MIS (ADAPT COMMERCIAL SOFTWARE)	\$20,000	CACM	INFORMAL COMPETITION	12/1/94	1/25/95	USAID/II (LEMPIRAS) I. POTENTIAL SOURCES: A. EA ASSOCIATES B. DDM (DIANA CARCAMO) C. PRICE WATERHOUSE
2	b. TA FOR WAREHOUSE MIS (DEVELOP MONITORING SYSTEM)	\$10,000					
4	c. TA FOR EXECUTING FINANCIAL MIS DIP	\$25,000					
4	d. TA FOR INSTALLATION & MAINTENANCE OF COMPUTER EQUIP.	\$15,000					
15	e. TA FOR ENVIRON. HEALTH MIS	\$9,000					
11	f. TA TO IMPROVE LOGISTICS FOR CONTRACEPTIVES	\$13,000	CACM				USAID/II (US\$)
	2. ORGANIZATIONAL/MANAGERIAL (ONE ACTION)	\$102,500					
6	a. TA FOR ALTERNATIVES FOR FINANCING LOW COST MEDICINES	\$15,000	CACM	INFORMAL COMPETITION	10/15/94	11/29/94	USAID/II (LEMPIRAS) I. POTENTIAL SOURCES: A. GEMAH B. CADERH C. ESA
6	b. TA FOR STUDY OF RETAINED REVENUES	\$7,500					
5	c. TA FOR DEVELOPING REGIONAL PLANS FOR STRENGTHENING HUMAN RESOURCES AT THE LOCAL LEVEL	\$5,000					
5	d. TA FOR DEVELOPING HUMAN RESOURCES AT THE LOCAL LEVEL	\$75,000					
4	3. TA FOR FINANCIAL MIS DIP	\$5,000	CACM	INFORMAL COMPETITION	9/16/94	10/7/94	USAID/II (LEMPIRAS)
15	4. TA FOR ENVIRON HEALTH RAPID RESPONSE SYSTEM	\$72,000	CACM	INFORMAL COMPETITION	12/1/94	1/25/95	USAID/II (LEMPIRAS) 2 PEOPLE FOR 1 YEAR EACH
15	5. TA FOR ENVIRON HEALTH ORGANIZATIONAL STRUCTURE IN MOH	\$18,000	CACM	INFORMAL COMPETITION	11/1/94	11/25/94	USAID/II (LEMPIRAS) 1 PERSON FOR SIX MONTHS
17	6. PROJECT ADMIN./TECH. PERSONNEL (IIRD)	\$150,000	CACM&(000)	USPSC, FSNPSC	6/1/95	8/1/95	USAID/II (US\$ LEMPIRAS)

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ELEMENT	DESCRIPTION	ESTIMATED COST	SOURCE/ ORIGIN	TYPE OF PROCUREMENT	DATE PIO IN O/CM OR AID/W	DATE ACTION CONTRACTED	PURCHASE AGENT (CURRENCY)
	II. USAID/H (O/CM)						
	A. COMMODITIES						
1 AND 14	VEHICLE SPARE PARTS	\$478,000	000	FORMAL COMPETITION	9/23/94	12/15/94	USAID/H (US\$)
1 AND 14	MOTORCYCLE SPARE PARTS	\$397,000	000/941 (JAPAN)	FORMAL COMPETITION	8/26/94	11/15/94	USAID/H (US\$)
4	HARDWARE & SOFTWARE FOR FINANCIAL MIS	\$100,000	000	INFORMAL COMPETITION	4/1/95	5/1/95	USAID/H (US\$)
9	REFRIGERATORS FOR MOH COLD CHAIN	\$35,161	000	INFORMAL COMPETITION	10/1/94 AND 6/1/95	11/1/94 AND 7/1/95	USAID/H (US\$)
10	ARI TREATMENT EQUIPMENT FOR 7 AREA HOSPITAL	\$637,664	000	FORMAL COMPETITION	12/1/94	3/15/95	USAID/H (US\$)
12	CLINICAL EQUIPMENT FOR MOH MATERNAL HEALTH PROGRAM	\$40,000	000	INFORMAL COMPETITION	3/15/95	4/15/95	USAID/H (US\$)

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ELEMENT NO.	DESCRIPTION	ESTIMATED COST	SOURCE/ ORIGIN	TYPE OF PROCUREMENT	DATE PIO IN O/CM OR AID/W	DATE ACTION CONTRACTED	PURCHASE AGENT (CURRENCY)
	III USAID/W A. COMMODITIES						
11	CONTRACEPTIVES	\$222,000	000	N/A	11/1/94	12/1/94	USAID/W (US\$)
19	CONDOMS FOR MOH AIDS PREVENTION PROGRAM	\$191,000	000	N/A	11/1/94	12/1/94	USAID/W (US\$)
	III USAID/W B. SERVICES						
	I. BASICS (ONE ACTION)						
7	a TA FOR COMMUNICATION POLICY	\$131,500	000		9/31/94	11/15/94	USAID/W (US\$)
8	b TA TO DEVELOP SRO/ORT COMMUNICATION STRATEGY FOR ADULTS	\$2,500					
10	c TA FOR EVALUATING MOH TRAINING IN ARI CASE MANAGEMENT	\$18,000					
10	d TA FOR EVALUATING COMMUNITY MANAGEMENT OF ARI & PIOT	\$40,000					
8	e TA TO DESIGN STRATEGY FOR IMPROVING SUCCESS OF COMMUNITY ORT UNITS	\$36,000					
8	f TA TO ANALYZE FEASIBILITY OF SOCIAL MARKETING FOR SOAP AND CHLORINE	\$25,000					
12	g TA TO EVALUATE TRAINING STRATEGY FOR POSAIN	\$7,500					
	2. DDM						
4	a TA FOR STRENGTHENING MIS CAPABILITIES	\$200,000	000	BUY-OUT	11/15/94	1/1/95	USAID/W (US\$)
19	3. AIDSCAP						
	A. TA FOR AIDS PREVENTION AND CONTROL	\$1,600,000	000	BUY-IN	9/9/94	12/1/94	USAID/W (US\$)
4	a TA FOR EFHS (EPI & FAMILY HEALTH SURVEYS)	\$120,000	000	BUY-OUT	11/31/94	1/15/95	USAID/W (US\$)
11	b TA TO DEVELOP UNIVERSITY CURRICULUM IN REPRODUCTIVE HEALTH	\$40,000	000	BUY-IN	10/15/94	1/15/94	USAID/W (US\$)
11	c TA TO DEVELOP CONTRACEPTIVE PROTOCOL FOR MOH HOSPITALS	\$40,000	000	BUY-IN	11/1/94	12/1/94	USAID/W (US\$)
17	d MID-TERM PROJECT EVALUATION	\$100,000	000	BUY-IN	9/23/94	11/1/94	USAID/W (US\$)

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MONITORING AND EVALUATION PLAN

I. PROJECT MONITORING

Under the Amendment, project monitoring will be continued by the MOH and USAID project personnel under the established system. In addition, AIDS prevention activities will be monitored under a new information system established under the AIDSCAP program.

1) Information Systems:

(a) Overall Project: The primary objective of the monitoring activity in the Project is to determine if the programmed activities in the Rural Health Centers (CESARES) supported under the project are: (1) being carried out according to plan; (2) to verify the existence and use of goods in compliance with the programmed goals; and (3) to identify and analyze implementation problems at the regional and local levels to serve as the basis of their solution. The responsibility within the MOH for monitoring lies with the "Dirección de Planificación" and the Project Coordination Unit (PCU). The 1991 Interim Project Evaluation found that PCU monitoring efforts needed to be strengthened. The following process resulted from this need.

Monitoring visits to the field are programmed jointly with the MOH at the beginning of the calendar year, and approved at the Vice-Ministerial level. Seven week-long visits are made annually; a visit per month to each health region. The monitoring visit consists of an initial meeting with the regional and area personnel. The purpose of the visit is explained and regional issues are discussed. Eleven CESARES are randomly selected in which the surveys will take place. On the final day of the visit, a meeting takes place with the regional and area personnel to discuss the results of the survey. Together, the group analyzes the problems identified and the regional staff commits to taking the corrective actions agreed upon. The PCU reports the results of the visit to policy level officials within the MOH.

The HRD Monitoring Specialist participates in the entire monitoring process, including the field visits, and is responsible for entering the results into the Mission's information systems: the Logical Framework at the project level, and the Action Plan at the program level.

(b) AIDSCAP: AIDS prevention efforts will be monitored at both the overall Detailed Implementation Plan and the subproject or component levels, and measured at intervention sites. Each subagreement will have a project manager from the Implementing Agency (IA) who is responsible for directing project

activities. The project manager will monitor implementation of his/her respective subproject and submit monthly "Logical Framework Process Indicator Forms (PIF)" to the AIDSCAP Resident Advisor. Indicators on the PIF are from the output level "measurable indicator" column of each subject Logical Framework and are specific to each subproject. Data will be gender-disaggregated to the maximum extent possible. Regular meetings between the Resident Advisor and each project manager will aid monitoring progress, identifying and resolving problems, and adjusting implementation as appropriate. Each project manager will also provide quarterly narrative summaries describing the accomplishments and constraints encountered in implementation during the period, and next steps foreseen for the following period. (See AIDSCAP DIP, Attachment 8, for further information)

(c) A final source of information to be used in assessing the impact of the Project is the periodic Epidemiological and Family Health Survey (EFHS) prepared by the MOH with USAID support under the Health Sector II and Private Sector Population projects. The results of the 1991/92 EFHS have just been published, and the fieldwork for the next survey is scheduled to begin in 1995.

2) Use of Information:

(a) Measuring Program Level Achievements: Project output indicators related to Mission Program Level monitoring will be measured for use in assessing achievement of Strategic Objective No. 3 – Improved Family Health. Indeed, the Project contributes to all three of this Strategic Objective's program outcomes:

- o Increased Percentage of Hondurans Who Practice Effective family Planning;
- o More Effective Child Survival Interventions; and
- o Increased Use of STD/HIV Prevention Practices.

This information will be collected from the project information system annually for reporting to USAID/W in the Mission's Action Plan. Additional information will be periodically obtained from the EFHS. The Mission is also continuing to study possible methodologies which would increase the collection frequency of certain indicators, such as the percentage of women who have made a prenatal visit to a local health center.

(b) Measuring Project Level Achievements: Project level achievements are tracked by project output indicators which are monitored on an ongoing basis. This information is used by the Mission through its inclusion in the Health Sector II Project Status Report prepared as part of the Agency-wide Semi-Annual Review.

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II. PROJECT EVALUATIONS

1) Interim Project Evaluation: Due to the plans for a FY95 project amendment and further extension of the LOP to 1998, an additional interim evaluation of the Project will be conducted in early FY95. The purpose of this evaluation will be twofold: (a) to assess project achievements since the last interim evaluation was completed in September, 1991; and (b) to define the outlines of the planned FY95 project amendment. In this latter sense, the interim evaluation will serve as a critical design input for the final amendment of the Health Sector II Project.

2) Final Project Evaluation: The final evaluation will assess Project results, including whether the Project purpose was achieved, as well as the Project's overall contribution to the Mission's Strategic Objectives. The evaluation will identify all significant Project impacts, including those which may not have been originally envisioned, and any followup activities which could help to sustain the positive effects of the effort. It will specifically address "lessons learned" that may be applicable to related USAID efforts in the health sector. The evaluation will contain a specific component addressing the impact and outcome of AIDS prevention activities, which will be evaluated against a baseline assessment of the AIDS situation in Honduras, conducted by the AIDSCAP program in early FY95. The final evaluation will be conducted at the beginning of the last planned year of the Project.

ATTACHMENT 8

Attachment 8 – AIDSCAP Detailed Implementation Plan (DIP) – can be found in the HRD/HPN office.

**PLAN DETALLADO DE IMPLEMENTACION DEL
PLAN DE APOYO AL PROGRAMA NACIONAL
DE PREVENCION Y CONTROL DE ETS/SIDA**

ABRIL 1994

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I. INTRODUCCION:

El presente documento ha sido elaborado por personal del Ministerio de Salud Pública (MSP), la Misión USAID en Honduras, y el Proyecto de Prevención y Control del SIDA (AIDSCAP) de Family Health International. El propósito del Plan Detallado de Implementación (PDI) es el de puntualizar el diseño del plan de apoyo, los mecanismos de coordinación entre MSP, USAID y AIDSCAP, y las entidades que van a ejecutar las actividades e intervenciones específicas de prevención y control de ETS/SIDA. Asimismo, el plan contempla los aspectos administrativos y logísticos, los requerimientos de asistencia técnica, un presupuesto ilustrativo y las estrategias de sostenibilidad. El PDI se basa en las recomendaciones de AIDSCAP a la Misión USAID/Honduras en agosto de 1993, las prioridades del Ministerio de Salud Pública en cuanto a la prevención y control de ETS/SIDA, y en un esfuerzo conjunto del personal experto de las tres instituciones mencionadas.

Las actividades e intervenciones descritas en este plan han sido cuidadosamente seleccionadas para complementar la programación de la División de ETS/SIDA del MSP, y los esfuerzos de otras dependencias estatales, organizaciones no gubernamentales (ONGs) y de otras agencias donantes. El PDI enfoca la reducción de la transmisión sexual del Virus de Inmunodeficiencia Humana (VIH) por medio de tres estrategias técnicas:

- ▶(' \$2Mejoramiento del diagnóstico y tratamiento de ETS.
- ▶(' \$2Comunicación para Cambios de Comportamiento (CCC).
- ▶(' \$2Mejoramiento de la disponibilidad y el uso correcto y consistente de condones.

Los objetivos básicos del PDI pretenderán (1) aumentar el reconocimiento del problema del VIH/SIDA/ETS a todos los niveles para generar apoyo y recursos que permitan la ejecución de intervenciones sostenibles de prevención, (2) aumentar el acceso de la población blanco a los servicios de prevención de VIH/SIDA/ETS, y (3) fortalecer la capacidad de las comunidades e instituciones locales para llevar a cabo programas de prevención de VIH/SIDA/ETS.

Para cumplir con los objetivos descritos, el Plan Estratégico de Prevención VIH/SIDA elaborado por AIDSCAP en 1993 identificó, juntamente con expertos del MSP, tres grupos de población blanco concentrados en cuatro áreas geográficas específicas. Una serie de intervenciones focalizadas se desarrollarán para atender las necesidades de estos grupos de población en las Regiones Metropolitana (Tegucigalpa), #2 (Comayagua), #3 (San Pedro Sula) y #6 (La Ceiba). Las poblaciones blanco seleccionadas son las siguientes:

1. Personas en el Lugar de Trabajo (PLT: adolescentes,

hombres y mujeres, incluyendo amas de casa)

2. Grupos Nucleares (Trabajadores del Sexo (TS) y su Clientes y Hombres que tienen sexo con Hombres (HCH))
3. Población Garífuna

En virtud de que las intervenciones en estas poblaciones dependen de la disponibilidad oportuna y permanente de preservativos y medicamentos esenciales para prevenir la dispersión de la infección por VIH/SIDA/ETS, el PDI incluye también actividades de mercadeo social de preservativos y manejo logístico que son indispensables para la ejecución efectiva del PDI. Asimismo, todas las intervenciones serán apoyadas y complementadas por medio de la identificación de oportunidades de desarrollo institucional, gestión política, iniciativas con el sector privado e investigación operativa.

Uno de los enfoques principales del Plan de Apoyo al Programa Nacional de Control y Prevención del SIDA será el fortalecimiento de la capacidad de varias instituciones e industrias para incorporar actividades de prevención de VIH/SIDA/ETS en la programación y los servicios existentes en la actualidad. Se proporcionará asistencia técnica en todas las fases de diseño del plan, implementación, monitoreo y evaluación. Las actividades de evaluación representarán un componente vital del PDI para facilitar el monitoreo y el ajuste de las intervenciones, optimizar su efectividad, y medir el impacto general del Plan de Apoyo.

Al aprobarse ^{planes} el Plan Detallado de Implementación, se elaborarán subproyectos o subacuerdos de trabajo para los distintos componentes de PDI con las entidades ejecutoras seleccionadas. Estos subproyectos, ~~que corresponderán con subplanes específicos~~ de implementación para cada una de las cuatro regiones geográficas, incluirán planes, cronogramas y presupuestos de trabajo detallados. La responsabilidad de elaboración de estos subproyectos estará a cargo del MSP ~~juntamente con AIDSCAP.~~ ^{planes}

La administración, el monitoreo y la evaluación del Plan de Apoyo estará a cargo de un Comité Coordinador del Plan de Apoyo (CCPA) representado por el Director de la División de ETS/SIDA, el Asesor Residente de AIDSCAP, un Asesor Técnico de la Misión USAID, y posiblemente representantes de otras instituciones involucradas. A nivel regional se establecerán Sub-Comités Regionales de Coordinación del Plan de Apoyo (SRCPA) consistentes en personal de la Región de Salud, el Asesor Residente AIDSCAP, y representantes de otras entidades ejecutoras o alcaldías municipales. Tanto el MSP como AIDSCAP, el CCPA y los SRCPA formarán parte de la estructura organizativa y coordinadora (ver Section VII Anexo 1) del Programa Nacional de Prevención y Control de SIDA que incluye a la Comisión Nacional del SIDA (COMSIDA) y al Comité de Coordinación Interagencial (CCI). De acuerdo al progreso y a la

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información y retroalimentación de los subproyectos, el CCPA, en consulta con las entidades ejecutoras y sub-comités regionales, refinarán la administración e implementación del plan permitiendo el fortalecimiento y las modificaciones pertinentes de las estrategias e intervenciones.

El Plan de Apoyo al Programa Nacional de Prevención y Control del SIDA ha sido diseñado para fortalecer la capacidad local para prevenir y controlar el VIH/SIDA/ETS. La Misión USAID en Honduras, a través del Proyecto AIDSCAP, colaborará con el Gobierno de Honduras, las agencias donantes internacionales, organizaciones no gubernamentales y grupos y asociaciones de la comunidad para movilizar recursos y participación comunitaria para ejecutar programas de prevención de VIH/SIDA/ETS. Se espera que por medio de la concentración de esfuerzos y recursos en intervenciones selectas y áreas geográficas limitadas, se desarrollen modelos sostenibles de prevención y control que puedan replicarse y detener la dispersión de la epidemia del SIDA en la población hondureña.

II. PRINCIPAL PROGRAM AREAS

A. PEOPLE IN THE WORK PLACE (PWP)

Description:

The MOH Division of STD/AIDS estimates an HIV seroprevalence for people 15-49 years old at 4% in San Pedro Sula and 1% in Tegucigalpa, and a seroprevalence for the general population at 2% in SPS and 0.5% in Tegucigalpa. Employed people comprise more than 50% of the AIDS case-load in Honduras, particularly in Sanitary Region #3 (SPS), and include working children and youth, men and women. The current health programming for the employed population in Honduras implemented by the Honduran Social Security Institute (IHSS) and company-based private health programs concentrate mainly on medical care. The fact that HIV/AIDS affects people in their most economically productive years supports the implementation and institutionalization of effective HIV/AIDS prevention programs in the work place.

It is estimated that women represent the largest working subgroup (70-80%) at the industrial park communities or Zonas Industriales de Producción (ZIP), which enclose many garment factories called Maquiladoras. Per the Honduran Social Security Institute and two of the major ZIPs (Municipalities of Choloma and Villanueva), 20% of these women are single with no children, 40% are single mothers who frequently engage in serial monogamy, and 40% are married. Hence, the traditional burden of women as housewives in Honduras is now compounded by working responsibilities outside of their homes.

A focus on PWP affords the opportunity for addressing the needs of women and other working subgroups, and building private-sector support for HIV/AIDS/STD prevention programs. This component of

the "Plan de Apoyo" will initially reach target groups at maquiladoras and other industries (manufacturing, construction and agriculture) through several subprojects in the Municipalities of San Pedro Sula, Choloma, Villa Nueva and La Lima in Sanitary Region #3, and the Municipalities of Ceiba and Tela in Sanitary Region #6. It is estimated that a population of 60,000 workers will be reached, with an indirect impact on the families of PWPs estimated at about 300,000 people distributed throughout Sanitary Regions #3 and #6.

The Plan will integrate interventions in STD diagnosis and treatment services, BCC and condom programming. Interventions for PWPs will emphasize technical assistance to enable the Honduran Social Security Institute, NGOs and private sector industries to develop and maintain their own prevention programs.

The first phase of the PWP component will be initiated in Sanitary Regions #3 and #6 due to their epidemiological importance. Additional sites and/or private sector businesses in Sanitary Regions #2 and Metro will be phased-in once a methodological experience is gained from the interventions in San Pedro Sula and La Ceiba and additional resources are leveraged from private sector enterprises and the IHSS. The effectiveness of this program component will be complemented by an active private sector leveraging effort and the policy promotion activities described in Section IIIB.

Objectives:

- ▶(' \$2Improve perception of risk of HIV/AIDS/STDs transmission and reduce high risk behaviors among adolescents, and women and men in the work place.
- ▶(' \$2Improve STD diagnosis, referral and treatment services.
- ▶(' \$2Increase access to and availability of condoms for targeted groups.

Activities:

Activities in support of the above objectives will build upon previous efforts of the Honduran Social Security Institute (IHSS), and will be extended to NGOs where feasible. Major activities will include:

1. Reduction of the rate of Transmission of STDs:

- ▶(' \$2Identify clinical sites where STD services can be provided for workers, both at and near work sites.
- ▶(' \$2Train health care providers in the work place (medical and paramedical) in HIV/AIDS, risk assessment, counseling and

algorithmic approach to STDs management.

- ▶('\$2Promote a partner referral system to both worksite and external clinical services.
- ▶('\$2Provide technical assistance in HIV/AIDS/STD prevention and control to both the IHSS, NGOs and private enterprises in order to incorporate prevention services with their ongoing activities.

2. Behavior Change Communication:

- ▶('\$2Develop and standardize BCC materials and/or methods to train both implementing agencies and people in the workplace in HIV/AIDS/STD prevention and control.
- ▶('\$2Design and implement BCC interventions at worksites incorporated into social, cultural, recreational and family events.
- ▶('\$2Develop and/or reproduce targeted BCC and promotional materials for HIV/AIDS/STD prevention and control.
- ▶('\$2Train health workers/volunteers and peer leaders to implement interpersonal education programs and peer support for behavior change.
- ▶('\$2Promote consistent and correct use of condoms, and STD knowledge and services at worksites and in other locations accessible to target audience.
- ▶('\$2Increase awareness and recognition of the problem and impact of HIV/AIDS/STD among industrial leaders in target sites to facilitate the implementation of prevention programs.
- ▶('\$2Develop an IEC package/tool to use at workshops for industrial and commerce chambers, and business and community leaders to generate support and resources for HIV/AIDS/STD prevention programs.

3. Condom Programming and Logistics Management:

- ▶('\$2Improve MOH and IHSS logistics management systems supplying condoms, pharmaceuticals and other necessary commodities to STD programs.
- ▶('\$2Strengthen the capabilities of industries and NGOs to identify a consistent/affordable source of condoms and to promote their use among workers.

Technical Assistance:

Technical assistance for this component will include behavior change communication, STD program development and strengthening, condom and pharmaceutical programming, logistics management and institutional development. Technical assistance will be provided by:

- ▶('2The technical staff of the MOH Division of STD/AIDS and Sanitary Region #3 STD/AIDS Program.
- ▶('2AIDSCAP/Honduras country office technical staff and/or in-country organizations/individuals able to assist the groups that work with PWP.
- ▶('2AIDSCAP Regional Office for Latin America and the Caribbean, and Headquarters staff, and/or subcontractors.

Implementing Agencies:

The following entities have been identified as possible implementing agencies for the PWP component of this Plan. The design, implementation and monitoring of PWP interventions will be coordinated by the STD/AIDS Programs of each Sanitary Region with support from the AIDSCAP/Honduras country office. In addition to the groups described below, maquiladoras and other industries will participate as co-implementing agencies and partners in all PWP prevention efforts.

- ▶('2The Honduran Social Security Institute for interventions in Sanitary Region #3. The IHSS will lead the prevention efforts by strengthening and expanding the intersectoral (MOH, IHSS, Municipality) intervention that is already in place in San Pedro Sula.
- ▶('2The Centro de Orientación y Capacitación en SIDA (COCSIDA) for interventions in Sanitary Region #6 (La Ceiba).
- ▶('2The Asociación de Mujeres Contra el SIDA for interventions in Sanitary Region #2 (Comayagua).
- ▶('2The Honduran Social Security Institute for interventions in the Metropolitan Sanitary Region (Tegucigalpa).

B. INTERVENTIONS FOR CORE GROUPS

Description:

This component of the "Plan de Apoyo" will focus on female commercial sex workers (CSWs) and men who have sex with men (MWM). These persons comprise the highest risk group for both STDs and HIV. Reduction of STDs in these populations is one of the most cost-effective interventions, since venereal genital ulcers and

other STDs which cause genital tract inflammation increase the risk for sexual transmission of HIV two to three-fold.

CSWs will be reached at Ministry of Health clinics and NGO medical facilities serving patient populations which include a large percentage of female CSWs and MWM. These will include STD clinics in Tegucigalpa, Comayagua, San Pedro Sula and possibly La Ceiba.

Objectives:

- ▶('2Reduce the incidence for sexually-transmitted HIV among CSWs and MWMs.
- ▶('2Improve the professional knowledge of physicians, nurses and pharmacists, and the clinical skills of health care providers who are responsible for the clinical management of persons with STDs.
- ▶('2Increase condom access and use in the target populations and their clients.
- ▶('2Increase the perception of risk of HIV infection among targeted groups, as well as health seeking behavior for STD and negotiation skills for condom use.

Activities:

Activities in support of the above objectives will be conducted to improve medical knowledge and professional skills of clinic personnel and to reduce risk behaviors in the target populations.

1. Reduction of the rate of transmission of STDs:

- ▶('2Conduct short and intermediate length courses consisting of lectures and demonstrations for syndromic and laboratory diagnosis of genital lesions and discharges, lower abdominal pain in women and the symptoms and signs of HIV/AIDS.
- ▶('2Determine prevalence levels of gonorrhea, chlamydia, and syphilis by conducting annual surveys for high and low risk groups.
- ▶('2Determine the antibiotic susceptibility of prevalent strains of N. gonorrhea from CSWs attending STD clinics in Tegucigalpa by measuring their susceptibility to the antibiotics recommended by the World Health Organization for treatment of gonorrhea.
- ▶('2Establish a list of recommended drugs for treatment of gonorrhea that are scientifically sound, cost-effective, and can be integrated into the health care system.

- ▶(' \$2Provide pharmacies with algorithms (flow charts) listing the syndromic diagnostic aspects of STDs and the recommended treatments for the different STD syndrome.
- ▶(' \$2Convene a task force of experts to develop criteria for the clinical and/or laboratory diagnosis for each STD in order to strengthen the national surveillance of these diseases.
- ▶(' \$2Update the guidelines for the treatment of STDs and AIDS-related opportunistic infections.
- ▶(' \$2Conduct a serosurvey for genital ulcers caused by chancroid and early venereal syphilis in high and low STD risk populations to determine the magnitude of the reservoir of these infections which increase the risk of HIV.

2. Behavior: Change Communications

Activities for female CSWs and their clients include -

- ▶(' \$2Identify peer leaders and involve them in the development of IEC materials.
- ▶(' \$2Assist implementing agencies to develop strategies for working in brothels and leveraging brothel owners' collaboration in prevention programs.
- ▶(' \$2Develop curricula and training strategies for peer educators and outreach workers to motivate health seeking behaviors of the target population.
- ▶(' \$2Design training materials and methodologies for peer educators to counsel on avoidance of high-risk sexual practices and inappropriate use of antimicrobial drugs and to provide referrals to STD services if indicated.
- ▶(' \$2Develop an educational strategy for locations where male youth congregate and socialize, including bars and recreational areas or activities.
- ▶(' \$2Develop and distribute educational materials appropriate for hotels, motels and other places used for commercial sexual activity.

Activities for MWM -

- ▶(' \$2Identify the peer leaders from the target group through community outreach and design a strategy to mobilize awareness and HIV/AIDS/STD prevention activities.
- ▶(' \$2Develop peer educator training strategies and assist agencies to implement them.

▶('\$2Develop IEC materials with the participation of the target group.

3. Condom Programming and Logistics Management

▶('\$2Assist NGOs to plan for and obtain an adequate condom supply for their programs with the target populations.

▶('\$2Improve distribution networks to NGOs;

▶('\$2Insure that condoms are available and that their use is recommended in public sector STD clinic services;

▶('\$2Review, modify, and implement guidelines for logistics and proper storage of condoms in public sector facilities treating STD patients;

▶('\$2Help NGOs and STD clinics in designing, testing and implementing innovative schemes for promoting condom use among CSWs and MWMs.

Technical Assistance:

Technical assistance for this program will be provided through the Honduran public sector, the AIDSCAP LAC Regional office and the University of Washington's Center for AIDS and STD.

Implementing Agencies:

▶('\$2The Ministry of Health will be the main implementing agency for programs for CSWs who are registered with the local health department and/or are brothel-based;

▶('\$2Proposed Honduran NGOs who may participate in the implementation of programs for unregistered CSWs and MWM, under the coordination/supervision of the respective region, are as follows:

- Lucha Contra el SIDA for programs with CSWs and MWMs in SPS and Tegucigalpa;
- COCSIDA for programs with street CSWs and MWMs in La Ceiba.
- Asociacion de Mujeres Contra el SIDA for programs with CSWs and MWM in Comayagua;
- Asociacion de Farmaceuticos de Honduras for training programs for pharmacy personnel and distribution of educational material for pharmacists and their customers.

Local organizations will also be sought who could develop targeted

activities for MWM.

C. INTERVENTIONS FOR THE GARIFUNA POPULATION

Description:

The Garifunas or "negros caribes" (Caribbean Blacks) are a sizable ethnic group in Honduras. They live throughout the Atlantic coast (litoral) of Honduras and number from 150,000 to 200,000. There are 46 Garifuna communities in the Atlantic coast. This program area will be carried out primarily in Sanitary Region # 6, where the Garifuna population is concentrated and receive health care through the MOH health centers and ecumenical mission clinics.

There are a number of factors that pertain to HIV/AIDS prevention and control efforts in the Garifuna communities. A large number of Garifuna men who migrate to the large cities and abroad for economic reasons or who are fishermen tend to come back to see their families. There is minimum commercial sex among the Garifuna population but early initiation of sexual activity and multiple sexual partners are among their cultural norms. Polygamy is a culturally accepted practice within the Garifuna communities and alcoholism is a growing concern as a co-factor for high risk behaviors, particularly among males dedicated to fishing. There is also a high pregnancy rate among adolescents but young Garifuna women tend not to communicate openly about sexuality. Women account for a larger proportion of the Garifuna population, play an important role in small-scale agricultural work, and provide care for their families.

There is a lack of information and knowledge about HIV/AIDS among the Garifuna population, particularly in the communities with difficult access. Compounding this situation, there are no Garifuna-language HIV/AIDS prevention communication materials. A large segment of the Garifuna population has low-literacy skills in Spanish and in Garifuna.

The "Plan de Apoyo" will target a population of about 50,000 Garifunas in Sanitary Region # 6 that correspond to MOH health centers in the following cities: La Ceiba, Trujillo, Tela, Olanchito, Roatan y Tocoa.

Objectives:

- ▶(')\$2Increase the perception of risk among the Garifuna population in order to reduce high risk behaviors, particularly unprotected sexual intercourse.
- ▶(')\$2Increase access to and availability, demand, and use of condoms for the Garifuna population.
- ▶(')\$2Increase health care-seeking behaviors and utilization of MOH

clinics among the Garifuna population, particularly for STDs diagnosis, referral, and treatment services.

Activities:

1. Reduction of the rate of transmission of STDs:
 - ▶('\$2Strengthen the HIV/AIDS/STD services at the MOH clinics in Health Region #6.
 - ▶('\$2Refer the Garifuna population to existing MOH clinics, where available, for STDs diagnosis and treatment as well as HIV counseling and testing.
2. Behavior Change Communication:
 - ▶('\$2Identify peer leaders through community outreach and the current grass-roots groups being formed in select Garifuna communities.
 - ▶('\$2Train peer leaders to implement interpersonal education programs and peer support for behavior change in relation to condom use and STD prevention, diagnosis and treatment. Involve HIV-positive Garifunas and traditional healers as spokespersons/peer educators.
 - ▶('\$2Develop a small-scale assessment in two communities regarding HIV/AIDS/STDs knowledge, attitudes, behavior, and practices.
 - ▶('\$2Develop and distribute age-specific Garifuna-language and bilingual (Garifuna-Spanish) IEC materials for people with low literacy skills. This will be accomplished through implementing agency's outreach workers and peer educators.
 - ▶('\$2Design risk reduction strategies that are innovative, participatory and reflective of real life situations in the Garifuna communities (e.g., improvisational theater, sociodramas, music, and small group discussions).
 - ▶('\$2Develop BCC strategies on condom use and partner reduction. Negotiating safer sex and condom demonstrations will be key components of these strategies.
 - ▶('\$2Develop and disseminate HIV/AIDS/STD IEC materials to reach Garifuna adolescents in and out of schools in collaboration with The Ministry of Education's regional and national offices.
3. Condom Programming and Logistics Management:
 - ▶('\$2Assist the NGOs working in these communities to identify a consistent and affordable supply of condoms to provide to the

Garifuna population.

- ('S2Develop and implement a condom distribution strategy at locations where Garifunas socialize.

Technical Assistance:

Technical Assistance for training peer leaders will continue to be provided by the Sanitary Region #6. TA for BCC materials development and condom promotion will be provided to implementing agencies by the MOH's HIV/AIDS/STDs Division. TA also will be provided by the in-country organizations/consultants, AIDSCAP/Honduras country office technical staff, and AIDSCAP Regional Office and Headquarters staff as needed.

Implementing Agencies:

All activities that target the Garifuna population will be coordinated by the Sanitary Region # 6. The following NGOs have been identified as potential implementing agencies:

- ('S2COCSIDA, an NGO involved in HIV/AIDS peer education training activities, may provide training to other implementing agency staff. It is possible that the Region may decide to use COCSIDA as an umbrella organization that will provide technical and administrative assistance to and coordinate the efforts of other implementing agencies involved.
- ('S2The "Organizacion Fraternal Negra Hondurena" (OFRANEH) to facilitate access to their outreach infrastructure of health education community groups known as "grupos sectoriales por barrio" located throughout the Garifuna communities.
- ('S2ODECO, another NGO representative of the Garifuna community and founded in 1992, to implement HIV/AIDS education community programs.

III. SUPPORTING PROGRAM AREAS

A. CONDOM PROGRAMMING AND LOGISTIC MANAGEMENT

This chapter will cover both the public sector condom supply program and the private sector marketing programs existing and being planned in Honduras. Three aspects will be targeted for particular attention in this "Plan de Apoyo":

- ('S2logistics management and public sector communications.
- ('S2private sector feasibility study for a socially marketed HIV/AIDS/STD prevention condom.
- ('S2condom supply, public sector and private sector, and delivery

to the CSW core target population.

Description:

Condom availability in Honduras, on the national level, is not a problem today. USAID furnished close to 5,700,000 condoms last year. A public sector logistics program was designed and implemented, and is functioning throughout the country. Condoms are delivered to a central warehouse in Tegucigalpa and are programmed for distribution to the 8 health regions, as well as to other major organizations such as the Honduran Social Security. Distribution from the Regional warehouse to their health areas is performed on request or by regional decision. The area warehouses distribute in the same manner to their area "health centers with doctors" (cesamos) or rural health centers" (cesares), as well as to other major users such as brothels, army bases, etc.

AID monitors the distribution system and results, as the following figures, from 1993 show, seem to be very good:

PRESENCE OF CONDOMS AT THE MOMENT OF MONITORING

Hospitals	98%
Cesamos	98%
Cesares	84%

There are, however, some discrepancies between these results and some other field observations. For example, stock outs in important STD centers have been noted, record keeping at the Regional level is not always clear, computers at the Regional level are most often not used as planned, records of any kind are often not kept at the Area level, and almost never kept at the health center level. A serious lack of field supervision was also noted.

A thorough evaluation of this system, leading to system modifications and training will be necessary if MOH resources are to be optimized in this field.

In spite of the global availability of condoms in the country, condom use is low. In the public sector it will be necessary to create demand, commensurate with the supply possibilities of the MOH. A correctly functioning logistics system will supply condoms to the distribution points, but only consumer demand will empty the shelves. A communications program with this objective in mind could be, and is being considered.

However, if the public sector condom distribution is a major element in the supply of condoms to potential users it is not the only means that could, or should, be used. The private sector, in both commercially marketed and socially marketed condoms, is possibly the major source of distribution for the future.

In the private commercial sector American and Asian condoms are found in ample quantities. Pricing in this sector is around 4 to 6 lempiras per condom "3-pack" (from \$0.18 to \$0.27 per condom).

Socially marketed condoms are also amply present on the private sector market, although they are only to be found in traditional pharmacy outlets and at family planning community based outlets. ASHONPLAFA is the family planning organization that is presently managing the condom social marketing in these sectors. They have three condom brands distributed in their family planning CBD network: 1 generic condom (\$0.07 per condom, and 2 brand name condoms, Guardian and Protector (\$0.11 to \$0.16 per condom). The 2 brand name condoms are equally sold at commercial pharmacies at these socially marketed prices. These condoms have a family planning image although there is a low key ASHONPLAFA communications program oriented towards AIDS prevention with the same condoms. ASHONPLAFA presently claims annual sales in each of their 2 sales networks, CBD and pharmacies of around 700,000 pieces each, or total annual sales of around 1,400,000 pieces for both family planning and HIV/AIDS/STD prevention. ASHONPLAFA information indicates that they may do 50% of the pharmacy market sales.

There is, at present, no socially marketed brand label condom directly aimed at the AIDS prevention market. It would certainly be interesting to fill this market space. This would allow commercial distribution to aim at non traditional sales outlets. These outlets could rapidly distribute more condoms than traditional outlets, if we judge the results of similar programs in other countries. This type of distribution increases condom accessibility to a larger number of the high risk target populations. USAID will with support the NACP to conduct a small feasibility study, and will provide technical assistance through this Plan de Apoyo in evaluation methodology. This study would develop a brand condom aimed at the STD/HIV prevention market and test a distribution system to NGOs working with core groups. It is envisioned that this study will provide information which could lead to a broader CSM program in the future.

One of the major problems that confront the AIDS prevention program is the distribution of condoms to CSWs. Distribution of condoms through the STD clinics is covered in this document, in the chapter covering this subject. However, the importance of condom use in this sector deserves an increased effort to serve this population. It would be of vital importance to study the improvement of present public sector distribution to this population. It would also be vital to study the possibility of using social marketing techniques with a brand label condom to increase condom availability and use in this highly volatile population.

Objectives:

The objectives of condom programming activities and logistics management are clear, and accessible. They are:

►('S2Optimize condom distribution through the public sector so as to:

- Insure the availability of condoms in all of the public sector distribution outlets.
- Control this distribution so as to insure the best use of MOH resources,
- Increase demand of condoms at the public sector outlet level by consumers,
- Study the possibility of creating and launching a brand label condom that could be sold through traditional, and non traditional, outlets, thus increasing accessibility to, and use of, condoms.
- Increase distribution and accessibility of condoms to the male and female CSWs and their customers, through both public and private sector channels.

Activities:

The above objectives require a diversity of interventions concerning a large field of activities. They are:

1. Public Sector Assistance:

- A thorough assessment of the present logistics system.
- Updating of the present logistics system and training of personnel to insure satisfactory operations.
- Provision of assistance to the MOH to design and implement a public sector communications program whose objectives are to increase demand for condoms in the public and private distribution sectors.

2. Private Sector Assistance:

- Assist NGOs who participate in the "Plan de Apoyo" to obtain and distribute condoms for their prevention programming.
- Provide technical assistance and training for NGOs in the proper storage and management of condom supplies.
- Assist NGOs to develop strategies for identifying new markets for condoms, including non-traditional outlets.
- Develop cost-recovery strategies appropriate for Honduras and provide assistance to NGO to participate in such activities.

3. Condom Social Marketing:

- Provide assistance to the proposed feasibility study to determine the need to create and launch a brand label condom aimed specifically at the HIV/AIDS/STD prevention market.
- If the above study demonstrates the need for a new brand label condom, assist with the launch of an expanded CSM effort.
- If the above product is launched, design and implement a social marketing program, through local NGOs, to sell the new product to the high risk target populations.
- If the preceding program has positive results, assist in the preparation of a campaign to launch the new condom on a large scale to the national market, through both traditional and non traditional outlets.
- Design and implement an improved system of distributing condoms to CSWs through both the public sector and with, the eventual, use of the brand label condom.

Technical Assistance:

Technical assistance, in each of the fields of expertise mentioned above, will be available as necessary, within the "Plan de Apoyo".

B. POLICY PROMOTION AND SUSTAINABILITY

Description:

Honduras has a technically sound STD/AIDS Control Division with solid regional offices and an improving surveillance system. The Honduran commercial sector has begun to realize the need to promote HIV/AIDS/STD prevention in the workplace. Honduran churches have developed hospices to specifically address the care of AIDS patients, and are beginning to confront the delicate issue of HIV/AIDS/STD prevention. Despite these successes in creating awareness and consolidating human and physical capital to confront AIDS, the country remains constrained by very limited financial resources.

The "Plan de Apoyo" will therefore try to encourage and sustain the positive policy environment which has been created, while encouraging private sector leveraging and the cost-effective use of Honduras's limited resources. Therefore, the Ministry of Health and AIDSCAP have jointly identified policy promotion and financial sustainability as the most critical policy issues needing to be addressed. Policy promotion must maintain HIV/AIDS/STD prevention as a priority among leading policymakers, including those in government, business, and the churches. Furthermore, the National AIDS Control Program should recognize the role of the NGOs as complementary to other AIDS prevention activities.

A number of policy obstacles have been identified which continue to prevent the success of an HIV/AIDS prevention program. Some of these obstacles include:

- ▶ the unwillingness of doctors to treat patients with HIV/AIDS in hospitals;
- ▶ the prescreening of potential employees for HIV;
- ▶ the unwillingness of some maquiladoras to offer time to their workers to attend HIV/AIDS/STD prevention activities;
- ▶ continued rivalry in HIV/AIDS/STD prevention efforts between the government, social security, municipalities, and NGOs;
- ▶ opposition by the churches to condom distribution and sex education;
- ▶ the harassment of licensed commercial sex workers by the country's police force;

Financial sustainability describes the need to meet the recurrent costs of HIV/AIDS prevention interventions for a specified period of time after the initial investment in the "Plan de Apoyo". Currently there are very limited resources available for HIV/AIDS/STD prevention in Honduras. It is therefore critical that: a) opportunities for cost recovery be explored and, where appropriate, implemented (e.g., creating revolving funds for the purchase of STD drugs), b) the commercial sector be encouraged to contribute their own resources to HIV/AIDS/STD prevention, and c) ongoing interventions be evaluated to assure that investments in HIV/AIDS/STD prevention are being spent in the most cost-effective manner.

Objectives:

The accomplishment of the following objectives is critical to the success of the "Plan de Apoyo":

- ▶ Assuring that HIV/AIDS/STD prevention remains a priority among leaders in the GOH and that appropriate policies are promoted;
- ▶ Encouraging the leveraging of human, physical, and financial resources, especially within the commercial sector;
- ▶ Assessing the recurrent and capital costs of interventions and identifying opportunities for financially sustaining these interventions beyond the "Plan de Apoyo";

Activities:

The policy activities will focus on three intermediaries: government policymakers/implementing agencies, business leaders, and religious leaders. The following describes how each of these intermediaries will be addressed:

1. Government Policymakers/Implementing Agencies
 - ▶ Develop 30 sets of slides of the socio-economic impact assessment, along with guides describing how to present findings from the study. 10 copies of the slides and the guides have already been disseminated to each of the health regions by the STD/AIDS Control Division.
 - ▶ Reproduce 200 copies of the final report from the socio-economic study and make this widely available to Honduran policymakers and journalists at the national and regional

level.

- ▶ Develop and distribute 30 copies of a video tape which summarizes the findings of the socio-economic study and incorporates clips from other AIDS videos.
 - ▶ Sponsor 1 annual HIV/AIDS policy dialogue to disseminate information and to promote national policy recommendations. These dialogues will include governmental and nongovernmental organizations, including members of the Honduran Congress, Presidential-level policymakers, community leaders, the Honduran Police Force, Ministries of Health, Labor, Finance, Planning and Education, the Armed Forces, business and commercial organizations (AMCHAM: American Honduran Chamber of Commerce; COHEP: Consejo Hondureño de Empresas Privadas), labor syndicates, journalists, etc.
 - ▶ Sponsor 1 HIV/AIDS journalist workshop, to assure that appropriate information gets disseminated to policymakers and their constituencies.
 - ▶ Develop a coordinated cost-effective strategy for HIV/AIDS intervention activities by assessing the following interventions: (1) an AIDS prevention program in the workplace, (2) a targeted condom distribution program with commercial sex workers, and (3) a public health STD clinic.
2. Commercial Sector Leaders
- ▶ Design and reproduce 200 policy guidelines and educational materials for policymakers in the workplace specifically for Honduran businesses.
 - ▶ Carry out 36 forums, roundtables, and workshops over the next 3 years with business leaders to promote HIV/AIDS/STD prevention in the workplace, assist in developing non-discriminatory workplace policies, and leveraging resources for HIV/AIDS/STD prevention interventions.
3. Religious Leaders
- ▶ Bring together leaders from various churches in Honduras for an annual HIV/AIDS/STD and religion workshop to discuss how they can best contribute to the national HIV/AIDS/STD prevention effort. These workshops would encourage greater investment in HIV/AIDS prevention by churches and collaboration between the churches and the GOH while trying to minimize those obstacles which may hinder future HIV/AIDS/STD prevention efforts.

Technical Assistance:

Technical assistance will be provided by AIDSCAP's country office and its Headquarter's Policy Unit. Additional technical assistance may be required of Honduran governmental and

nongovernmental organizations.

Implementing Agencies:

The following represents some preliminary suggestions regarding potential implementing agencies.

- ▶ The dissemination of the "Socioeconomic Impact Assessment" will be continued by the STD/AIDS Control Division.
- ▶ The "AIDS and the Workplace" policy activities will be implemented by IHSS.
- ▶ The activities designed to assess the costs of interventions will be performed by the University of Honduras and the Ministry of Health.
- ▶ The annual "National AIDS Policy Dialogues" and journalist workshops will be implemented by the Ministry of Health.
- ▶ Workshops with religious organizations will be facilitated by one of Honduras's national council of Catholic and/or Evangelical Organizations.

C. EVALUATION AND MONITORING

Overview:

This plan encompasses measurements of process, outcome and impact, addressed at both the country program level and the subproject or component level, and measured in intervention sites. Both quantitative and qualitative data collection methods will be used during most phases of evaluation. The evaluation plan incorporates "core" measures consistent with those developed collaboratively by WHO/GPA and USAID--the AIDS Priority Prevention Indicators (PPIs).

Each intervention will be monitored and evaluated according to individual subproject evaluation plans appropriate to the nature and scope of the activity, the implementing agency and the objectives of the intervention. Evaluation plans for subproject activities will be included in each subagreement as the subagreement is developed. Country project level indicators will be measured within subprojects where relevant to the activity, along with process, benchmarks and outcome indicators specific to the activity.

Data from the monthly process indicator form (PIF) reports from each subproject collected along with quarterly summary reports generated at both headquarters and regional levels will provide feedback through the Honduras AIDSCAP Resident Advisor to individual country subproject implementing agencies.

This evaluation plan will be implemented by the Resident Advisor and one or more identified

possible providers.

Specific evaluation tasks to measure all country and subproject goals, purposes and outcome indicators will be completed in the evaluation component subagreement and will be consistent with this implementation evaluation plan.

Impact and Outcome Evaluation:

Impact (biological) of HIV prevention programming: HIV and syphilis seroprevalence

Impact indicators for evaluating the effects of all HIV prevention programming in Honduras include measuring, both at baseline and at the EOP, the GPA's PPIs (amended):

- #8. percent of pregnant women aged 15–24 who have evidence of recent infection by venereal syphilis serological
 - #9. rate of reported urethritis in men aged 15–49 in the preceding 12 months
 - #10. percent of women with first pregnancy aged 15–24 seropositive for
- HIV

The MOH's Epidemiology Division HIV sentinel surveillance system will provide data for these indicators with assistance from the AIDSCAP project, through the STD component which will strengthen the sentinel surveillance system at four sentinel sites serving CSWs in the four project regions (Metro, #2, #3, and #6). The specific sites to be strengthened will be Metro Tegucigalpa, Comayagua, San Pedro Sula and La Ceiba.

Syphilis testing and treatment will be done routinely in four STD clinics serving CSWs at sentinel sites.

Specific objectives of the "Plan de Apolo" include:

1. short-term epidemiological training for clinical staff including (a) doctors (b) nurses (c) microbiologists
2. develop national guidelines for the management of HIV-related infections, and review guidelines for the management of STDs
3. developing/strengthening four sentinel surveillance sites (STD clinics—one in each region)
4. initiate (a) counseling (b) outreach services in each of the clinics identified
5. strengthen the condom distribution system in each of the clinics identified
6. address the purchase and use of appropriate STD drugs and some opportunistic

infections

Outcome (behavioral) of HIV prevention programming: reported behavior change

There are three basic behavior change PPI's that will be measured both at baseline and EOP. These include:

- #1. percentage of people in the population aged 15–49 citing at least two acceptable ways of protection from HIV infection
- #4. percentage of people aged 15–49 who report having been sexually active in the last 12 months who also report having at least one sex partner other than their regular sex partner(s) in the last 12 months
- #5. percentage of people aged 15–49 who report sexual intercourse of risk in the last 12 months who also report the use of a condom during the most recent act of sexual intercourse of risk

Other key remaining questions will be identified that can best be addressed through use of quantitative approaches to qualitative methods such as focus group discussions, in-depth individual interviews, or rapid ethnographic assessments. Subagreements developed will address developing and/or strengthening peer counseling, IEC messages, and outreach and BCC messages in the workplace among the target groups in order to measure to what extent PPI 1, 4 and 5 have been addressed.

Outcome indicators: Condom distribution and availability:

The two Priority Prevention Indicators that need to be measured at baseline and at follow-up include:

- #2. percentage of total number of condoms available for distribution during the preceding 12 months in the population aged 15–49
- #3. percentage of number of people who acquire a condom in the population aged 15–49

In addressing these PPI's this Plan will concentrate its efforts on:

1. improving the condom logistics distribution system at the MOH
2. implementation of a concentrated condom communication system by the MOH

3. conducting a brand label feasibility study to include the creation and launching of the same for use by the private sector
4. improving the condom distribution to CSWs by the MOH.

Outcome indicators: Facility-based STD case management:

STD control and prevention programs for populations targeted by interventions implemented will incorporate measures of appropriate levels of diagnosis and treatment, in accordance with national standards. A brief baseline assessment of appropriate management will be performed but a more thorough evaluation will not be done until some progress has been made in upgrading STD services. A follow-up evaluation will be conducted yearly in the context of routine facility supervision. The PPI's to be measured with this methodology include:

- #6. percent of individuals presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards)
- #7. percent of individuals seeking STD care in health facilities who received appropriate advice on condom and on partner notification

For the purpose of the country project evaluation, the total number of patients seen at the four STD clinics in which project interventions will occur will be aggregated at baseline, yearly, and at the end of the project, by gender, diagnosis and age in the target subgroups.

Other aggregate process data will include the total number of STD clinic providers trained in proper diagnosis and treatment of STDs (both clinic and laboratory personnel), and the total number of STD clinic provider training sessions held.

Policy analysis and dialogue:

Evaluation of this component will focus on the sustainability of progress made to date, progress made on private sector leveraging, and the cost effective use of resources. Changes in policies will be the major responsibility of the Project's policy unit to implement. As shown in the LOGFRAME these issues will be addressed through the use of process evaluation, i.e. outcome indicators, and will be reported on the PIF's. The AIDSCAP Resident Advisor for Honduras will also include a policy update section in all reports to AIDSCAP Regional Office and headquarters functioning as a qualitative process measure of changes in policies effecting HIV/AIDS interventions.

Baseline Assessment of HIV/AIDS in Honduras:

The evaluation component will complete the collection of baseline data regarding the HIV/AIDS situation in Honduras, including general information for the whole country, but focusing on the

four regions where interventions will occur. This assessment will include a review of HIV and STD prevalence in the intervention regions. The report will also analyze the supply, distribution and promotion of condoms in Honduras, the status of STD case management in STD clinics in the intervention regions, and the policy environment for AIDS interventions in Honduras, building on the technical analysis already conducted vis a vis the "OPTIONS FOR AIDS PREVENTION PROGRAMMING FOR USAID/HONDURAS", and "SOCIO-ECONOMIC STUDY OF THE IMPACT ON AIDS IN HONDURAS".

In addition, the baseline assessment will contain a literature review of the key HIV/STD quantitative and qualitative behavioral research conducted in Honduras; a review of the equipment available in the targeted STD clinics; and a brief description of significant behavior change communication strategies, campaigns, messages, materials, training efforts, curricula, with the targeted populations.

Comprehensive baseline assessments of AIDSCAP country programs are conducted at the beginning of the implementation phase. These assessments use existing data whenever possible but also might include collection of new data. The literature review will assess the extent and quality of recent research to enable decisions about the need for further original research at baseline. Ultimately, this baseline assessment will constitute the "background" for each country's final evaluation, which will occur in FY 1997.

Activities related to the baseline assessment will set the stage for interventions among the targeted populations. Individual components of the baseline assessment will likely be completed at staggered intervals, but the entire assessment should be completed by December 1994.

Project Monitoring:

Monitoring will be completed through the use of the instruments presented in the following chart:

- IV. General Administration
- V. Budget
- VI. Logframe

draft COUNTRY LOGFRAME for USAID/HONDURAS HIV/AIDS PREVENTION PROGRAM
April 17, 1994

* These are WHO Global Program on AIDS (GPA) Priority Prevention Indicators (PPIs).

Those OVI's in regular print are attainment indicators, those in bolded print are comparison indicators.

Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Goal:</p> <p>Reduce the rate of sexually transmitted HIV in (a) Metro Tegucigalpa (b) Comayagua (c) San Pedro Sula (d) La Ceiba.</p>	<p>1. HIV prevalence maintained at 0.3% or less, 1.5% or less, 3.6% or less, and 1.4% or less, respectively, during life of project in pregnant women throughout LOP. *[PPI 10]</p> <p>2. Syphilis prevalence maintained between 12-15 % or less during LOP. *[PPI 8]</p>	<p>1. HIV sentinel surveillance.</p> <p>2. Syphilis sentinel surveillance</p>	<p>(Goal to supergoal)</p> <p>Sexual intercourse is the primary mode of HIV transmission.</p>

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Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Purpose:</p> <p>To reduce high risk sexual behavior among (a) CSW's, and PWP populations in Metro Tegucigalpa, Comagua, San Pedro Sula, and La Ceiba.</p>	<p>3. HIV prevalence maintained at 5.5% or less in Metro Tegucigalpa; and 19.8% or less in San Pedro Sula in CSWs.</p> <p>4. Decrease the rate of increase in incidence rates from 151, 34, 378, and 23, respectively, reported in 1993.</p> <p>1.1 Statistical significant increase from baseline target population reports condom use in the most recent sexual intercourse of risk (with a non-regular partner) by EOP. *[PPI 5]</p> <p>1.2 Statistical significant decrease from baseline target population report one or more non-regular sexual partners in the last 12 months by EOP. *[PPI 4]</p> <p>1.3 Statistical significant increase from baseline target population can identify at least 2 correct preventive strategies by EOP. *[PPI 1]</p> <p>1.4 Statistical significant increase from baseline target population in perceptions of quality services received at targeted STD clinics.</p>	<p>Project narrative reports of major findings from target population-based surveys complemented by focus group discussions and/or key informant interviews.</p>	<p>(Purpose to goal)</p> <p>Reducing the number of sexual partners and reducing STDs have an impact on HIV transmission.</p> <p>Condom are available and accessible to the target population.</p> <p>STD diagnosis and treatment services targeted by the project are the primary providers of STD care for target populations.</p>

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Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Outputs:</p> <p>1. Implement targeted behavior change communication interventions to reduce high-risk behavior in target populations.</p>	<p>targeted clinics.</p> <p>1.1 5,000 brochures, 30 training manuals for CSWs; 1,000 posters, 20,000 brochures, 100 training manuals for PWP; and 1,000 posters, 20,000 brochures, 120 training manuals, 50 information kits for schools, 3 radio spots for Garifunas materials produced and distributed by EOP.</p> <p>1.2 65 CSWs, 100 PWP, and 120 Garifunas trained in educational activities by EOP.</p> <p>1.3 8 CSW, 20 PWP, and 16 Garifuna training sessions conducted by EOP.</p> <p>1.4 6,500 CSWs, 50,000 PWP, and 50,000 Garifunas reached by communication activities.</p>	<p>Project process data.</p> <p>Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>1.1 Accurate mobilization of target population to participate in project activities.</p> <p>1.2 Communication activities lead to behavior change.</p> <p>1.3 Communication strategies will be consistent with social, cultural, and religious norms for various segments of society.</p>
<p>2. Condom Programming and Logistics Management.</p>	<p>2.1 1.2 million total condoms available for distribution during LOP to CSWs. *[PPI 2]</p> <p>2.2 30 percent increase in population (aged 15-49) who can acquire a condom. *[PPI 3]</p> <p>2.3 X training sessions held during LOP.</p> <p>2.4 X materials distributed during LOP.</p> <p>2.5 X radio and TV spots broadcast during the LOP.</p> <p>2.6 feasibility study on brand label completed by 2nd qtr of 1995.</p>	<p>Process data/logistic reports/surveys.</p>	<p>Condom logistics infrastructure exists.</p> <p>Constant and consistent supply of quality condoms is secure.</p> <p>Accessibility is major barrier to condom use.</p> <p>Pricing structure allow purchase by target population.</p>

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Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
3. Increase access to improved STD prevention and treatment services.	3.1 80 % of target population with STDs receives treatment according to standard STD diagnosis and treatment protocols. *[PPI 6]		3.1 Target population(s) will feel empowered to access STD diagnosis and preventive services
3. (continued) Increase access to improved STD prevention and treatment services.	<p>3.2 50 % of target population with STDs receive appropriate preventive education, including advice about partner notification and condoms. *[PPI 7]</p> <p>3.3 80 % target population aware of/has access to [improved/high-quality] STD services.</p> <p>3.4 30 percentage points decrease in proportion of surveyed male population aged 15-49 reporting episode(s) of urethritis in the last 12 months. *[PPI 9]</p> <p>3.5 25,000 condoms distributed in each of four STD facilities participating in project activities per month.</p> <p>3.6 four clinics/posts participating in STD diagnosis and treatment activities.</p> <p>3.7 1 training sessions per month conducted for each of the four clinic personnel/number of people trained (by gender and type)</p> <p>3.8 26 % of STD diagnosed clients participate in partner referral system.</p>	<p>Provider assessments/surveys.</p> <p>Target population surveys.</p> <p>Project process data.</p> <p>Project narrative reports of major findings from focus group discussions and/or key informant interviews.</p>	<p>3.2 Laboratory and technical capabilities to manage effectively with increase demand on STD diagnosis and treatment services.</p> <p>3.3 STD service providers will want to work with target population(s).</p> <p>3.4 Target populations are easily identified.</p> <p>3.5 Sociocultural norms permit activities focusing resources on target population(s).</p> <p>3.6 Physical, human, and financial resources will be available throughout life of project.</p>

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Narrative Summary (NS)	Measurable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>4. Facilitate dialogue to positively address AIDS-related policy issues.</p>	<p>3.9 Provide updated information to 450 pharmacists on STD diagnosis and treatment.</p> <p>3.10 Establish a National STD Committee.</p> <p>4.1 900 (300/yr) national collaborators trained in policy analysis, projection and simulation modeling, economic impact assessments, etc. through life of program.</p> <p>4.2 200 copies of the socio-economic study report disseminated by end of year one.</p> <p>4.3 50 copies of the socio-economic study video disseminated by end of year one.</p> <p>4.4 Analysis of the projected costs of AIDS prevention programs completed by end of 1st quarter in 1996.</p> <p>4.5 200 copies of both policy guidelines and educational materials developed and distributed by end of year 2.</p> <p>4.6 36 workshops held with business leaders by EOP.</p> <p>4.7 50 people attend workshops for religious leaders each year.</p> <p>4.8 10 slides developed of the socio-economic study.</p> <p>with business leaders by EOP.</p> <p>4.7 50 people attend workshops for religious leaders each year.</p>	<p>Training curricula and attendance records.</p> <p>Meeting minutes.</p> <p>Process indicator reports.</p>	<p>4.1 Multisectoral policy environment that is conducive to the development and implementation of comprehensive AIDS prevention activities is created.</p> <p>4.2 Government policies strongly influence effectiveness of intervention strategies.</p>

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APPENDIX A

KS

APPENDIX B

TIMELINE 1995 1996 1997

ACTIVITY/quarters	1	2	3	4	1	2	3	4	1	2	3	4
Behavior Communication:												
materials produced and distributed	X	X	X	X	X	X	X	X	X	X	X	X
training activities conducted	X	X	X	X	X	X	X	X	X	X	X	X
target population reached	X	X	X	X	X	X	X	X	X	X	X	X
Policy:												
dissemination of socioeconomic impact assessment report—June, 1994												
dissemination of socioeconomic impact assessment video—September, 1994												
annual aids policy dialogues		X				X				X		
analysis of projected costs of aids prevention programs					X							
workshops with religious organizations	X	X	X	X	X	X	X	X	X	X	X	X
workshops on aids and the workplace policy initiative	X	X	X	X	X	X	X	X	X	X	X	X
STDs:												
target population with stds receive appropriate treatment	X	X	X	X	X	X	X	X	X	X	X	X
target population with stds receive appropriate preventive education	X	X	X	X	X	X	X	X	X	X	X	X
training sessions conducted for clinic personnel	X	X	X	X	X	X	X	X	X	X	X	X
Condoms:												
improvement of logistics distribution system	X	X										
communications system implemented			X	X	X	X	X	X	X	X	X	X
feasibility study completed on brand name					X							
creation and launch of brand name condom								X				
condom distribution to csws	X	X	X	X	X	X	X	X	X	X	X	X

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ACTIVITY/quarters	1	2	3	4	1	2	3	4	1	2	3	4
Evaluation:												
baseline assessment—December, 1994												
pifs	X	X	X	X	X	X	X	X	X	X	X	X
semi-annual program review		X		X		X		X		X		X
annual program review				X				X				X
final evaluation												X

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APPENDIX
ADDITIONAL POTENTIAL ACTIVITIES

1. Assessing Needed Support of Families Affected by AIDS

Since the major mode of HIV transmission is sexual contact, AIDS is predominantly affecting those in the years of prime economic productivity, and the periods when individuals are most likely to build and support families. Consequently, those who are becoming ill and dying of AIDS are often precisely those responsible for supporting, or contributing to the support of a household. They are the laborers producing income or food for families, caretakers of children and the elderly, and the managers of family farms and households.

Families in which one or more members are HIV-positive or have AIDS are likely to experience a reduction in income and productivity precisely as their expenses increase to care for the sick. Income and productivity decrease because neither ill family members nor their caretakers are able to work sufficiently to provide for the household. Furthermore, school-age children often must interrupt their educations to become caretakers for ill parents or siblings, to become income or food producers, or simply because the family can no longer afford school fees.

Because of the likelihood that HIV has been transmitted between husbands and wives within a household, the phenomena of 'AIDS orphans' is increasing throughout Honduras. Grandparents, other extended family, and communities are taking responsibility for the care of these children, although in some cases, orphaned siblings must adapt to taking care of themselves and managing their own households.

The ongoing NACP/AIDSCAP socio-economic impact assessment has focused predominantly on the costs of treating patients with AIDS and assessing the impact of AIDS on productivity. However, this study has provided no insight into the issue of how AIDS affects families or how greater support might be provided to families which have an ill family member. This information is critical both in terms of promoting further AIDS prevention efforts and in developing appropriate responses by the government, churches, and NGOs to support afflicted families. As Barnett and Blaikie conclude in their observations about the household impact of AIDS, "it will be of utmost importance that the coping capacity of households and communities is closely monitored in order that policies and programmes are designed which can support them as their present coping mechanisms cease to be adequate."

It is these destabilized patterns of income production and expenditures, as well as altered caretaking responsibilities, family configurations and schooling patterns that a household impact assessment will document. This joint NACP/AIDSCAP study will provide the Honduran Government with the economic and socio-economic data needed to inform and develop supportive and effective social policy to assist families in managing and surviving the HIV and AIDS epidemic.

A household impact assessment will serve to gather the data that Honduran policy makers can then use to develop targeted policies and programs to provide support and relief for families, households and communities affected by AIDS. It is hoped that the information gathered through the study, and the conclusions drawn, will stimulate the formulation of appropriate and useful social policies that will improve the functioning of household economies of families impacted by the epidemic.

Specifically, the proposed study will address the resource needs of families as related to:

- basic needs such as food, clothing and shelter due to income changes resulting from family member's illness;
- caretaking for young children or orphans whose caretaker is ill or has died;
- health care;
- payment of school and other fees, and general living expenses;

The purpose of AIDSCAP's collaboration in the Honduran study involves: 1) training Honduran collaborators in a household impact methodology that focuses on AIDS and socio-economics; 2) assisting collaborators in promoting a policy dialogue among Hondurans about programs likely to be needed by Honduran families; and 3) promoting the development of recommendations for NGOs and the GOH regarding methods to alleviate the impact of AIDS on families and communities.

The data for the household impact assessment will be gathered through case studies and surveys conducted with individual households in AIDSCAP's target regions.

Activity	FY1	FY2	FY3	FY4
Assessing Needed Support of Families Affected by AIDS				
- Subagreement		\$30,000	\$60,000	
- T.A.		\$10,000	\$10,000	

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II. Simulation Modeling

INTRODUCTION

Honduras is experiencing a growing AIDS epidemic. In response, a variety of AIDS intervention programs have been planned and/or implemented with the assistance of international donors including USAID, the World Bank, and the World Health Organization, etc. Such intervention programs include: (1) enhanced STD treatment for at risk populations, (2) promotion and distribution of condoms, (3) communications programs to reduce the number of sexual partners, (4) school based AIDS education, (5) workplace AIDS education, and (6) policy reform programs.

Given the scope of the AIDS epidemic in Honduras, and the large financial expenditures allocated to AIDS prevention, it is imperative that a coordinated cost effective strategy for AIDS intervention activities be developed. To accomplish this, it is proposed that an analysis of the projected efficacy of AIDS prevention programs be conducted in Honduras. This analysis will help policy makers make better decisions about how to effectively allocate scarce funds.

This analysis will be conducted using simulations models [iwgAIDS or SimulAIDS]. The analysis, together with cost estimates of prevention programs, will be used to generate projections of: (1) epidemiologic impacts of various prevention programs by population group, and (2) comparisons of cost effectiveness across prevention programs and targeting strategies.

Goals:

EPIDEMIOLOGIC

- (1) To identify how behavioral changes found to occur through AIDS prevention programs impact the scope and distribution of HIV and AIDS in Honduras by type of program, geographic region, age, gender, and sexual behavior.
- (2) Given that AIDS intervention programs will have varying levels of efficacy in changing behavior across groups with different HIV serostatus, gender, region, and age, the modeling will seek to identify the best targeting strategies for each intervention program.
- (3) Since the effects of prevention decay over time, the modeling will examine varying levels of decay to see how this will affect the efficacy of prevention at slowing the epidemic in areas with different patterns of epidemics.
- (4) Examine how individual level effects of prevention programs impact macro public health outcomes. (For example, some programs that are 100% effective at changing risk behavior among certain target groups could have an insignificant impact on the general course of the epidemic).
- (5) Identify goals levels for coverage and effectiveness of behavioral interventions that will lead to significant reduction in the incidence of HIV on a population level.
- (6) Identify optimal target groups (by geographic location, age, sex, risk behavior, and infection status) for various HIV vaccines (with varying levels of effectiveness). Even though there is currently no HIV vaccine available, this analysis will provide a better understanding of the potential impact that a vaccine will have, and will help in the preparation for developing vaccination programs when a vaccine is available.

ECONOMIC

- (7) Compare the cost-effectiveness of various prevention programs.
- (8) Examine how the promotion and distribution of condoms affects HIV prevalence and incidence in various settings.
- (9) Examine the relative cost-effectiveness of (hypothetical) HIV vaccination programs versus behavioral and STD interventions.

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METHOD:

Analysis will be conducted with simulation models and associated Honduras data files. Simulation models are complex software packages that use advanced multivariate mathematics to make estimates of the future impact of the AIDS epidemic. In essence, these models simulate actual epidemics using computers. Moreover, these models have the capacity to evaluate the impact of behavioral and biologic interventions on the AIDS epidemic allowing the user to compare the relative effectiveness of different intervention strategies. Data generated from simulation models can be disaggregated by a host of variables including gender, region, HIV serostatus, condom use, and coupling status (for example married versus single).

When modeling data are coupled with cost data it will be possible to calculate the cost-effectiveness ratio of various intervention approaches, with results disaggregated by independent variables. It is proposed to simulate projections through the year 2010 using this advanced technology.

The modeling will develop a baseline dataset for San Pedro Sula with behavioral and demographic data. This dataset will be developed from extensive literature review and country level studies, and can be modified as-needed for specific country level analysis.

Having a datasets available for San Pedro Sula will allow for the most sophisticated modeling analysis of interventions, cost-effectiveness, targeting, and impact assessment. Results from analysis of the dataset can be used by policy makers in both San Pedro Sula and Honduras in total.

Impact projections will be coupled with cost estimates to generate population specific evaluations of the comparative impact and cost of various intervention programs. It is proposed to examine the following intervention programs:

- (1) Condom promotion and distribution programs / socially marketed and targeted programs.
- (2) Behavior change / reduction of number of sex partners.
- (3) STD treatment programs.
- (4) HIV vaccines with varying levels of effectiveness (hypothetical).
- (5) Combinations of above.

Projected effects of these prevention programs will be distributed by the following independent variables:

- (1) Age.
- (2) Gender.
- (3) Geographic location -- urban/rural.
- (4) Paring status -- paired to single or multiple partners.
- (5) Risk behavior -- high/low risk.
- (6) Combinations of above.

Findings generated from this analysis will be used to facilitate decision making by policy makers and international donors. A detailed report of the findings to be distributed in appropriate forms to various target groups of policy makers will include: (1) politicians and government workers, (2) private sector business owners and managers, (3) church leaders, and (4) international donors. Data generated from these analyses can be used with ongoing AIDS Impact Model (AIM) activities with little delay since AIM can read iwgAIDS files. These findings will also be used in policy maker workshops in Honduras.

It is estimated that it will take approximately 1 year to compile the baseline dataset for analysis. Cost data will also be collected during this period, and will likely be available for analysis within 1 to 1.5 years. Modeling analysis will be ongoing, and will be initiated once the baseline datafiles are available.

Activity	FY1	FY2	FY3	FY4
Cost Analysis of Interventions /Simulation Modeling				
- Subagreement		\$10,000	\$35,000	
- T.A.		\$15,000	\$10,000	
TOTAL		\$ 25,000	\$ 45,000	

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APPENDIX D

In November of 1992, a study was jointly initiated by the Ministry of Health and AIDSCAP with funding from the LAC Bureau of USAID. This study was designed to assess the social and economic impact of HIV/AIDS. This was accomplished by developing projections of the epidemic and the corresponding economic impact in San Pedro Sula and Tegucigalpa. By August of 1993, the results from the study had been presented to over 400 people in both cities at 2 national workshops attended by the President and the First Lady.

The next steps in this study are to assure that there is sufficient distribution of the study. This is to be accomplished by completing the following activities:

- April, 1994 A copy of the socioeconomic impact assessment was delivered to AIDSCAP/FHI by the Ministry of Health.
- April, 1994 AIDSCAP will approve a revised field budget which includes funds for the production of a video tape.
- May, 1994 Comments on the socioeconomic impact assessment will be sent to the Ministry of Health and will be copied to USAID/Honduras.
- May, 1994 A copy of the final report (including graphics) will be sent to AIDSCAP by the Ministry of Health.
- June, 1994 AIDSCAP will reproduce 200 copies of the final report in Spanish and 50 copies in English. All Spanish copies will be sent to the Ministry of Health and USAID/Honduras for distribution.
- September, 1994 The copy of the videotape will be finalized.

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To: Thomas Johnson@DF@TEGUCIGALPA
Cc:
Bcc:
From: Clifford Brown@PDSO@GUATEMALA
Subject: re: HSII ProAg Admt. and Amended Auth.
Date: Friday, August 26, 1994 22:50:52 LOC
Attach:
Certify: N
Forwarded by:

I hereby clear the amendment 19 to the HSII proag and the related authorization amendment in the form e-mailed to me on the afternoon of August 25. Good job.

CLEARANCE PAGE FOR ACTION MEMORANDUM FOR THE MISSION DIRECTOR
SERVING AS A PROJECT PAPER SUPPLEMENT AMENDING THE DESIGN OF THE
HEALTH SECTOR II PROJECT (522-0216)

Drafted by: TJohnson, DF
Cleared by: DLosk, HRD DL
 LSimard, DP
 MSnyder, OCM
 RBonaffon, CONT

**CLEARANCE PAGE FOR ACTION MEMORANDUM FOR THE MISSION DIRECTOR
SERVING AS A PROJECT PAPER SUPPLEMENT AMENDING THE DESIGN OF THE
HEALTH SECTOR II PROJECT (522-0216)**

Drafted by: TJohnson, DF

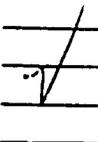


Cleared by: DLosk, HRD

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RBonnaffon, CONT



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Cleared by: DLosk, HRD
LSimard, DP
MSnyder, OCM
RBonnaffon, CONT

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