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

HONDURAS

PROJECT PAPER

PRIVATE SECTOR POPULATION III

AID/LAC/P-942

PROJECT NUMBER: 522-0389

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8. Costs \$000 or Equivalent \$ 1 =									
A. Funding Source		First FY 95			Life of Project				
		B. FX	C. L/C	D. Total	E. FX	F. L/C	G. TOTAL		
AID Appropriated Total									
(Grant)		298	0	298	1,310	9,944	11,254		
(Loan)									
Other	1. ASHONPLAFA		0	0		13,370	13,370		
U.S.	2.								
Host Country									
Other Donor(s)									
TOTALS		298	0	298	1,310	23,314	24,624		
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)	Population					2,559		11,254	
(2)									
(3)									
(4)									
TOTALS						2,559		11,254	
10. Secondary Technical Codes (maximum 6 codes of 3 positions each)								11. Secondary Purpose Code	
12. Special Concerns Codes (maximum 7 codes of 4 positions each)									
A. Code									
B. Amount									
13. Project Purpose (maximum 480 characters) To promote the sustainable provision of reproductive health services, including family planning services, by the private non-profit sector.									
14. Scheduled Evaluations MM YY MM YY Interim 0 6 9 8 Final 1 2 0 0						15. Source/Origin of Goods and Services [X] 000 [] 941 [] Local [] Other (specify) _____			
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	Title: Elena L. Brineman Mission Director		Date Signed: 7/27/95						

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Private Sector Population III Project Paper
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PRIVATE SECTOR POPULATION III (522-0389)

PROJECT PAPER

I. PLANNED RESULTS

A. At the Strategic Objective (SO) Level

The Private Sector Population III Project (PSP III) will contribute to the achievement of USAID/Honduras' SO No. 3, *"Improved Family Health"*, by helping to reduce Honduras' Total Fertility Rate (TFR) from 4.7 in 1995 to 4.2 by 2001. This project will also have an impact on the Maternal Mortality Rate (maternal deaths/women of fertile age), but it will not be possible to measure this impact during the life of project.

B. At the Program Outcome (PO) Level

PSP III will contribute directly to a major portion of USAID's Program Outcome 1.1 within SO No. 3, *"Increased Use of Reproductive Health Services, Including Family Planning Services."* Specifically:

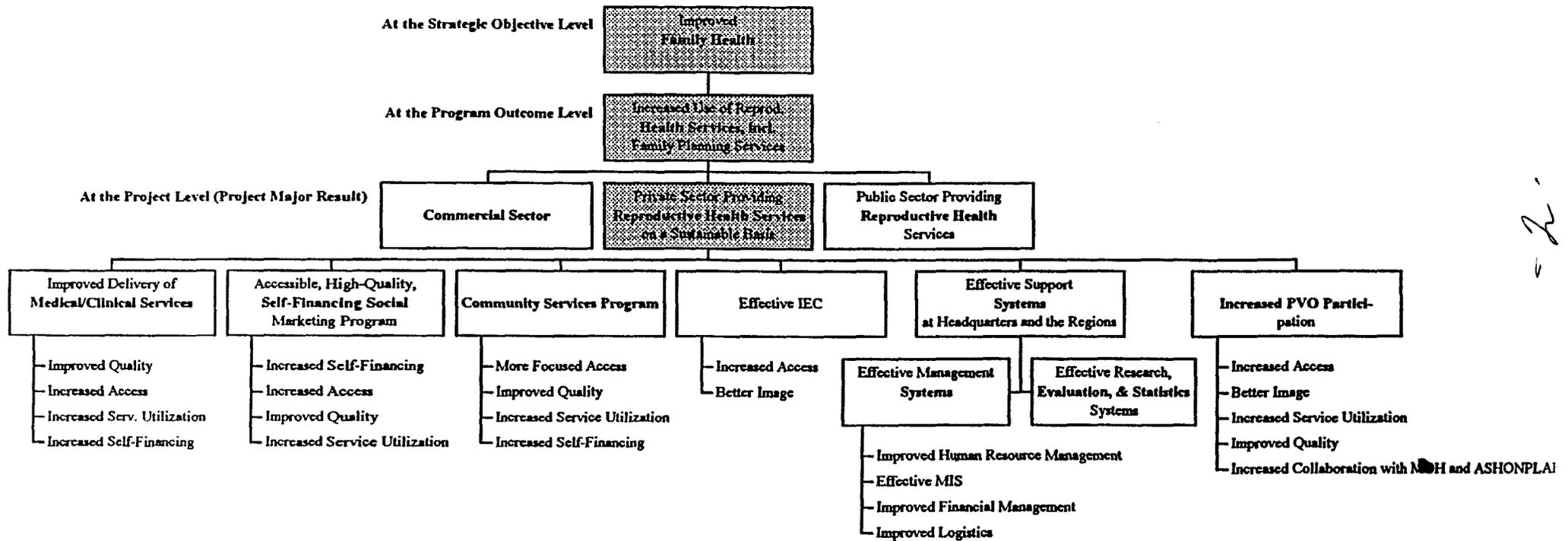
- National Contraceptive Prevalence Rates (CPR) will increase:
 - from 50.1% in 1995 to 54.6% in 2000 (all methods)
 - from 38.6% in 1995 to 43.0% in 2000 (modern methods)
- Urban CPR will increase:
 - from 63.4% in 1995 to 66.7% in 2000 (all methods)
 - from 52.4% in 1995 to 55.7% in 2000 (modern methods)
- Rural CPR will increase:
 - from 40.1% in 1995 to 45.4% in 2000 (all methods)
 - from 28.1% in 1995 to 33.4% in 2000 (modern methods)

The relationship between these objectives is shown in the attached Objectives Tree, and the benchmarks (or "checkpoints") by which USAID and its partners will measure progress toward them, is set forth in Annex Two, "Results Framework", to this Project Paper (PP).

At the same time, efforts funded under PSP III will:

- **Increase ASHONPLAFA self-financing** from 31% in 1995 to 63% in the year 2000.
- **Substantially increase the client volume** (as measured by CYPs provided) of ASHONPLAFA and other PVO reproductive health services.
- **Improve the quality** of ASHONPLAFA and other PVO reproductive health services.
- **Increase the access of underserved rural populations** to reproductive health services.

Table 1: **Objectives Tree**
Private Sector Population III Project



The PSP III Project will also contribute – to a lesser extent – to the other two Program Outcomes within SO No. 3, "Increased Use of Selected Child Survival Interventions" and "Increased Use of STD/AIDS Prevention Practices."

C. Project "Customers"

More than previous projects, this project is targeting the un- and underserved populations who are interested in planning their families but who do not do so due to a lack of information or fear, as well as those who use ineffective traditional methods. These are women, men, and adolescents of fertile age in Honduras, primarily in rural and periurban areas. They are the "customers" of this project. Further detail on the project's customers may be found in Annex 4.

II. MAJOR CONSTRAINTS TO ACHIEVING RESULTS/PROBLEM ANALYSIS

A. Constraints at the National Level

At present, several major constraints impede the progress of Honduras' national family planning program¹ toward the above objectives. These include the following:

- Honduras is a family planning "plateau country" where the use of modern methods of contraception has grown slowly. In 1984, 30% of women of reproductive age (WRA) indicated they used modern methods; seven years later only 35% did so. Growth was slow in both urban (from 45% to 50%) and rural areas (20 to 24%). Over this period, however, the use of traditional family planning methods grew considerably (5% in 1984 to 12% in 1991) in both rural and urban areas. In the large rural region covered by ASHONPLAFA's Santa Rosa de Copán office, 18% of women in 1991 reported using traditional methods.
- Lack of a firm Honduran public policy commitment to family planning is a constraint to family planning in general and to the performance of the PSP III Project in particular. The main reason for the lack of commitment has been the influence of the Catholic Church and local pro-life organizations, which fiercely oppose family planning. Typically, once or twice a year, the Church makes a highly visible public attack on some aspect of the family planning programs. In these attacks family planning is equated with abortion, and the side effects and risk factors associated with contraception are exaggerated. As a result, politicians prefer to remain noncommittal on the subject of family planning. For example, just one year ago the church, together with a local pro-life organizations, successfully halted discussion of the 1994

¹ The term "national family planning program" refers to the combined efforts of the public sector (the Ministry of Health and the Honduran Social Security Institute), the private sector (ASHONPLAFA and other PVOs), and the commercial sector.

International Conference on Population and Development and formed part of the Honduran delegation to the Conference where it tried to block the final plan of action.

- Whereas in an effective and sustainable national family planning program, the **public, private non-profit (PVO) and commercial sectors** all play essential roles, serving different market segments², in Honduras, the private non-profit sector is the dominant sector, and USAID-subsidized ASHONPLAFA is the most significant provider. The 1991 Epidemiology and Family Health Survey (EFHS) attributed to ASHONPLAFA the supply of family planning services and contraceptives for 60% of all Honduran women who use modern contraceptive methods.³ The Ministry of Health (MOH), which through its extensive network of primary health care facilities has the potential to be an important family planning provider, traditionally has been weak in family planning. In 1991, 22% of women using modern contraceptive methods reportedly received family planning services from the MOH.⁴ MOH staff and facilities have been insufficiently trained, supervised, equipped and supplied. Stockouts have been frequent, and clients wait hours for service.
- The third sector in the national family planning program, **the commercial sector, has also been weak**; indeed, it was weaker in 1991 than in 1987. In 1991, only 13% of family planning services and supplies were attributed to this sector, which includes private physicians, hospitals, and pharmacies, down from 21% of users in 1987. Of the 13% in 1991, most (9%) went to pharmacies to purchase contraceptives at commercial prices. At that time, an additional 16% of users went to pharmacies to purchase USAID-subsidized oral contraceptives and condoms distributed through the Social Marketing Program of ASHONPLAFA.⁵ Thus, although 25% of users of modern methods have developed the practice of purchasing contraceptives in pharmacies, only 9% have developed the habit of paying commercial prices.
- **Quality of care** is a national problem. As indicated, it is not good in the MOH. In pharmacies, knowledge of the correct use, indications and contraindications of Social Marketing Program oral contraceptives is low. In 1994, 15-31% of interviewed women did not know how to take the pill correctly; nationwide, 59% were unaware of

² The key to which, policy makers say, is "getting prices right." Technical assistance in strategic planning for such sustainable sectoral balance is available in the Global POLICY Project.

³ This percentage is higher than that previously reported (41.6%). To arrive at the more accurate 60% figure cited here, this paper attributes to ASHONPLAFA those users who reported they purchased certain brands of oral contraceptives and condoms which were recognized as having been obtained from either ASHONPLAFA's Community Services Program (CSP) or its Social Marketing Program on the basis of brand and price.

⁴ The public sector is a critical component of a sustainable national family planning program and an indispensable participant and collaborator in achievement of USAID's strategic objective and program outcome. If USAID is to achieve improved reproductive health on a national level, the family planning component of the Health Sector II Project with the MOH must function more effectively.

⁵ Until Social Marketing Program products are no longer subsidized, product sales are and will continue to be viewed as being part of private sector activities (ASHONPLAFA), and not part of the commercial sector.

the contraindications of its use and in Choluteca, Santa Rosa and Juticalpa, this figure reached 80%.⁶ ASHONPLAFA is also recognizing that quality is a problem within its programs: recent evaluations indicate inconsistent quality in the areas of counseling, technical competence, and interpersonal client-provider relations. The unavailability of adequate equipment and supplies exacerbates the problem within both the MOH and ASHONPLAFA.

- **National access to services and supplies** is an issue that USAID and ASHONPLAFA began to address in the Private Sector Population II Project. In 1995 services and supplies are readily available in urban areas, at least in terms of distance and cost; access continues to be a barrier, however, in rural areas.

B. Constraints Within ASHONPLAFA

In addition to the national-level constraints cited above, many of the impediments to achieving desired results lie in one, or another, department or program of ASHONPLAFA. Four critical problems are institution-wide and amenable to change only at that level; all affect ASHONPLAFA's potential to become a sustainable institution.

1. Institution-Wide Constraints

The first of these is ASHONPLAFA's **corporate culture**, in which harmony and relationships are of the utmost importance and where donor dependence is taken for granted. If ASHONPLAFA is to become self-financing and sustainable, it must adopt additional values stressing productivity and efficiency, with the bottom line being an entrepreneurial mentality sensitive to opportunities for profit and loss. Such an organizational change is possible – with strong, determined and committed leadership from the Executive Director and the Board of Directors.

Such **leadership**, however, is the second constraint. The Executive Director, who is planning to retire within the next year, may not be in a position to make the necessary organizational changes alone. Over the longer-term, the concern is that his successor will have to continue to lead and promote such change aggressively. To achieve the results expected of this project, ASHONPLAFA needs senior executive staff with strong leadership, planning, finance and marketing skills. That staff needs to have both the charisma and authority to lead and command the synchronized implementation of many interdependent activities, as well as to make the hard decisions in human resource management which will be necessary as ASHONPLAFA focuses on performance and productivity.

⁶ Perfil de Usuarías del Programa de Mercadeo Social, ASHONPLAFA, Departamento de Investigación y Estadística, June 1994.

The third institutional constraint is **inconsistent quality** and the lack of an institutional commitment to quality and customer satisfaction. Although the problems vary from program to program, quality problems exist in each of them. ASHONPLAFA staff, from the highest to the lowest levels:

- o must understand that quality and customer satisfaction are fundamental to sustainability;
- o be competent to provide safe and effective services, satisfying their clients; and
- o be motivated and compensated for doing so.

The fourth institutional constraint is the **lack of a good Management Information System (MIS)** with cost accounting. ASHONPLAFA must get a good MIS, which provides timely and accurate data on key areas of institutional performance, including levels of self-financing, up and running smoothly at the headquarters and in each regional office by the end of 1996.

2. Constraints in the Medical Clinical Program (MCP)

a. Access to Medical/Clinical Services

MCP staff have identified three factors which impede access to MCP services: 1) Lack of knowledge about family planning in general and ASHONPLAFA services in particular; 2) distance; and 3) cost. Through this project, the MCP will try to address each factor.

Lack of knowledge is the principal reason Honduran women don't use family planning. The Information, Education and Communication (IEC) Unit and PVOs must remedy that lack and, using culturally appropriate materials and messages, inform women, men and adolescents in targeted areas of the benefits of family planning, of indications and contraindications, and of the location and hours of new services being opened. Success in this effort will depend on the MCP's own efforts, on the efforts of other ASHONPLAFA departments (e.g., in launching effective IEC campaigns), and on the efforts of ASHONPLAFA's partners, the PVOs, in reaching out and providing information to rural populations.

Although ASHONPLAFA has grown significantly over the past few years and has clinics distributed throughout the country, **distance** continues to be a constraint especially in Regions 5 and 6 (Santa Rosa de Copán and Juticalpa). The dispersed population and difficult access in these regions are major constraints to offering cost effective reproductive health and family planning services.

ASHONPLAFA debates the extent to which cost is a constraining factor. Several studies indicate that the cost of family planning services is not an impeding factor for the population at large (1991 EFHS) and that the cost of ASHONPLAFA MCP services, in particular, (John Bratt, June 1995) is not a deterrent to ASHONPLAFA clients. ASHONPLAFA staff, however, insist that for many families, including periurban families, cost is an important factor limiting access. The pricing policy to be established in the near future should ensure

that while costs are recovered to the extent possible in all MCP clinics, no client is turned away for inability to pay.⁷

b. Quality of Medical Clinical Services

The MCP has always taken pride in the quality of the services it offers; recent evaluations, however, have led the MCP to more critically assess itself and acknowledge that MCP quality can be inconsistent.⁸ Not all new users receive full and unbiased counseling; not all providers are technically competent; and not all facilities, equipment and supplies are safe, effective and consumer oriented. Several factors contribute to the inconsistency; perhaps the most important is the lack of a Quality Assurance (QA) system with clear norms covering clinical competence, protocols, administrative procedures and specification of equipment and supplies. This lack, while critically important, is relatively easily remedied, and MCP personnel welcome the opportunity to introduce such a system. The more daunting constraint, which would impede a QA system moving rapidly to address problems which it detected, is ASHONPLAFA's internal bureaucracy and the bureaucracy between regions and headquarters.

Whereas to successfully address access constraints the MCP will depend on successful IEC and PVO collaboration, to improve quality, the MCP will depend on good planning, monitoring and prompt decision making by the *Consejo Técnico* and prompt and smooth collaboration from the Human Resource Management Unit (HRM).

c. Utilization of Medical Clinical Services

There are three major constraints to increasing the utilization of the MCP services. First, the clinics of the regional centers are being underutilized, in some regions more than others, as a result of poor promotional services and inadequate schedules. Second, poor quality of care may prevent the promotional multiplier effect that satisfied clients would otherwise provide to prospective clients. Third, ASHONPLAFA has not targeted medical clinical services to adolescents.

d. Self-Financing of Medical Clinical Services

There are three principal obstacles to increasing the MCP's level of self-financing from the 1994 baseline of 34%. First, ASHONPLAFA does not use cost center accounting for any of its clinics and laboratories, and is therefore unable to assess the true cost of each of these cost centers on a regular basis. Consequently, there have been few if any modifications of the MCP based on progress (or lack thereof) toward financial self-sufficiency. Second, the Association has been unwilling to increase prices at even the rate of inflation. The MCP has

⁷ Such a policy is followed at other Family Planning Associations in Latin America (INPPARES and PROFAMILIA in Colombia).

⁸ Cobb et al, *Evaluation of the Private Sector Population II Project*, April 1995 and Robert Lederer, *Medical Clinical Analysis*, July 1995.

raised prices only minimally for fear that such increases would have a tremendous effect on client volume, especially on female voluntary surgical contraception (VSC). Third, there is no incentive system to motivate staff to increase productivity and provide services in a more cost-efficient manner. ASHONPLAFA has only recently begun to discuss how to implement such an incentive system.

3. Constraints in the Social Marketing Program (SMP)

a. Constraints to Self-Financing of Social Marketing Program Services

Until recently, the principal constraint to self-financing of the SMP was its weak and ineffective structure, with authority and responsibility for commercial success spread over several units lacking commercial management and expertise.⁹ Other constraints (lack of market segmentation, product mix, poor advertising, low prices etc.) are a consequence of that structure and management.

USAID and ASHONPLAFA expect that the SMP will reach at least 110% self-sufficiency at the end of Year One, thereby generating a surplus with which to subsidize ASHONPLAFA's revenue-losing activities. If it is to reach this objective, the SMP will have to overcome a second major constraint (which, is in part, a consequence of the first): its aversion to charging market-based prices for its products. As the technical analysis of the SMP indicated, "ASHONPLAFA has bought the formal sector market (75% of contraceptive pills and 45% of condoms in pharmacy sales) based on subsidized products, and it has foregone - and continues to do so - easily realizable income with which to contribute to its own self-sufficiency."¹⁰

b. Access to the Social Marketing Program

Access per se is not a major constraint to success of the SMP. SMP products are sold in almost 100% of Honduran pharmacies at prices (as described below) well below what the market value of those products could command. Thus, in this sense, the SMP is *too* accessible. This notwithstanding, it is true that the program is not taking advantage to the extent that it could of other obvious sales opportunities (e.g., sales in supermarkets, bars and *pulperias*), nor is it fully using certain simple but potentially effective marketing techniques. In this sense, access to the SMP could be even greater than it currently is.

⁹ Joseph Burke, Social Marketing Analysis, July 1995.

¹⁰ Ibid.

c. Quality of the Social Marketing Program

Quality is a problem in many social marketing programs throughout the world. It is a particular problem in Honduras. Many women buy oral contraceptives from the pharmacy without knowing their correct use, indications or contraindications and without knowing which side effects are normal and which are an indication of medical problems.¹¹ Quality – in terms of both safety and effectiveness – is compromised. As a consequence of unanticipated side effects, including both those that genuinely stem from a medical problem and those that do not, consumer satisfaction with the pill falls and fears mount about modern methods.

d. Utilization of Social Marketing Services

The principal constraint to utilization of SMP services will be the planned 1996–97 change in USAID–donated oral contraceptive Noriday (marketed as Perla) to Duo–Fem. Perla, which is the lead oral on the market (45% of market share), will no longer be available through USAID/W Central Contraceptive Procurement because the pharmaceutical company which produces Noriday did not participate in the last procurement bidding process. However, ASHONPLAFA will have enough Noriday in stock through June 1997. The SMP, therefore, must prepare consumers for Noriday's market demise and promote their switching to Duo–Fem. The campaign will have to be timed and worded carefully: Noriday is a standard dose oral, and Duo–Fem is a low–dose. It is reasonable to assume that there might be some drop in sales during the transition. ASHONPLAFA's success will depend on planning and synchronizing multiple activities. In this case, ASHONPLAFA must distribute Duo–Fem, launch a major campaign for it, raise prices on Noriday, and exhaust the remaining stocks of it.

4. Constraints in the Community Services Program (CSP)

a. Access to the Community Services Program

The same three factors that hamper the Medical Clinical Program also impede access to CSP services: lack of knowledge about family planning; distance; and cost. Recent analyses show that the CSP has devoted too much of its effort to expand services to more easily–reached urban and periurban customers in the Tegucigalpa, San Pedro Sula, Choluteca and La Ceiba regions, and not enough to meeting the needs of the primarily rural regions of Santa Rosa de Copán and Juticalpa, where access to modern family planning methods and modern contraceptive prevalence rates remain lowest.¹² The consequence has been two–fold: Those couples with the least access to family planning remain under– or unserved, while couples in

¹¹ Perfil de Usuarias del Programa de Mercadeo Social, ASHONPLAFA, Departamento de Investigación y Estadística, June 1994.

¹² See Annex 1 for Background Data used in this analysis.

urban and periurban areas have access to orals and condoms at prices which undercut the more sustainable commercial sector (pharmacy).¹³

b. Quality of Community Services Program Services

A second constraint the CSP has identified is the inconsistent quality of counseling the *consejeras* give their clients. *Consejeras* do not always give accurate information on methods the client chooses in terms of advantages and disadvantages, correct usage, resupply and complications that would require follow-up, nor do they always give accurate, unbiased overviews of all methods available to their clients. This latter constraint is, in part, due to the fact that *consejeras* are not generally encouraged to distinguish between appropriate VSC or IUD candidates and ideal oral or condom users. Moreover, they are monetarily discouraged from doing so. With the sales of condoms and orals, they receive a 20% to 30% commission, while a referral to a regional ASHONPLAFA clinic represents no monetary gain, just a lost client.¹⁴

c. Utilization of Community Services Program Services

The major obstacle to utilization of CSP services is poor promotional efforts, especially by the *consejeras*. Contraceptive stock-outs have also been an obstacle to utilization of CSP services. Finally, as with any other family planning services offered by ASHONPLAFA, religious beliefs also impede increased utilization of CSP services.

d. Constraints to Increasing Community Services Program Self-Financing

The two principal constraints to increasing the CSP's planned level of self-financing (70% by the end of year 2000) during this project are low post productivity and low prices. The CSP's 2020 posts individually generate an average of 30 CYPs a year. Among the CSP posts, CYP generation (and thus productivity) varies tremendously; in some cases, it is as low as zero. In urban and periurban areas where SMP pharmacy products are readily accessible, low post productivity represents a heavy financial burden for the CSP with little gain in access (since nearby pharmacies already sell temporary methods). As for the prices of CSP products, ASHONPLAFA has been unwilling to increase them at even the rate as inflation for fear that there will be a decline in CYPs generated. Consequently, the costs related to program operation (particularly salaries) have increased faster than income generated by the program.

¹³ Joseph Burke, Community Services Program Analysis, July 1995.

¹⁴ Joseph Burke, Community Service Program Analysis, July 1995.

5. Constraints to Implementation of an Effective Information, Education and Communication Strategy

ASHONPLAFA's IEC program has had difficulty disseminating focused and targeted information on family planning and reproductive health services in general, and on ASHONPLAFA services in particular, in a timely and consistent manner.¹⁵ This is particularly worrisome given the large expenditures devoted to IEC activities. Target groups which have especially been overlooked are those which are in the most need of information: men and adolescents.¹⁶ In large part, this is due to the program's lack of focus and institutional expertise, and to the high degree of centralization with which the program is currently managed. To a lesser degree, it is also the result of poor planning and coordination between the IEC program and the direct service delivery programs within ASHONPLAFA.

A second impediment to an effective IEC program is the lack of sustained strategies to improve the image of family planning. The opposition of the Catholic church and other institutions, such as Pro Vida, have historically put enormous strains on the resources of the IEC program. Consequently, that program has substantial expertise in "defending" family planning and the activities of the institution during times when ASHONPLAFA and family planning are under public attack,¹⁷ but little experience in developing and launching sustained campaigns to improve ASHONPLAFA's image. Consequently, most Hondurans have only limited knowledge about the services ASHONPLAFA offers.¹⁸

6. Constraints in Support Systems at the Headquarters and Regional Level

a. Human Resource Management (HRM)

In the last several years, ASHONPLAFA and USAID invested in ASHONPLAFA's HRM systems; considerable progress has been made. This project, however, will place new demands upon those systems and ASHONPLAFA personnel – in terms of performance, productivity, and the need to make hard decisions about staffing levels and qualifications to accomplish the planned results.¹⁹ Some departments may be understaffed and others overstaffed; some may have competent personnel, while others may have a number of personnel unable to significantly contribute to the results required in their unit.

One constraint to hiring and maintaining qualified personnel is the compensation system: there is no incentive system, and ASHONPLAFA has been reluctant to pay good salaries for top-notch people, even in programs in desperate need such as the SMP. Having fewer – but

¹⁵ Diane Urban, IEC Analysis, July 1995.

¹⁶ MULTI/MARKETING, 1995, Conocimientos, Actitudes y Prácticas de Adolescentes, Hombres y Mujeres.

¹⁷ Diane Urban, IEC Analysis, July 1995.

¹⁸ MULTI/MARKETING, 1995, Conocimientos, Actitudes y Prácticas de Adolescentes, Hombres y Mujeres.

¹⁹ See the pre-design analyses of Joseph Burke, Robert Lederer, Zoe Kopp and Diane Urban for assessment of staff competence in critical new areas of institutional results.

more highly qualified and well compensated (in terms of both salaries and incentives) – staff might be more effective and efficient than having a greater number of underqualified and moderately paid staff. ASHONPLAFA's ability to achieve program results while becoming increasingly self-financing may be constrained by its ability to make such hard, but necessary, personnel decisions.

b. Management Information Systems (MIS)

Over the last year, ASHONPLAFA and USAID have invested heavily in ASHONPLAFA's MIS, and considerable progress has been made. Development and implementation of the cost accounting and the information and statistics systems are underway. Much work has yet to be done, however. The MIS still do not address the management needs of ASHONPLAFA, nor have ASHONPLAFA staff been trained in how to use the data that the MIS will produce in the near future.

c. Logistics

In recent years, ASHONPLAFA has experienced stock-outs of several USAID-donated and IPPF-purchased contraceptives. In part, this is due to less than optimal practices concerning rotation and storage of contraceptives in the regional warehouses. But to a larger extent, the problem lies in weak inventory control at regional warehouses and at specific service delivery points.

d. Research, Evaluation and Statistics

ASHONPLAFA recognizes that its statistics unit has an unclear role in the management of services data. Duplication of data collection and processing activities, slow dissemination of information, and insufficient use of data for decision making are just a few of the constraints that result from this unclear role. In large part, this is due to the lack of institutional expertise, excessive data collection forms, the lack of functional software, the absence of a database which tracks programmatic activities and outdated equipment. To a lesser extent, though, the constraint is institutional. ASHONPLAFA has not been accepting of, nor is the institution experienced in, information-based decision making.

The research and evaluation unit has historically placed great importance on qualitative research, and, as a result, is very capable in this area. The lack of technical expertise, however, in other research areas, such as operations research and quantitative data analysis, has limited the type of research this department undertakes and the speed with which research results are made available. Consequently, dissemination of results often occurs after important decisions have been made and is of limited impact.

The research and evaluation unit also has ample experience in national impact surveys that measure the long term effects and impact of family planning efforts (Total Fertility Rate, Contraceptive Prevalence Rate, etc.), but it has little experience in carrying out evaluations

that measure the progress of ASHONPLAFA service delivery programs (program evaluations). ASHONPLAFA has identified this lack of expertise as the principle weakness of the evaluation department and will require at least one additional, experienced staff person in order to ensure that the several program evaluations which are scheduled throughout the life of the project occur and are of high quality.

C. Constraints in the PVO Component

Most PVOs that received USAID support under the PSP II Project chose to work primarily in training and IEC; only a small number of them opened community based distribution (CBD) posts in their catchment areas or provided referrals and transportation to their beneficiaries for clinical contraception. Consequently, many of the results of the PVO component were process-oriented, and did not emphasize utilization of services as a measurable result.

For those PVOs that opened CBD posts or provided referrals to their beneficiaries, there were different constraints. PVOs that incorporated CBD posts into their programs often overlooked the quality of services the community workers provided to beneficiaries, while PVOs that referred beneficiaries to the MOH found that the MOH facilities were unable to respond adequately to the referrals.²⁰ Given that rural women prefer clinical contraception and that clinical methods are more cost-effective than orals and condoms,²¹ this latter point is especially problematic. Though the MOH is the logical provider of these services given its extensive clinical coverage and affordable prices, most of the MOH clinics and health posts lack the trained personnel, equipment, and supplies necessary for the provision of reproductive health services such as family planning and pap smears. As a result, access to high-quality family planning continues to be a problem in the rural areas where many of the PVOs work.

Another area of concern is coordination among the different PVOs, ASHONPLAFA and the MOH. Many of the PVOs that received funding under PSP II worked independently in small defined areas and did not always collaborate effectively with the MOH. This is especially apparent in the development and distribution of IEC materials and training. IEC materials not in alignment with MOH policies were, at times, developed and distributed by the different PVOs. PVO training of rural health workers and health professionals also needs to be adjusted to fit the MOH's recently published national norms for integrated reproductive health care to women.²²

Only a small amount of funding was provided to PVOs under the PSP II Project.²³ Consequently, the interventions many PVOs were able to undertake were quite limited. Other

²⁰ Sandra Wilcox, PVO Analysis, July 1995.

²¹ Tania Dmytraczenko, Trade-off Between Rural Expansion and Financial Self-Sufficiency, May 1995.

²² Manual de Normas y Procedimientos de Atención Integral a la Mujer.

²³ Under the PSP II Project, a total of seven subgrants were awarded to four PVOs through the Population Council buy-in. The average amount of each subgrant was approximately \$85,000.

constraints to the success of the PSP II PVO component were particular to each PVO. One PVO dismissed its health staff at the end of its sub-grant; thus, family planning and reproductive health activities were not truly incorporated into this institution with PSP II support. Another PVO at times had difficulty coordinating with other organizations (MOH, ASHONPLAFA and other PVOs) due to extensive bureaucracy and approval times required for implementation of projects.²⁴

For those PVOs interested in receiving support from USAID under the PSP III Project, but who did not participate in the PSP II Project, other constraints exist. The majority of these "new" PVOs are small and do not have a large number of beneficiaries nor a very solid infrastructure. Further, many are interested in continued IEC efforts, while not so interested in direct service delivery or in channelling people in their catchment areas to services. Finally, many have never worked with USAID, and are unfamiliar with USAID regulations and reporting requirements.²⁵

In light of these constraints, only two new PVOs stand out as potential candidates, both of which would need help to become familiar with USAID procedures. One PVO, in particular, would need technical assistance in data collection, reporting, quality assurance, IEC, and training of medical personnel. The other PVO is closely allied to and supported by the Catholic church, and is therefore limited to the promotion of natural family planning methods.

III. STRATEGIES OF THIS PROJECT

In light of the above constraints – difficulties with rural access, inadequate quality of care, and dominance of the national program by one sector and one provider, the urban-oriented ASHONPLAFA – it is perhaps not surprising that the Contraceptive Prevalence Rate in Honduras has reached a plateau. Nonetheless, several factors suggest that the time is ripe for a concerted effort to move beyond this plateau:

- First, data show that women and men in Honduras want to plan their families and want fewer children than they are currently bearing.²⁶ There is considerable – and growing – unmet demand. **This desire and demand for effective and safe contraception will form the basis for a sustainable national program.**
- Second, the reasons most commonly cited by women for not using modern contraception – lack of knowledge and fear that those methods are not safe or effective – can be overcome given proper IEC and marketing efforts. Only .03% of women cite cost as a factor.

²⁴ Sandra Wilcox, PVO Analysis, July 1995.

²⁵ Ibid.

²⁶ EFHS, 1991/1992.

- **Third, ASHONPLAFA is committed to family planning and to achieving results in Honduras; it also has a history of coping with difficulty and change. With consistent direction and support, it will try mightily to meet the new challenges facing it.**
- **Fourth, over the last several years the major international PVOs working in rural areas of Honduras have decided at the international headquarters level to move into family planning and reproductive health. They are a resource increasingly to be tapped.**
- **Finally, even conservative Honduran institutions are recognizing Honduran couples' demand for planning their families. As will be discussed below, a local PVO, Natural Fertility Regulation (RENAFE–MOB), is a new potential ally. There are increasing numbers of institutional participants in the national family planning program.**

To take advantage of these opportunities, the PSP III Project will employ two principal strategies to promote a private sector able to provide reproductive health services on a sustainable basis. Project efforts will seek to:

- **Strike a more effective and sustainable balance between the various sectors (public, private non–profit and commercial) of the national family planning program by:**
 - **Slowing the expansion of ASHONPLAFA's CSP into urban and periurban areas in order to free resources for rural expansion; in some cases, ASHONPLAFA will close urban and periurban CBD posts. This will reduce the subsidized competition these posts provide to the commercial (pharmacy) sector's sales of both subsidized and non–subsidized contraceptives.**
 - **Expanding the number and type of PVOs providing non–profit family planning promotion and services, with a particular focus on PVOs serving rural areas. This will stimulate greater service utilization at MOH and ASHONPLAFA facilities; it will also provide healthy competition to ASHONPLAFA.**
 - **Supporting increased collaboration between leading PVOs working in rural areas, ASHONPLAFA, and the MOH. If and as necessary, PVOs may provide support to MOH facilities in targeted areas.**
- **Further the sustainable development of ASHONPLAFA, which will require:**
 - **a growth in self–financing;**
 - **improvement in quality;**
 - **slow and steady increase in volume as measured by CYPs provided; and**
 - **increased subsidized access for underserved rural populations.**

Project-funded activities will lead to six intermediate results. The first five of these are related to ASHONPLAFA; the sixth will be a consequence of activities with international and Honduran PVOs:

- Improved Delivery of Medical and Clinical Services
- Accessible, High-Quality, Self-Financing Social Marketing Program
- Focused, High Quality Community-Based Distribution Program
- Effective Information, Education, and Communication Strategy
- Effective Support Systems at the Headquarters and Regions
- Increased PVO participation in reproductive health

IV. PLAN OF ACTION FOR ACHIEVING RESULTS

A. ASHONPLAFA

The general strategy for carrying out activities with ASHONPLAFA is as follows:

- > USAID will finance technical assistance, training, commodities, and a percentage of ASHONPLAFA operating costs; and
- > ASHONPLAFA will deliver reproductive health services, distribute contraceptives, conduct research and provide training to other PVOs.

The principal tool will be a Cooperative Agreement between USAID and ASHONPLAFA through which USAID will fund technical assistance, training, commodities, and operating costs. USAID will decide whether to provide annual incremental funding to the Cooperative Agreement during its review of ASHONPLAFA's annual workplan and activity report (see Section V, "Monitoring and Evaluation", for full description of the review process). These annual reviews will focus on progress toward planned results. USAID/Honduras will also provide extensive oversight of project implementation through joint monitoring, frequent consultations and formal external evaluations. Finally, USAID-supported cooperating agencies will provide technical assistance which will be funded through OYB transfers and Global Field Support attributions to G/PHN.

1. Improved Service Delivery

This section describes the three service delivery programs of ASHONPLAFA (Medical/Clinical, Social Marketing, and Community Services), and the Information, Education, and Communication program that supports and promotes those programs. In each of these four programs, a plan of action is presented in terms of the four aspects of those programs and corresponding activities critical to achieving the intermediate results of this project: access, quality, service utilization, and increased self-financing.

a. Improved Delivery of Medical/Clinical Services

⇒ Results end of Year Five:

- MCP will be providing safe, effective and high quality services;
- MCP services will be more accessible in terms of distance and cost, particularly in rural areas;
- Average annual CYP growth rate over the last four years of project increases 7% a year; and
- Total level of financial self-sufficiency exceeds 50%.

1) Improved Quality of Medical/Clinical Services

Improving quality will be the MCP's highest priority during the first year of the PSP III Project. Quality has several dimensions in this project and is understood to include both the provision of safe and effective care and customer satisfaction with that care.²⁷ As indicated previously, while the MCP has taken pride in the quality of its services, recent evaluations have led it to acknowledge that MCP quality (safe and effective care) can be inconsistent.²⁸ In Year One, USAID will fund technical assistance to ASHONPLAFA to establish a Quality Assurance (QA) system with clear norms covering clinical competence, protocols, administrative procedures and specification of equipment and supplies. During this process, ASHONPLAFA will establish baseline data on quality (both dimensions) and set targets for future years. In the first year, the QA system will cover ASHONPLAFA clinics and satellite clinics; in Year Two, USAID will fund technical assistance to help ASHONPLAFA expand the system to ensure that it is able to provide high quality (safe and effective) care in any new service before that service is initiated.

While recent evaluations have indicated the need to improve quality in terms of safety and effectiveness, there is relatively little data on the quality of customer satisfaction with MCP services; clients may or may not be very satisfied.²⁹ ASHONPLAFA will obtain data on customer satisfaction during the baseline study in Year One. ASHONPLAFA seeks high customer satisfaction, knowing that this is the basis for continuing demand.

As a further aspect in its efforts to improve quality, over the next five years ASHONPLAFA will expand the currently available method mix in its clinics. ASHONPLAFA will add injectables and natural family planning (Billings) in Year Two; that same year, ASHONPLAFA will initiate an operations research study on NORPLANT and will also add

²⁷ Indicators for safe and effective care and for customer satisfaction are in Annex 2, the Results Framework.

²⁸ Cobb et al, *Evaluation of the Private Sector Population II Project*, April 1995 and Robert Lederer, *Medical Clinical Analysis*, July 1995.

²⁹ New user data indicates that 70% of all new clients come to ASHONPLAFA as a results of friends' or relatives' recommendations. While this is useful data, it is not the same as data on the percent of clients who are satisfied with the service they received.

this method in Year Three (in Tegucigalpa and San Pedro Sula at full cost to clients) depending on the results of an operations research study.

In conjunction with the Association's Human Resources Management Unit, the MCP will undertake a staffing and performance assessment of the program and identify personnel changes needed to effectively and efficiently achieve the results desired. Accordingly, staff may be hired, transferred, terminated or trained. This assessment is to begin as soon as the new project begins, and ASHONPLAFA should move immediately to hire, transfer, terminate, supervise and train MCP personnel. Also during Year One of this project, USAID will finance extensive performance-based training to ASHONPLAFA to enable it to address the performance constraints identified above. The immediate results of this training in improved quality will be fully informed new users; safe and effective clinical procedures (including new methods to be introduced during this project); and increased customer satisfaction with MCP services. During this same year, the MCP will, in accordance with quality norms established with the Quality Assurance II Project, upgrade MCP facilities, equipment and supplies.

2) Increased Access to Medical/Clinical Services

Expanding access to its services will be MCP's chief priority during the second year of the project. In this effort, the MCP will work very closely with the IEC program and with PVOs in the relevant regions to lessen existing barriers to service: lack of knowledge about family planning in general and ASHONPLAFA services in particular, distance to MCP clinics and cost of MCP services, particularly VSC. As indicated previously, lack of knowledge is the principal reason women don't use family planning. The IEC unit and PVOs must remedy that lack and, using culturally appropriate materials and messages, inform women and men in targeted rural areas of the benefits of family planning, of indications and contraindications, and the location and hours of new services being opened.

Project efforts will take a two-pronged approach to lessening distance to MCP services. First, the PVO component will include provision for PVOs to transport rural clients to ASHONPLAFA clinics. Second, the MCP will extend its reach into rural and periurban communities through rural brigades (in Juticalpa and Santa Rosa de Copán) and through a select number of satellite clinics (following cost studies in Year One) in small cities. For both the rural brigades and the satellite clinics, the MCP will depend on the IEC unit and PVOs to advertise and promote those services.

Additionally, beginning in Year Two, the MCP will open services targeted at two particular market segments with high unmet need: men and adolescents. In Year Two the MCP, in collaboration with an IEC men's campaign and with PVO promotion, will open at least two

men's services in Choluteca, La Ceiba, Santa Rosa or Juticalpa. In Year Three the MCP, in collaboration again with the IEC program, will offer adolescent counseling in all regional clinics.

3) Increased Utilization of Medical/Clinical Services

The result of improved quality, access and the collaboration of the PVOs will be a steady and sustainable increase in the utilization of ASHONPLAFA's Medical/Clinical services (as measured by CYPs provided) and in the use of other reproductive health services.

ASHONPLAFA expects that in Year One, CYPs provided by the MCP will increase by 5% over 1995.³⁰ In the following four years, CYPs are expected to increase by 7% annually, with an annual CYP growth in Regions 5 and 6 (Santa Rosa and Juticalpa) of 10%. Over the five years, the annual number of male VSC operations is expected to rise from 124 in 1994 to 700 in 2000. New users of other services, including STD diagnosis and treatment, are projected to increase 10% annually.

4) Increased Self-Financing of the Medical/Clinical Program

Increasing the level of MCP self-financing will be a priority throughout the life of this project. One means of doing so will be improved management in terms of cost containment and cost recovery. Prior to Year One (CY 1996), ASHONPLAFA will develop a pricing policy and implement that policy on a regional basis. It will then adjust its pricing structure semi-annually to at least keep up with inflation. Also during the first year of the project, the MCP, in conjunction with the finance department, will implement cost center accounting for each clinic. Budgets will be specifically allocated at the clinic level to initiate local promotion of services. Finally, during Year One, the MCP will open clinical laboratories in Santa Rosa, Juticalpa or La Ceiba after having conducted a marketing study to determine where such laboratories have good prospects for becoming self-financing. Once opened, these laboratories will be staffed with contracted personnel with an incentive plan.

Starting in Year Two, and in every subsequent year of the project, the MCP will implement two family clinic diversification projects in existing clinics using contracted personnel with an incentive plan; specific activities will be determined after the research department has conducted marketing studies. A reserve for start-up costs to implement diversification projects will be created beginning in Year One. Also in Year Two, and in every subsequent year, ASHONPLAFA will review and evaluate each MCP clinic to determine individual progress of each cost center. Those clinics which do not generate at least 85% of projected income for the year and do not operate at least at a 25% self-financing level by end of 1996 will be closed or will be subject to a change in personnel, operations, and/or reduction in budget.

³⁰ The projected rate of CYP growth in 1996 (5%) just exceeds the annual rate of growth of women of reproductive age (4%). If ASHONPLAFA is to significantly increase the national CPR, its rate of CYP growth must significantly exceed 4%.

Lastly, starting in Year One, at least four clinics will implement one or two of the agreed-upon incentive plans to increase productivity as well as cost efficiency.³¹ The MCP will monitor: (1) unit cost per service delivered based on current total costs assigned to each clinic as of 1995 (to be further defined upon completion of ASHONPLAFA's cost studies in 1996); and (2) the total clinic income/total clinic personnel cost.

b. Accessible, High-Quality, Self-Financing Social Marketing Program

⇒ Results end of Year Five:

- The SMP is at least 110% financially self-sufficient³² and USAID provision of commodities for SMP ceases;
- SMP products accessible to low and middle income clients in 95% of pharmacies, 75% of supermarkets and 20% of *pulperias*;
- Women and men are more knowledgeable about and satisfied with the SMP contraceptive they have purchased: its correct use, contraindications and its use in preventing STDs/HIV/AIDs;
- On average, sales have grown at least 4% per year.

1) Increased Self-Financing of the Social Marketing Program

The most important result to be achieved under this component of the project will be to ensure that the SMP progresses as a **real profit center** throughout the next five years. Efforts to move toward this result will begin in Year One. USAID will finance Contraceptive Social Marketing (SOMARC) technical assistance for the development of a five-year plan detailing activities which will enable SMP to increase self-financing and improve quality and customer satisfaction.

As this assistance is provided, ASHONPLAFA will restructure the SMP during Year One, establishing it on a department level with a commercial orientation and its own promotion and advertising budget, and will hire experienced marketing personnel including a highly qualified Director for the program via annual contracts. In the first year, with SOMARC's technical assistance, the SMP and the Research and Evaluation Unit will conduct a market quantification and qualification study. They will develop and implement a pricing policy with subsequent semi-annual adjustments to keep up (at a minimum) with inflation. Also, in the first year, SMP must launch Duo-Fem, the new USAID-donated oral, and Protector; launch a major campaign for them; raise prices on Noriday and Norminest, the two USAID-donated orals being withdrawn from the market; and exhaust ASHONPLAFA stocks of Noriday and Norminest. Additionally, the SMP will implement an incentives program during the first year of the project.

³¹ Cost efficiency is defined as the reduction in costs for providing units of service. Cost efficiency can occur by any combination of increasing productivity without increases in clinic costs, or decreasing clinic costs without decreasing productivity.

³² Roy Brooks, Financial Analysis, August, 1995.

2) Increased Access to the Social Marketing Program

In Year Three, the SMP will select and contract distributors for central, southern, eastern and north western zones and distributors who will sell through channels in addition to MANDOFER-supplied³³ pharmacies (i.e., supermarkets, bars and *pulperias*). During Year Three, the SMP will launch additional ASHONPLAFA-purchased contraceptives. In Year Four, ASHONPLAFA will market an additional ASHONPLAFA-purchased oral contraceptive. In Year Five, USAID provision of commodities for the Social Marketing Program will cease.

Expanding access to, and distribution channels of, SMP products will serve ASHONPLAFA's interests because this will contribute to increased volume of sales. Such expanded access and distribution within the commercial sector also serves to promote the sustainability of the national family planning program by strengthening the participation of the commercial sector within that program.

3) Improved Quality of the Social Marketing Program

SMP activities will lead to improved quality as a consequence of extensive advertising, promotion and training on the correct use, indications and contraindications of oral contraceptives for family planning, and condoms for family planning and STDs/HIV/AIDS prevention. Year One will begin with a baseline study, carried out or contracted out by ASHONPLAFA's Research and Evaluation Unit with technical assistance (TA) from SOMARC, on SMP quality and customer satisfaction.³⁴ On the basis of that study, the SMP, with SOMARC TA, will provide training to distributors, pharmacists and sales persons on the correct use, indications and contraindications of oral contraceptives for family planning and condoms for family planning and STDs/HIV/AIDS prevention. It will also develop materials for the public to promote correct use. ASHONPLAFA will carry out yearly exit interviews which will assess customer satisfaction with the SMP products and with service obtained in the pharmacy or supermarket. In the latter part of Year Four of this project, ASHONPLAFA's research and evaluation unit will conduct an endline study on quality and customer satisfaction.

4) Increased Utilization of the Services of the Social Marketing Program

During the first two years of the project, utilization of SMP services is unlikely to increase due to the significant change occurring within the SMP (indeed, utilization of the SMP may actually decline for a time). During the last three years, however, there should be significant growth due to strong management and new products (ASHONPLAFA-purchased

³³ MANDOFER is a local distributing firm with which ASHONPLAFA contracts to distribute SMP products to pharmacies throughout the country.

³⁴ See the indicators of quality in the Intermediate Results Indicators table contained in Annex 2, the PSP III Project Results Framework.

contraceptives). By end-of-project, sales will have grown on the average at least 4% for all five years of the project.

c. Focused, High Quality Community Services Program

⇒ Results end of Year Five:

- CSP program will be more accessible in terms of distance and cost in rural and periurban areas;
- *Consejeras* will offer higher quality services to CSP clients in terms of: (1) greater method mix; (2) complete and unbiased overview of all methods; and (3) complete information on chosen contraceptive. These interventions, successfully implemented, will result in a higher level of client satisfaction;
- CBD services will increase by 6% annually in rural areas and by 5% annually in periurban and urban areas during the last four years of the project;
- The CSP will be at least 70% financially self-sufficient, and urban and periurban posts will generate an annual average of 50 CYPs.

1) More Focused Access to the CSP in Rural and Periurban Areas

Over the next five years, ASHONPLAFA will work to bring the urban-rural coverage disparity into balance by restructuring the CSP program so that its focus is on expansion of services in rural areas of Santa Rosa de Copán and Juticalpa regions and by withdrawing those urban and periurban posts which compete with nearby pharmacies. This will happen in two phases. In Year One of the project, the CSP will begin closing those posts in the Tegucigalpa, San Pedro Sula, Choluteca and La Ceiba regions which are unprofitable or which compete with the commercial sector. ASHONPLAFA will close those periurban and urban posts which are located less than two kilometers from a pharmacy or another post and generate less than 13 CYPs annually, and those rural posts which are located less than two kilometers from a pharmacy or another post and produce less than two CYPs annually. 190 posts fulfill these criteria. By the end of Year Two, and in all subsequent years, ASHONPLAFA will close all those urban and periurban posts located in Tegucigalpa, San Pedro Sula, Choluteca and La Ceiba which generate less than 20 CYPs annually and are located more than two kilometers from a pharmacy or an other post, and all those posts which generate less than 50 CYPs annually and are located less than two kilometers from a pharmacy or other post. ASHONPLAFA will also close all rural posts in the above mentioned regions which are located within 10 kilometers of a pharmacy or other post and that generate less than 5 CYPs annually.

The second phase will be expansion in underserved areas. Beginning in Year Two and continuing through the PACD, the CSP will collaborate with local PVOs in the selection of *consejeras* in rural areas of Olancho, Santa Barbara, La Paz, Ocotopeque, Lempira, Copán and Santa Rosa. Criteria for opening posts will be: communities with no more than 2,000 inhabitants, which are at least 20 kilometers away from an urban setting and which have no posts or pharmacies serving the population already. Starting in Year Two and all years

thereafter, 20 new posts (and *consejeras*) which fulfill these criteria will be opened. Together with HRM, the CSP will hire or relocate one promoter for each of these two regions to assist in the expansion of services by the end of Year One. The success of this activity is highly dependent on the IEC unit and PVOs to advertise and promote the new posts.

To a much lesser extent, the CSP will also recruit and select *consejeras* in key periurban areas where pharmacies and other CSP posts are inaccessible. Inaccessible periurban areas are those where there is no pharmacy or other CSP post within two kilometers.

2) Improved Quality of Community Services

Quality for the CSP has three important dimensions: 1) method mix, 2) counseling; and 3) client satisfaction. Improving the quality of the CSP will occur in three stages. In conjunction with the HRM unit, ASHONPLAFA will undertake a staffing and performance assessment of the program in Year One. This assessment will identify personnel changes needed to effectively and efficiently achieve the results desired in this program: staff will be hired, transferred, terminated. ASHONPLAFA will move immediately upon initiation of the PSP III Project to make required changes. Year Two will begin with the collection of baseline data on quality of care and customer satisfaction, carried out or contracted out by the evaluation unit with technical assistance from Primary Providers' Education and Training in Reproductive Health (PRIME). On the basis of the results of this study, the CSP, with technical assistance from PRIME, will design and implement a more effective training program for both the *consejeras* and the promoters which will include a strong follow-up component. The training program will emphasize the *consejera's* role in provision of complete and unbiased overviews of all methods available to her clients, and training on the correct use, indications and contraindications on the method her client chooses. All CSP *consejeras* will be trained.³⁵

In Year Three, the research unit will conduct an operations research study which will test different *consejera* incentive plans to determine how to successfully motivate the *consejeras* to refer CSP clients to ASHONPLAFA clinics for clinical methods, natural family planning and other reproductive health services. By the end of Year Three, based on the results of the operations research study, the CSP will implement an incentive program nationally and establish targets for Years Four and Five of the project.

3) Increased Utilization of CSP Services

The result of increased quality, access and PVO collaboration will be a steady increase in the provision of CYPs in rural areas. Additionally, referrals to ASHONPLAFA clinics for clinical methods and natural family planning in periurban, urban and rural areas will increase. If, as planned, the CSP expands access, improves the quality of counseling, implements a referrals/incentives program and IEC program and the other PVOs successfully promote the

³⁵ At present, 2020 *consejeras* participate in the CSP.

CSP posts, the CSP will easily achieve an annual increase of 6% in CYPs, with an annual CYP growth in Regions 5 and 6 (Santa Rosa and Juticalpa) of 8% after the first year. Due to the fact that several posts will be closed in Year One, it is anticipated that total CYPs will remain at their 1994 baseline level during Year One. See Annex 1, Background Data, for 1994 baseline data by region.

4) Increased Self-Financing of the CSP

Increasing the level of self-financing of the CSP will require a three-pronged approach: improved cost containment, increased revenues, and increased cost-efficiencies. As noted, the CSP will improve cost containment by closing down those posts in the above mentioned regions which generate low CYPs in especially urban and periurban areas on an annual basis (see Access section on criteria for closing posts). Average annual CYPs for periurban and urban posts will climb from 38 to 50, while average annual CYPs for rural posts will increase from 23 to 26 by Year Five of the project. Additionally, the CSP will implement a pricing strategy on a regional basis and will make subsequent adjustments semi-annually to (at a minimum) keep up with inflation. Finally, ASHONPLAFA will develop a more motivating incentive plan for both *consejeras* and promoters by the end of Year One of the project.

d. Effective Information, Education, and Communication Strategy

⇒ Results end of Year Five:

- Women, men and adolescents well informed on family planning, cytology, STDs/HIV prevention, reproductive risk, contraceptive technology, the advantages of postponing initiation of sexual relations, and ASHONPLAFA services; and
- Women, men, adolescents have an improved image of family planning and ASHONPLAFA.

During much of Year One, the IEC program will become skilled in synchronizing activities with other departments. In doing so, the IEC program will undertake a staffing and performance assessment in collaboration with HRM. This assessment will identify personnel changes needed at the central level to effectively and efficiently achieve the results desired in this program. Staff will be hired, transferred, terminated or trained. Additionally, the IEC program will hire or relocate one local IEC specialist for each of the regions at this time.

The local IEC specialists will be responsible for the day-to-day IEC support which the different direct service delivery programs require and for coordination with PVOs working in local communities. All new personnel will be both contracted and hired within 1995 personnel budget limits.

Additionally, the research and evaluation unit, with the USAID-financed assistance of Population Communication Services, will carry out or contract a baseline Knowledge, Attitudes, and Practices (KAP) survey during Year One. Baseline data for the IEC program will be collected and targets for future project years will be set.

Starting in Year Two and every year thereafter, the department will launch, in collaboration with local PVOs, the MOH and technical assistance from Population Communications Services, a nationwide IEC campaign on selected topics. During Year Two of the project, the department will carry out a reproductive health campaign; during Year Three, a men's campaign; and during Year Four, an adolescent campaign. All three campaigns will contain modules which promote and advertise the different services ASHONPLAFA offers in the CSP and the MCP. Starting in Year Two and every year thereafter, the IEC program will also develop and launch modules for each of the above mentioned campaigns which will address the image of family planning, ASHONPLAFA's image, and the services ASHONPLAFA offers.

In the latter part of Year Four, the research and evaluation unit will carry out or contract an endline KAP survey to determine the impact of the IEC campaigns.

2. Effective Support Systems at Headquarters and Regional Level

a. Improved Human Resource Management

⇒ Results end of Year Five:

- ASHONPLAFA personnel motivated and capable of achieving institutional goals; and
- ASHONPLAFA appropriately and sustainably staffed to achieve planned results.

A new ASHONPLAFA, seeking self-sufficiency and high quality services including service to the poor and underserved, needs systems and staff focused on performance, productivity and efficiency. The task in Year One will be to assess staffing levels and personnel qualifications and performance in light of the planned results.³⁶ USAID will finance international technical assistance to ASHONPLAFA to assist it in this task. This technical assistance will:

- assess staffing levels in each department and program, in each region, in terms of the results to be achieved in this project (number of staff compared to department requirements);
- complete, in each department, program, and region, a performance and training needs assessment which presents past performance and professional skills/competence available, in terms of the results to be achieved in this project;
- recommend any necessary staff "right-sizing" (increase or decrease of staff by department, program and region) compatible with the financial self-sufficiency targets for ASHONPLAFA set forth elsewhere in this PP;

³⁶ See the pre-design analyses of Joseph Burke, Robert Lederer, Zoe Kopp and Diane Urban for assessment of staff competence in critical new areas of institutional results.

- recommend training to address Knowledge, Attitude or Skill needs identified in the assessment; and
- present in writing, for USAID's approval, a HRM plan for staffing, "right-sizing" and training to achieve the results of this project.

Beginning in Year One, all ASHONPLAFA staff will have written semi-annual performance evaluations. For providers, a semi-annual quantitative minimum and maximum range of productivity target will be included. For key management, a quantitative level of self-sustainability for their respective departments will be included. All staff will receive their raises, which could be zero to the defined annual maximum, based on their achievement of the written semi-annual targets and goals.

Some departments may be understaffed and others overstaffed; some departments may have competent personnel, while others may have a number of personnel unable to significantly contribute to the results required in their unit. ASHONPLAFA's senior management must decide how to handle such discrepancies; although hiring, transferring and training may be the solution in many cases, staff termination may be the least costly in a number of other cases.

A substantial amount of training and reorientation will be needed in any case to support the organizational change and increased demands of this project. That training will lie in the following areas:

- Quality Assurance
- Social Marketing
- CSP counseling ³⁷
- Focusing ASHONPLAFA's HRM systems on performance and productivity, including development of an institution-wide incentive plan
- Strategic Planning
- MIS, including training in the use of data for decision making
- Contraceptive Logistics

USAID will finance the technical assistance needed to carry out this training. See Short Term Technical Assistance Plan beginning on page 33 for more detail on technical assistance.

ASHONPLAFA will create a reserve for incentive systems using locally generated income beginning in Year One.

³⁷ It is important that ASHONPLAFA develop the knowledge and skills to recruit, train and supervise CSP workers well. In addition to training their own *consejeras*, ASHONPLAFA is to train PVO staff who will be recruiting, training and supervising PVO community-based family planning counselors who, in turn, will promote, counsel, provide temporary methods, and refer clients to ASHONPLAFA clinics.

b. Effective Management Information System (MIS)

⇒ Results end of Year Five:

- MIS presents accurate and relevant information on finance, service utilization, and quality, and these data are used for decision making.

One of ASHONPLAFA's foremost priorities for Year One will be to implement in each regional office and in the headquarters a computerized MIS, including cost accounting, *Sistema de Administración de Clínicas (SAC)*, *Sistema de Información y Estadísticas de Servicios (SIES)* and *Sistema de Control de Inventarios (SCI)*. The MIS should be functioning smoothly, and should integrate, consolidate and present accurate and reliable service and financial data to managers on a monthly basis. As mentioned above, over the last year ASHONPLAFA has made tremendous progress in this area, but much work remains to be done.

During Year One of this project, USAID and ASHONPLAFA will purchase the necessary hardware and software, install service utilization software, information and statistics software, inventory control software and the cost-accounting system in all regions and at headquarters. All relevant regional and headquarters personnel will receive training in the management of these various software at this time. Also in Year One, USAID and the International Planned Parenthood Federation will finance technical assistance during both the installation and training phases of MIS implementation. The culmination of these activities should guarantee that by December 31, 1996, the MIS will be computerized and fully functional in all five regions and at headquarters.

Once the MIS is up and running, USAID will fund technical assistance from FPMD or another qualified source so that each of ASHONPLAFA's Division Heads, Department Heads and Regional Chiefs receives training in data for decision making.

c. Improved Financial Management

⇒ Results end of Year Five:

- ASHONPLAFA has an effective cost accounting system in place and is 63% financially self-sufficient.³⁸

In 1995 ASHONPLAFA will implement a pricing strategy on a regional basis for all service delivery programs with subsequent semi-annual adjustments to keep up with inflation. In addition, during the first month of 1996 the finance department will implement cost center accounting at clinic and program levels and will ensure that a monthly budget variance analysis is produced as well as a comparative summary analysis report for all activities for staff to review monthly. ASHONPLAFA has calculated yearly and end-of-project self-

³⁸ In Roy Brooks' Financial Analysis of August, 1995 the level of self-financing is calculated as the total income divided by total expenses minus actual expenses of private clinics.

sufficiency targets, taking into consideration 1) yearly increases in prices in all service delivery programs; 2) establishment of incentives programs which will increase productivity and self-sufficiency; 3) increased cost controls in all service delivery and support programs; and 4) use of surplus income generated from the SMP to subsidize other service delivery efforts.³⁹

d. Improved Logistics

⇒ **Results end of Year Five:**

- ASHONPLAFA provides adequate quantities of high quality contraceptives to the right service delivery points, in a timely manner.

During Year One, the Administration and Finance Division, with USAID-financed technical assistance from Family Planning Logistics Management, will train all appropriate regional and central staff in contraceptive storage at acceptable standards, minimum/maximum stock levels, and use of inventory control software. Additionally, the Administration and Finance Division will install inventory control software at each of the regional warehouses. By the end of Year One, all regional offices will be generating reports on quarterly consumption and stock levels. In the years that follow, the Administration and Finance Division will develop and implement a monitoring program that will consolidate all regional and headquarters inventory information and ensure that ASHONPLAFA orders and distributes supplies within the adequate timeframes.

e. Effective Research, Evaluation, and Monitoring Systems

⇒ **Results end of Year Five:**

- ASHONPLAFA enjoys complete service and programmatic statistics system that is timely, accurate, standardized, provides comparative analysis and is widely used; and
- ASHONPLAFA uses timely and accurate research and evaluation results for decision making and for program modification.

During Year One of this project, the statistics unit will streamline data collection forms; install a functional information and statistics system; train all relevant personnel at the regional and central levels in the use of the system, and improve dissemination of results. In Year Two, the unit will develop a database to track planned and accomplished activities of ASHONPLAFA service delivery and IEC programs. In Year Three and every year thereafter, the unit will assist other ASHONPLAFA departments and programs to integrate the use of statistics data for decision-making into programmatic monitoring and performance reviews.

³⁹ Roy Brooks, Financial Analysis, August, 1995.

In Year One of this project, the USAID-funded Population Council resident advisor will provide training to research and evaluation unit personnel in operations research methodology and data analysis. Training, in addition to improved planning and coordination between the research unit and other programs, will result in the timely completion of at least six research studies each year, annual client satisfaction surveys for the MCP and the SMP, and at least one operations research study a year. In Years One and Two of this project, the research and evaluation unit will also receive technical assistance from the QA II Project, PRIME and SOMARC in the collection of baseline data for the SMP, MCP and CSP, and from Population Communications Services in the collection of baseline IEC data (KAP survey). USAID will fund all of the above mentioned technical assistance. During Years Four and Five, the unit will conduct three program evaluations on the SMP, MCP and CSP, one KAP endline survey and one EFHS.

The research and evaluation unit will disseminate written study results to key internal and external audiences and present findings to relevant audiences within a month of study completion dates. The ultimate success of this unit, however, rests with high level management. Management must make effective use of the research results in program-related decision making.

f. Technical Committees

ASHONPLAFA Medical Clinical, Social Marketing, Community Services and IEC programs will form and participate in a Marketing and Promotion Technical Committee to ensure coordination between and among programs and timeliness of promotional and marketing activities.

Additionally, ASHONPLAFA, together with USAID, the MOH and other PVOs, will participate in the three interagency technical committees to be created under PSP III to ensure coordination of activities. See Section IV.D for more detail on these interagency technical committees.

B. PVO Component

1. Strategic Approach to Work with PVOs

The PVO component of the PSP II Project demonstrated that PVO promotion of family planning and referrals to ASHONPLAFA and MOH services can be a cost-effective alternative to expansion of ASHONPLAFA service delivery programs into underserved rural areas (Gomez study). PVOs have also played an invaluable role in training rural family planning workers.

In view of these achievements, the growing commitment to reproductive health and family planning activities among many PVOs presently working in Honduras, and the continued low contraceptive prevalence rate in rural areas, USAID/Honduras will support **increased PVO**

participation under the PSP III Project. The PVO component will be more technically and geographically focused under PSP III than under PSP II. USAID will give priority to PVO efforts in those rural municipalities of the eight Health Areas where the public sector Health Sector II Project plans efforts to improve the provision of local health services, including supplying health center facilities to better respond to referrals for family planning and obstetric emergencies. These Health Areas span the country from north to south, including the Departments of Cortés, La Paz, Marcala, Siguatepeque, and Sabana Grande (see map in Annex 1). In these eight Health Areas, USAID will grant PSP III funds to PVOs to promote an integrated reproductive health package of maternal and neonatal care, with the requirement requisite that interventions include a primary emphasis on family planning. Additionally, although these are outside the eight key Health Areas, USAID will also encourage PVOs to work in the most underserved of ASHONPLAFA's regions--Santa Rosa de Copán and Olancho--to help ASHONPLAFA recruit *consejeras* for the CSP and refer and transport women, men and adolescents to ASHONPLAFA clinical facilities for family planning and reproductive health services. All assistance provided through PVOs will be consistent with the MOH's National Norms for Integrated Reproductive Health Care to Women.

2. Selection of Participating PVOs

As part of the design process, USAID has identified 16 institutions that meet basic criteria such as being established as a legal PVO in Honduras (i.e., having their *personería jurídica*) and having an interest in working in reproductive health and with selected populations targeted by USAID. USAID further rated these 16 organizations in terms of developed infrastructure, institutional experience in family planning and reproductive health, their location in strategic geographic areas, the number of beneficiaries they serve, and their experience in working with project target groups (rural populations, adolescents and men). Further, because those PVOs that wish to work in ASHONPLAFA's Santa Rosa de Copán and Olancho Regions will have to rely heavily on ASHONPLAFA to assure that their referrals culminate in successful service utilization, such PVOs must have the institutional capacity to establish a close working relationship with ASHONPLAFA offices in these regions.

The PVOs that meet most of the criteria mentioned above tend to be the larger international PVOs who have core support from U.S.-based donors and central offices. These are PLAN; Save the Children and CARE. All these institutions have well developed infrastructures and institutional experience with family planning and reproductive health; their home offices have made commitments to family planning and reproductive health; and their Honduras offices have all had USAID-funded child survival grants under the Health Sector II Project and at least one population sub-project funded under PSP II. With the exception of PLAN, these PVOs work in the eight Health Areas which the extended Health Sector II Project will assist. Additionally, PLAN, CARE and Save the Children tend to have the largest numbers of beneficiaries in comparison with the other Honduran PVOs, while CARE is now targeting men in reproductive health IEC activities under its Agroforestry Community Project (PACO). All three PVOs are interested in gender issues.

In addition, two Honduran PVOs show particular promise: Center for the Adolescent and Family Development (CDJF) and Natural Fertility Regulation (RENAFE-MOB). CDJF has a developed infrastructure (not as strong as the international PVOs but stronger than that of the other local PVOs), provides some clinical family planning services at its 10 periurban clinics and one hospital in 7 areas (San Pedro Sula, Lima, Puerto Cortés, La Ceiba, Tegucigalpa, Choluteca and Santa Barbara), and works extensively with adolescents. Support to CDJF is appealing because CDJF would present ASHONPLAFA with a healthy dose of competition in the area of clinical contraception.

Support to RENAFE is appealing for different reasons. With the increased popularity of less effective natural family planning methods (i.e., rhythm and *coitus interruptus*) throughout Honduras between the last two Epidemiology and Family Health surveys,⁴⁰ it appears necessary to provide as much information and services as possible regarding effective natural methods. RENAFE is equipped to provide training to ASHONPLAFA and PVOs in effective natural methods. RENAFE is also equipped to provide services to those clients referred by ASHONPLAFA, PVOs and the MOH in a total of 28 church offices around the country (Francisco Morazán, El Paraíso, Yoro, Olancho and Atlántida). Finally, support to RENAFE may well diffuse some of the church opposition toward use of modern family planning, given that the director is very close to the archbishop.

Thus, USAID plans to consider at least two international PVOs (CARE and Save the Children) and one national PVO (CDJF) as potential grant recipients under this component of PSP III. These groups seem to meet all the major criteria outlined above. Further, although they do not work in the eight Health Areas that the extended Health Sector II Project will assist, USAID will also consider PLAN and RENAFE as potential grant recipients. Support to RENAFE would respond to the high demand for natural family planning throughout the country, while support to PLAN would ensure the integration of family planning services into that organization's reproductive health activities.⁴¹ Moreover, two of PLAN's regional offices are located in the most underserved areas of the country--ASHONPLAFA regions 5 and 6. Though the Mission cannot ensure upgrading of the MOH centers in these regions, PLAN has successfully coordinated with ASHONPLAFA in the past and would likely be able to work with and rely on ASHONPLAFA to respond to PLAN's outreach and referrals.

3. Expected Results of Work with PVOs

USAID expects that participating PVOs will work closely with ASHONPLAFA and the MOH to increase access to CBD posts and clinical services by opening CBD posts in underserved rural catchment areas, by providing referrals and transportation to clinical family planning services, and by participating in a national reproductive health IEC campaign which will be

⁴⁰ Epidemiology and Family Health Survey, 1991/92; Epidemiology and Family Health Survey, 1987.

⁴¹ With the support of the PSP II Project, PLAN successfully incorporated IEC and referral activities into its ongoing programs over the last five years. PLAN now would like to establish 150 CBD posts which would provide high quality services in its catchment areas, but will need financial support to do so.

coordinated by the IEC Technical Committee (see Section IV.D for more detail on this committee). The Mission further expects that the PVOs will also work with ASHONPLAFA and the MOH to improve the quality of services offered at local MOH facilities and ASHONPLAFA-run CBD posts, and improve the image of family planning and reproductive health through an IEC campaign. Finally, USAID anticipates that the PVOs will work to increase utilization of the services of ASHONPLAFA-run CBD posts in the PVO catchment areas, a select number of their own clinics, and the local MOH facilities.

USAID/Honduras has never worked directly with the majority of the eligible PVOs because a contractor, the Population Council (INOPAL II and III Projects), managed the PVO component under the PSP II Project through a USAID buy-in. Consequently, the Mission does not have the same familiarity with these PVOs as it does with ASHONPLAFA, and it is premature in the absence of specific grant proposals to put together benchmarks, indicators or a results framework. PVOs will be asked to submit respective benchmarks, indicators and results frameworks along with their proposals to USAID. During review of these proposals, USAID will work with the prospective grantees to reach agreement on specific planned results and indicators of progress toward those results.

4. Illustrative Tactics

As noted, one constraint all participating PVOs faced under PSP II was the absence of an adequate system for handling referrals. This absence was due to the fact that the MOH lacks trained personnel, equipment and supplies for the provision of reproductive health services. This gap will be partly resolved by focusing the PVOs' work on the Health Areas where the Health Sector II Project will strengthen MOH services. Moreover, USAID expects that PVOs participating in PSP III will use funds from their grants to assist MOH facilities in those areas to develop service delivery systems which systematically provide integrated reproductive health services. Save the Children, for instance, has recently begun to support two MOH Health Regions (2 and 4) in the "organization of reproductive health services including: 1) cytology and IUD insertion, 2) voluntary surgical contraception; and 3) postpartum contraception."⁴² The PSP III Project will also form three technical committees, ensuring coordination of activities between and among the MOH, the PVOs and ASHONPLAFA. All PVO grantees, ASHONPLAFA, USAID and the MOH will participate in these technical committees. See Section IV.D for more detail on committees.

In addition, PVOs will be encouraged to establish sub-agreements with other cooperatives and small PVOs working in the eight Health Areas. Cooperatives such as the *Union Nacional de Campesinos* (UNC) and its affiliate *Federación Hondureña de Mujeres Unión Campesina* (FEHMUC) have offices and representation all over the country and much influence with rural campesinos. These unions are very interested in offering family planning services to

⁴² Systematic Provision of Reproductive Health Services by Community and Institutional Personnel, INOPAL III Project and Save the Children Proposal.

their membership and are open to either having a PVO work with them or to having a PVO set up services in their offices. Sub-agreements between the PVOs and the cooperatives may include direct service delivery (in particular, CBD posts, referrals and transportation), training, and IEC activities.

5. Prospective Tools

Originally, USAID considered using an umbrella agency to administer the PVO component under PSP III. PVOs being considered for such role included CARE, Save the Children and PLAN. However, the use of an umbrella funding mechanism could be detrimental to efforts to increase participation among the different PVOs and coordination with ASHONPLAFA and the MOH. If any PVO receives an umbrella grant, its relations with others could deteriorate. Consequently, USAID/Honduras plans to support a total of five PVOs with five direct grants. Further, since much of the PVO component is dependent on ASHONPLAFA and MOH collaboration, the Mission will require that PVOs sign a Memorandum of Understanding with the MOH and ASHONPLAFA detailing their prospective involvement in the efforts that PVOs propose to undertake.

To select the PVOs that will participate in PSP III, the Mission will issue a Request for Application (RFA) to a short list of PVOs that the Health, Population and Nutrition Office (HRD/HPN) will compile. This list will be based on the objective and quantified criteria discussed above. USAID will review proposals received in response to this RFA in accordance with its standard procedures for review of grant proposals.

The funding range of the five grants will likely vary between \$50,000 for the smaller PVOs to \$500,000 or more for the larger PVOs, who in an effort to expand geographic coverage may want to work through sub-agreements with several PVOs and cooperatives. HRD/HPN will be able to manage the administration and accounting of these direct grants in house, as the administrative staff person currently working on the remaining six grants under the Health Sector II Project PVO component will be available to apply these same skills to the PSP III PVO grants as of January, 1996.

C. Short Term Technical Assistance Program

To carry out the Plan of Action described above and achieve the results planned, ASHONPLAFA and the PVO component will need international technical assistance. The table on the next page outlines areas of clear needs for technical assistance and training, the approximate level of effort and possible Cooperating Agencies (CA) that may provide that training or technical assistance. USAID will use PSP III funds to fund this technical assistance and training.

Table 2: Short Term Technical Assistance (TA) and Training Plan

Area of TA and recipients of TA	Approximate number of days and time period	Date of TA initiation	Possible CAs
MCP Quality Assurance (QA)	45 days year 1, 10 days year 2, 10 days year 3 (mid-term evaluation), 10 days year 5 (final evaluation)	Early in Year 1	Quality Assurance II Project
SMP	45 days year 1, 30 days year 2, 30 days year 3	Early in Year 1	SOMARC
CSP	45 days year 2, 10 days year 3	Early year 2	PRIME
Contraceptive Logistics	30 days year 1, 15 days year 2, 5 days year 3	Early year 1	Family Planning (FP) Logistic Management (FPLM) Project
HRM Incentive Plan	15 days year 1, 15 days year 2	Early year 1	FP Management Development (FPMD) Project
Organizational Dev.	20 days year 1, 10 days year 2		
Strategic Planning	15 days year 1, 15 days year 4	Mid year 1	FPMD Project
MIS (statistics, information and cost accounting systems)	35 days year 1, 10 days year 2	Early in year 1	FPMD Project
Management Dev. - Consejo Técnico and regional directors	10 days each staff member- year 1 and 2	Late in year 1	INCAE
Data for Decision Making for Consejo Técnico and regional directors	10 days each staff member - year 1 and 2	Late in year 1	INCAE or FPMD Project
IEC Campaigns - IEC committee	20 days year 1, 45 days year 2, 15 days year 3	Mid-year 1	Population Communications Services
External Training, Curriculum Dev. and Implementation	30 days year 3, 10 days year 4	Early in year 3	PRIME
Operations Research, Coordination and Management of Technical Committees	Local Resident Advisor for all five years of project	Early in year 1 through life of project	INOPAL III Project (the Population Council)
Self-Sustainability: Market Research for Diversification Planning, Budgeting and Implementing Diversification Projects	 25 days year 1 24 days year 1 20 days year 2	Mid-year 1 through late in year 2	FPMD Project
Mid-term Evaluation	80 days in year 3	Mid-year 3	POPTECH
Final Evaluation	80 days in year 5	Early in year 5	POPTECH

D. Interagency Technical Committees

As stated previously, the PSP III Project will form three technical committees: Training, IEC and Service Delivery. All PVO grantees, ASHONPLAFA, USAID and the MOH will participate in these technical committees. The work of the committees will be coordinated by the local resident Population Council Advisor. The advisor will have an office in ASHONPLAFA and will work on problem detection and solution and on expediting implementation.

The Training Committee will be composed of trainers from the different PVOs and ASHONPLAFA. In view of the training needs of CSP *consejeras* and health center personnel, this committee will develop and implement a training needs assessment and a training plan to meet each participating agency's needs. Of particular importance, the committee will focus training on direct service providers, such as CBD workers and MOH personnel. The IEC Committee will be composed of communicators from the different PVOs, ASHONPLAFA and the MOH. These communicators will work together to develop and implement a national reproductive health IEC strategy, which USAID expects will include a mass media component along with interpersonal communication activities. The Service Delivery Committee will be composed of health personnel from the different PVOs, ASHONPLAFA and the MOH. This committee will take corrective actions so that the required standards of care, equipment and supplies, as stated in the MOH's National Norms for Integrated Reproductive Health Care to Women, are available in all ASHONPLAFA, MOH, and other PVO health facilities. The committee will also be responsible for advising the ASHONPLAFA, MOH, USAID and other PVO grantees on development and implementation of more effective referral systems that will increase utilization of reproductive health services.

V. MONITORING, EVALUATION, AND AUDIT PLAN

A. Monitoring and Evaluation

1. Monitoring

Within three months of signing the Cooperative Agreement, ASHONPLAFA will submit for approval to USAID/Honduras a monitoring plan. The results framework in Annex 2 presents those indicators ASHONPLAFA will use to monitor critical activities. The monitoring plan will discuss, in detail, how ASHONPLAFA plans to monitor critical activities (e.g. data collection procedures), and how often monitoring will be conducted. Project data will be gender-disaggregated.

USAID/Honduras anticipates that service utilization, self-financing and logistics indicators will become part of and be monitored through ASHONPLAFA's computerized MIS. ASHONPLAFA will monitor quality assurance according to the procedures to be established in Years One and Two with technical assistance from QA II Project and SOMARC.

2. Evaluation

a. Evaluation by ASHONPLAFA

Within three months of signing the Cooperative Agreement, ASHONPLAFA will submit an evaluation plan for USAID's review and approval. This evaluation plan will give detail on those baseline, yearly and endline studies which ASHONPLAFA will complete during the LOP and propose dates for setting yearly and endline targets. These dates will depend on baseline studies in some cases, the availability of the 1995 EFHS in other cases, and the start-up date of the MIS in still others.

b. External Evaluation

The results framework in Annex 2 presents indicators for assessing achievement of project results. This assessment will be carried out by independent evaluators in a mid-term and a final evaluation. The evaluators will analyze project achievements, using the Results Framework and indicators for assessing these results through: analysis of the results of the 1995 and 1999 EFHS, analysis of the results of the CSP, SMP, MCP and IEC baseline and endline studies, yearly client satisfaction studies for the SMP and the MCP, a review of project documents and data, interviews with ASHONPLAFA staff at the headquarters and regional offices, observation of facilities, equipment, supplies and provider-client interaction, focus groups with CSP and MCP clients, exit interviews with MCP and SMP clients, and "mystery client" visits to pharmacies.

The mid-term and final external evaluations will be funded with Global Support funds and will be conducted by the centrally-funded Population Technologies (POPTECH) Project.

3. Reporting Requirements

a. Annual Workplans

ASHONPLAFA will submit annual workplans for USAID's review and approval. These workplans will include activities to be undertaken during the workplan period, delineated by calendar quarter and linked to project benchmarks and results; a statement of anticipated accomplishments for the year; and a projected budget for the year. USAID/Honduras will compare these workplans against the Results Framework in determining whether to approve them. ASHONPLAFA will submit annual workplans in conjunction with Annual Activity Reports (see below) at the beginning of the last quarter of each calendar year (December 1).

b. Quarterly Reports

ASHONPLAFA will also submit quarterly reports 30 days after the end of each calendar year quarter comparing actual accomplishments with the targets established for the period. If goals are not met, ASHONPLAFA will explain in these reports why and propose solutions. The

reports will include levels of self-financing; couple years of protection; number of non-family planning reproductive health services provided; new activities initiated during the period; ongoing activities; follow-up to technical assistance received; studies undertaken and completed; study results, conclusions and recommendations; and those actions taken as a consequence of study results. Each quarterly report will include achievements during the current quarter and work objectives for next quarter. Goals for each quarter will also be set in annual workplans.

c. Annual Activity Reports

No later than December 1 of each year during the LOP (except 1995), ASHONPLAFA will submit to USAID/Honduras annual activity reports describing the past year's activities, including progress in service delivery, quality, access, evaluation, research, HRM, MIS, self-financing, planning, logistics and the monitoring of indicators as described in the Results Framework. This document will also contain baseline study results and proposed yearly and endline targets. USAID/Honduras will use this document during the annual workplan review to assess ASHONPLAFA's progress toward achieving benchmarks and results. USAID's decision as to the amount of funding to be made available for the following year will depend, in large part, on the extent to which ASHONPLAFA accomplishes those benchmarks as delineated in the Results Framework. Annual activity reports will include in annexes all study results, monitoring activities/findings and actions taken as a result during the year.

Each of the following annual activity reports must include the following:

CY 1996: Baseline results of the KAP study, SMP quality and customer satisfaction study, and MCP quality and customer satisfaction study. The reports will also include proposed annual and end-of-project targets for each of those indicators in the Results Framework which correspond to these studies.

CY 1997: Baseline results of the CSP quality and customer satisfaction study and proposed annual and end-of-project targets for those indicators in the Results Framework which correspond to these studies; the results of client MCP and SMP satisfaction surveys; and baseline data on contraceptive logistics and proposed annual and end-of-project targets for the indicators listed Annex 2, the Results Framework.

CY 1998: The results of client MCP and SMP satisfaction surveys.

CY 1999: Endline study results of the SMP and MCP quality and customer satisfaction studies and the KAP impact study.

CY 2000: Endline quality and customer satisfaction survey results for the CSP and results of client MCP and SMP satisfaction surveys.

d. Technical and Research Reports and Publications

ASHONPLAFA will prepare summaries of technical reports and research activities funded by this project, and will distribute these summaries to USAID/Honduras. These summaries are to be distributed within 30 days after completion of each activity.

e. Final Report

Within 90 days of the estimated completion date of the Cooperative Agreement, ASHONPLAFA will submit five copies of a final report to the HRD/HPN project officer. In addition, two copies will be submitted to USAID's Center for Development, Information and Evaluation (CDIE)/Development Experience Information Division (DI). This report will cover the entire period of the Cooperative Agreement and include a summary of all the program's accomplishments and failures, an overall description of activities under the Cooperative Agreement, a description of methods of work used, comments and recommendations regarding unfinished work and or program/continuation and direction, and a fiscal report that describes how the USAID grant and counterpart funds were used.

B. Audit

If 100,000 dollars or more are disbursed directly to ASHONPLAFA and/or other to-be-selected PVOs ("recipients") in any one calendar year under the Cooperative Agreement, in the case of ASHONPLAFA, or Grant Agreements, in the case of other PVOs, each recipient, except as USAID may otherwise agree in writing, shall have annual financial audits made of the funds disbursed to its organization under the Agreement in accordance with the following terms:

The audits shall determine whether the receipt and expenditure of the funds provided under the Agreement are presented in accordance with generally accepted accounting principles and whether the recipient has complied with the terms of the Agreement. Each audit shall be completed no later than one year after the close of the recipient's fiscal year.

The recipient shall select an independent auditor in accordance with the "Guidelines for Financial Audits contracted by Foreign Recipients" issued by the USAID Inspector General ("Guidelines"), and the audits shall be performed in accordance with the "Guidelines".

USAID may, at its discretion, also conduct financial reviews of the funds provided under the Agreements. The recipients shall afford authorized representatives of USAID/Honduras CONT/FARS office the opportunity at all reasonable times to conduct these reviews.

VI. SUMMARY ANALYSIS OF FEASIBILITY, KEY ASSUMPTIONS, AND RELATED RISKS

A. Why Has USAID Chosen These Approaches?

1. Are these approaches feasible?

a. Technically: Why does USAID believe they will get the desired results?

USAID believes that this project will achieve the desired results (if sufficient funds are available) because its design is based upon lessons learned in international family planning in terms of: 1) the relationships between family planning demand, family planning supply/service utilization and contraceptive prevalence; and 2) the correlations between self-financing, quality, access and image, and service utilization.

! The overall design is based upon the conceptual framework of family planning demand and program impact on fertility recently developed by the Office of Population, G/PHN.⁴³

! The approach for promoting a sustainable national family planning program is based upon lessons learned with the USAID cooperating agency community over the last ten years.⁴⁴ One of their key conclusions was that "getting the prices right" with each of the three sectors (public, commercial and private non-profit) was essential to the sustainability of the whole program.

! Efforts to promote self-financing are based upon USAID lessons learned with other family planning associations (FPAs) in Latin America.⁴⁵ As the Midterm Evaluation of the IPPF/WHO Transition Project concluded:

"Several factors are critical for achieving financial sustainability. These included: institutional commitment to the concept; appropriate management structure and staff; identification of market niches and relevant strategies; activities which generate a surplus; sound pricing strategies; and quality services delivered in an efficient manner.

⁴³ See Bertrand, J., R. Magnani and J. Knowles. 1994. HANDBOOK OF INDICATORS FOR FAMILY PLANNING PROGRAM EVALUATION, The Evaluation Project, USAID.

⁴⁴ See Laurel Cobb and Susan Adamcheck "Emerging Population Policy Assistance Needs: A Summary of Response to a USAID Survey", POPTECH Report No. 94-020-008, October 1994.

⁴⁵ See Wickham, R., R. Brooks, L. Cobb, and C. Steele Verme, *Midterm Evaluation of the International Planned Parenthood/Western Hemisphere Region (IPPF/WHO) Transition Project*, POPTECH Report No. 95-039-20, June 1995.

Additionally,

- Sufficient time is critical for a successful transition (to sustainability).
- Adequate resources are essential to enable FPAs to develop the capability to be more self-reliant, including thorough development of diversified services.
- FPAs must attract talented and dedicated staff who understand the business world and must compensate them accordingly.
- With the phase-out of USAID funds and donated contraceptives, and the consequent emphasis on sustainability, FPAs may be less able in the future to continue to reach substantial numbers of low-income clients."

■ Efforts to improve quality are based upon studies and analysis of the link in international family planning programs between good quality and increasing service utilization.⁴⁶

■ In designing this project, USAID focused on the role of access in service utilization. This focus stemmed from the 1991 EFHS, which identified lack of knowledge and fear as the principal reasons for not using modern methods of contraception in Honduras, and from recent research that reached similar conclusions on unmet need internationally.⁴⁷ In line with the conclusions in these studies, USAID and its partners expanded the concept of access beyond simple distance to include other principal factors creating barriers to use and leading to unmet need – lack of information, fear of side effects, and cost.

■ Promoting the image of family planning in general and of ASHONPLAFA in particular is essential to achieving service utilization and contraceptive prevalence results. Women and men are inadequately informed about the benefits, correct use, indications and contraindications of modern family planning methods – and consequently use them incorrectly, use ineffective traditional methods or none at all. ASHONPLAFA and participating PVOs must together aggressively correct the negative image and lack of knowledge about modern family planning, particularly in rural areas.

b. Socially: How do these approaches meet our customers' needs and desires?

The customers of this project are those women and men who want to stop or delay childbearing, including those already receiving reproductive health services, including modern

⁴⁶ Jain, A. 1989 Fertility Reduction and the Quality of Family Planning Service, *Studies in Family Planning* 20, 1:1–6
Bruce, J. 1990. "Fundamental Elements of Quality of Care: A simple Framework." *Studies in Family Planning* 21, 2:61–90
Jain, A. (ed), 1992 *Managing Quality of Care in Family Planning Programs*. West Hartford: Kumarian Press.
Jain, A, J.Bruce and B.Mench. 1993. "Setting Standards of Quality in Family Planning Programs ." *Studies in Family Planning* 23, 6:392–395.

⁴⁷ Bongaarts, J and J. Bruce, 1995, "The Causes of Unmet Need for Contraception and the Social Content of Services." *Studies in Family Planning* 26, 2:57–73.

family planning, as well as those who are not. A fundamental assumption of this project (one grounded, however, in empirical evidence) is that the unmet need presented by this latter group is significant and growing. As the 1991 EFHS, the 1995 ASHONPLAFA KAP survey, and other ASHONPLAFA studies⁴⁸ indicate:

- The greatest area of unmet need is in rural areas. This project will address that need through development of PVO capacity to promote, educate, refer and transport rural women and men to clinical services.
- A second group of customers with unmet needs are men whose level of knowledge about the correct use of condoms and other methods of contraception is low, and who consequently are not contracepting but wish to do so.⁴⁹
- Adolescents are another group with unmet needs.⁵⁰ Eight percent of adolescents are living in union. Seventy-one percent of adolescent boys and 19% of adolescent girls interviewed in the recent KAP study have had sexual relations. The vast majority of adolescents (87%) indicated that they had not used any form of contraception during their first sexual relation. Only 15% of adolescent girls who were sexually active reported using a modern method of contraception. This project will approach adolescents with such unmet needs through special MCP adolescent services to be initiated in Year Three in Tegucigalpa and San Pedro Sula.

This project is also, obviously, directed to current users of reproductive health services, about whom there is relatively little data on the level of client satisfaction. To understand and meet their needs and desires, ASHONPLAFA will undertake baseline studies in Years One and Two of the project. That data will be used to modify programs to increasingly satisfy customers.

- c. Politically: How will we and our partners address the interest or opposition of local stakeholders to planned approaches?

There are three key local stakeholders: the Government of Honduras (GOH) in general, the Ministry of Health (MOH) in particular, and the Catholic Church and its close collaborators such as Pro Vida. The first two stakeholders, the GOH and MOH, support USAID's work in reproductive health; the third stakeholder is a potential opponent with which ASHONPLAFA and USAID have traditionally struggled over family planning.

The GOH identifies increasing the contraceptive prevalence rate as an important means to reaching two of the country's three principal health-related goals for the decade: reduction of

⁴⁸ See the 1988 ASHONPLAFA-AVSC study, *Evaluación de las Barreras a la Vasectomía en Honduras e Implementación de Estrategias para Incrementar la Demanda por la Anticoncepción Quirúrgica Voluntaria Masculina* and Martin, R., J. Buttari, H. Macias and L. Cobb, USAID's Family Planning Program in Honduras, USAID Center for Development Information and Evaluation, USAID Technical Report No. 9, June 1993.

⁴⁹ MULTI/MARKETING, 1995, *Conocimientos, Actitudes, y Prácticas de Adolescentes, Hombres y Mujeres*.

⁵⁰ IBID.

infant mortality and reduction of mortality among children younger than five years of age. The target for the nation is an increase in contraceptive prevalence from 46.7% in 1991 to 60% by the year 2000.⁵¹ In response to the GOH commitment to increase contraceptive prevalence, the MOH recently created the National Women's Program of Integrated Reproductive Health Care.⁵² This Program explicitly includes family planning as a preventative strategy to reduce the number of total maternal deaths caused by pregnancy-related complications and the incidence of unintended and mis-timed pregnancies. As part of this Program, collaboration between PVO project partners and the MOH will be ensured by formation of three technical committees discussed above.

The Catholic church and Pro Vida are potential opponents. In this project, both USAID and its partners will address this stakeholder's opposition to family planning. ASHONPLAFA will develop a sustained campaign to improve the image of family planning, while USAID will probably support RENAFE, a local PVO which promotes natural family planning. It is expected that support to RENAFE will ease the degree to which the Catholic church publicly opposes family planning.

- d. Institutionally: Are our partners *committed to and capable of* using planned approaches and resources to achieve planned results?

Past ASHONPLAFA planning performance does not indicate that the Association is presently capable of using planned approaches to achieving its planned results. ASHONPLAFA, however, is committed to carrying out the actions necessary to achieving the results contemplated for this project and is aware that this will require the synchronized execution of planned activities. ASHONPLAFA is also aware that planning is not one of its strengths. In response, it recently created a Planning Department to assist it in planning and synchronizing activities between and among departments. Moreover, ASHONPLAFA's improving capacity to plan is illustrated by the fact that it has had less difficulty executing its annual budgets in recent years than was previously the case. The Association expended over 95% of its proposed annual budget in 1993 and 1994.

The PVOs that participated in PSP II Project have, for the most part, proven themselves capable of and committed to using planned approaches and resources to achieve planned results. All participating PVOs executed close to 100% of proposed budgets and successfully integrated family planning/reproductive health activities into their ongoing programs within the timeframe they had proposed.

- e. Financially: Are these the most *cost effective* means of getting these results? Do these approaches *maximize the impact* of our scarce development resources? What

⁵¹ *Desarrollo Humano, Infancia y Juventud*, Primer Informe de Seguimiento y Evaluación del Plan de Acción Nacional, UNIS/DGEC/SECPLAN.

⁵² Programa Nacional de Atención Integral de la Mujer, Resolución Ministerial No. 0042.

progress will our partners have made toward self-financing by the time USAID support ends?

Given the investment in time and money made by USAID over several years in ASHONPLAFA, the proposed PSP III Project is the most cost effective means of producing the results planned. ASHONPLAFA's infrastructure and trained personnel, and resulting client demand for its services, have reached a momentum that would be extremely costly to produce if other alternatives were to be considered. ASHONPLAFA fully intends to improve both its level of financial sustainability and operational efficiency, and realizes that yearly approval of USAID funding will depend on these two criteria. ASHONPLAFA is fully committed to increasing its 1995 level of self-financing of 31% to 63% by the end of the year 2000.

f. Economically: Do these approaches represent a wise investment of taxpayer resources?

To assess the economic viability of PSP III, the Mission's Economic Advisor computed economic benefits and costs. The economic benefits of the project consist of the summation of budgetary savings from births averted (i.e. GOH's budgetary savings in primary education, health services, urban transportation subsidies, safety net programs, etc.) and reduced population size. The economic costs of the project consist of (a) USAID assistance to ASHONPLAFA -- both operating budget support and in-kind, (b) USAID assistance to other participating PVOs, and (c) ASHONPLAFA's own resources. Utilizing a 20 year benefit-cost stream and a discount rate of 15% , the project will have a benefit-cost ratio of 2.04, suggesting the project is an economically viable proposition. This ratio, however, understates the value of the project. In addition to budgetary savings, the project will be producing other economic benefits that are more difficult to quantify (i.e., labor productivity, greater private savings, and improvements in health). If these other benefits could be quantified, the project's benefit-cost ratio would be considerably higher than 2.04.

2. Do these approaches complement the plans of other donors and of other USAID projects?

Other than USAID, only United Nation's Population Fund (UNFPA) provides funding to Honduras for family planning activities. Under a project entitled "Reproductive Risk and Women's Health," UNFPA is currently helping the MOH to implement its integrated reproductive health care norms for women in Tegucigalpa and in Region 7 (Olancho). Under this project, UNFPA is also supporting limited PVO training activities in these same regions through the Honduran Association for Breastfeeding (AHLACMA) and RENAFE. Though ASHONPLAFA support will be national, the majority of PSP III support to PVOs other than ASHONPLAFA will be provided to PVOs that work in the western part of the country. Consequently, the UNFPA project and the PSP III Project will complement one another geographically.

The PSP III Project will also complement the extended USAID-funded Health Sector II Project by supporting PVOs which work in the eight Health Areas where Health Sector II will fund local health services activities. These PVOs will work closely with the MOH in the implementation and execution of the MOH norms for integrated reproductive health care for women. PSP III may complement other USAID-supported activities as well. At present, CARE is testing different strategies for integrating family planning and reproductive health activities into its Agroforestry Community Project (PACO) project. Depending on the results of PACO, CARE and other PVOs may choose to integrate family planning and reproductive health into the Land Use and Productivity Enhancement (LUPE) Project.

Finally, the USAID/Honduras Primary Education and Efficiency (PEEP) and Basic Education and Skills Training (BEST) Projects complement this project. The PEEP Project has contributed to a dramatic increase (70%) in the percentage of primary school-aged children who graduate from primary school, of which 52% are girls. This gain will undoubtedly result in an increase in the percentage of girls who complete secondary education in near-future years. Female education, and especially the completion of secondary school, is a strong predictor of whether a couple chooses to use family planning services.⁵³

3. Do these approaches comply with applicable USAID policies?

This project is entirely consistent with agency principles and guidance in the population health and nutrition (PHN) sector and will contribute to the PHN sectoral goal of stabilizing world population and protect world health through the agency's Strategic Objective No. 1: "Reduction of Unintended Pregnancies." This project also contributes to the PHN Center Strategic Plan. That Center's Strategic Objective No. 1, "Increased Use by Women and Men of Voluntary Practices that Contribute to Reduced Fertility," closely resembles the PSP III Project Program Outcome of "Increased Use of Reproductive Health Services, Including Family Planning Services." Both the PHN Center Strategic Objective #1 and the PSP III Program Outcome share "increased contraceptive prevalence" as the key indicator of success.

Further, the Program Outcome 1.4 of the PHN Center S.O. No. 1, "Increased Access to High-Quality Family Planning and Other Selected Reproductive Information and Services" parallels PSP III Project intermediate results of "Improved Delivery of High Quality Medical Clinical Services," "Accessible, High Quality, Self-Financing Social Marketing Program," "Focused, High Quality Community Based Distribution Program," and "Increased PVO Participation."

4. Are these approaches environmentally safe?

The only potential negative environmental impact that this project may have is that of small amounts of medical wastes generated during project implementation, which, if not properly

⁵³ EFHS, 1991/92.

disposed of, may contribute to contamination of the environment. The small quantities of waste produced, however, will not have a significant environmental impact.

On September 15, 1995, the LAC Bureau's Chief Environmental Officer issued a Categorical Exclusion for PSP III activities including technical assistance, procurement, studies and a Negative Determination for medical waste disposal (see Annex 6).

USAID will ensure that ASHONPLAFA and other PVOs undertake several mitigation measures to insure that environmental concerns for medical waste are addressed. These include: (1) periodic measures of the quantity of medical waste generated, (2) provision of written instructions to the clinics on how to handle disposal of medical wastes; (3) training of all personnel in clinics on proper handling and disposal of medical wastes; (4) provision of appropriate waste containers and needle disposal systems to the clinics; and (5) provision that each planned Project Evaluation shall evaluate the quantity of medical waste produced and the disposal procedures at each clinic.

B. Principal Assumptions and Risks

1. Assumptions on which progress toward sustainable results depends

a. Macro Assumptions

This project rests on two macro-level assumptions:

Contraceptive Prevalence: Updated contraceptive prevalence data were not available to project CPR for 2000, the Program Outcome indicator. Instead, design of PSP III relied heavily on past trends and a series of assumptions to project the Program Outcome. The following is a summary of these trends and assumptions.

Though total contraceptive prevalence increased substantially between 1984 and 1991 (34.9% and 46.7% respectively), modern contraceptive prevalence increased less dramatically (30.3% and 34.7% respectively), while the increase in modern contraceptive prevalence in rural areas was even more modest (20.2% and 23.9% respectively). Since 1991, however, the PVO Component and ASHONPLAFA under PSP II have expanded services into rural areas at an accelerated rate. For this reason, USAID and ASHONPLAFA assume that the observed annual rate of increase in the contraceptive prevalence rate in rural areas between 1984 and 1991 (.53% annually) will double between 1992–2000 (to 1.06% annually). Further, it is assumed that the observed annual rate of increase in urban areas between 1984 and 1991 will remain constant between 1992–2000 (.67% annually) as contraceptive prevalence in urban areas was already quite high in 1991 (50%). Once 1995/96 EFHS data are available, USAID will correct contraceptive prevalence rate targets to reflect real increases in rural and urban contraceptive prevalence between 1992 and 1995, and will adjust projections for 1996 through 2000.

The Catholic Church and *Pro Vida*: Though religious opposition to family planning has always existed in Honduras, in recent years this opposition has increased. The Catholic church and one group in particular, *Pro Vida*, have launched large-scale campaigns in opposition to family planning in general and to ASHONPLAFA in particular. It is assumed that some form of opposition will continue throughout the life of the PSP III Project, though support to the local PVO RENAFE should lessen the intensity of the opposition. Even if support to RENAFE does not have this affect, however, it is doubtful that the Catholic church and *Pro Vida* could ever successfully halt the national family planning program in Honduras. The 1991 EFHS indicated that only a very small proportion of women who do not contracept cite religion as the reason.

b. Assumptions About the Key Participants in this Project

USAID: USAID assumes that it will have sufficient funds over the next five years to provide the level of support necessary to assist ASHONPLAFA in the transition from a heavily donor-dependent, welfare-oriented institution to an increasingly self-financing entrepreneurial institution. This transition takes time, money and institutional resolve.

ASHONPLAFA: USAID assumes that ASHONPLAFA's Executive Director and Board of Directors will have both the institutional resolve and management capability to make this transition, starting with the appointment of an appropriate new Executive Director when the current one retires. In particular, USAID assumes that ASHONPLAFA will raise prices in accordance with increases in the cost of service provision. Otherwise, ASHONPLAFA self-financing targets will not be reached.

IPPF/WHR: USAID assumes that IPPF/WHR will continue to supply ASHONPLAFA with the same level and same brands of donated contraceptives it has in the previous three years.

International PVOs: USAID assumes that: 1) they are a more effective and more efficient means of rural access than is ASHONPLAFA; and 2) despite changing international staff in Honduras, the PVOs will remain committed to promoting rural access.

MOH: USAID assumes that the MOH will increasingly be an effective and important actor in the national family planning program.

2. Risks to achievement of sustainable results

There are two substantial risks in this project: the first is the institutional history of ASHONPLAFA and the second is reliance upon PVOs for expansion in rural areas.

ASHONPLAFA is a subsidized dependent monopoly in the dominant sector of the national family planning program. USAID assumes that a moderate investment over five years, combined with ASHONPLAFA resolve, can turn it into a self-reliant, increasingly self-financing institution. In all likelihood, however, in five years it will still be in a monopoly

position. The risk is that ASHONPLAFA will be unable to make the transition to sustainability because one or more of our assumptions above proved false, and therefore that in five years it will still be a dependent monopoly dominating the national family planning program. In an era of reduced USAID funding, USAID will have to balance the need to invest sufficiently in ASHONPLAFA to give it a fighting chance of becoming self-financing before USAID funding for population in Honduras ends with the competing desire to develop alternative service providers to reduce ASHONPLAFA's monopoly position.

USAID plans to respond to this dilemma by providing some funding for the only other private voluntary organization which currently provides clinical family planning services, the *Centro de Desarrollo de Juventud y de la Familia*. Promotion of a second family planning agency would give the Mission investment options in future years.

The second major risk is depending upon PVOs for expansion into rural areas. In this project, expanded access to and increased utilization of family planning and reproductive health services in rural areas will primarily be the responsibility of participating PVOs other than ASHONPLAFA. The basis for this approach is the success of the PVO Component of the PSP II Project in demonstrating that PVO promotion of family planning and referrals to ASHONPLAFA and MOH services can be a cost-effective alternative to expansion of ASHONPLAFA service delivery programs. Consequently, ASHONPLAFA will depend on these PVOs for promotion of family planning, identification of new post locations, and referrals and transportation for rural clients. If the PVOs do not act, ASHONPLAFA will probably not increase the proportion of rural clients served. Moreover, whereas ASHONPLAFA success is dependent on the efforts of other PVOs, the success of the efforts of those PVOs will in turn depend on the MOH. The MOH must respond adequately to PVO referrals. All of this coordination depends on good teamwork fostered by the project's formation of three technical committees. Historically, these three groups of actors have not worked well together.

3. Management and Monitoring of Risks

The USAID Health Population and Nutrition (HPN) Officer, with the assistance of a FSN PSC Project Liaison Officer, a FSN PSC Population Advisor, a Western Consortium Fellow, and a Population Council resident advisor who will serve as the technical committee coordinator, will monitor and manage the above risks by working closely with ASHONPLAFA, PVOs and the MOH to identify problems in project implementation. The technical committees, in which the PVOs, MOH and ASHONPLAFA will collaborate, will assist in the identification and resolution of problems in inter-institutional coordination. Project funds will finance technical assistance from Family Planning Management and Development to ASHONPLAFA in the area of sustainability. HRD/HPN and Family Planning Management and Development will closely monitor ASHONPLAFA progress in this.

4. Checkpoints

See the Results Framework for the benchmarks and results ASHONPLAFA will seek to meet each year prior to approval of further USAID funding. Annual benchmarks for the PVO component will be developed by USAID and the prospective PVO grantees during USAID's review of PVO grant proposals.

VII. SUSTAINABILITY

Increasing the financial self-sufficiency of ASHONPLAFA, and thus furthering its ability to continue to provide reproductive health services in the absence of continued USAID support following the completion of assistance from this project, will as noted be a major intermediate result of the Private Sector Population III Project. As discussed elsewhere in this Project Paper, achieving this result will in turn depend on improving *access to, the quality of, and the utilization of the services of* all ASHONPLAFA's services delivery systems, its IEC efforts, and its support systems.

It is extremely important to note, however, that even if all our assumptions prove true, and all planned activities work as expected, ASHONPLAFA will be covering no more than 63% of its costs at the December 31, 2000 PACD⁵⁴. Achievement of 63% financial self-sufficiency would be a major success, for this level would be approximately the same as that reached by the most successful (in these terms) USAID-assisted family planning association in the world, Colombia's PROFAMILIA. Nonetheless, even this level would not provide the Association with full financial independence from continued donor support. **If ASHONPLAFA is to continue to provide reproductive health services, and thus if Honduras is to maintain the CPR levels expected to be reached by the end of PSP III, further donor assistance in this sector will still have to be provided following the completion of this project.**

When PROFAMILIA reached a similar level of self-sufficiency in Colombia, USAID elected to replace direct project support to it with an endowment. The Agency did so in the belief that 60-70% financial self-sufficiency was the maximum level that could reasonably be expected of a family planning association in the Latin American context. Come December 2000, it is likely that USAID will face a similar decision with respect to ASHONPLAFA and the entire national family planning program in Honduras. Certain aspects of this family planning program - particularly the outreach work into underserved rural areas that PVOs will undertake with resources from the PSP III Project - simply cannot be made financially sustainable. Thus, to maintain the annual CPR and CYP levels expected to be reached by the end of this project, USAID and/or other donors will have to decide to either endow ASHONPLAFA (or perhaps another organization) to continue critical but revenue-losing efforts, or to provide further project assistance to continue these efforts.

⁵⁴ Roy Brooks, Financial Analysis, August, 1995.

VIII. FINANCIAL, HUMAN RESOURCE, AND MANAGEMENT PLAN

A. Resource Requirements – USAID and Counterparts

1. Financial Requirements

a. Planned Life of Project (LOP) Cost

The total cost of the PSP III is estimated at \$28,289,700, with USAID providing \$14,920,000 in grant funding and ASHONPLAFA contributing a counterpart contribution of \$13,369,700.

Of the \$14,920,000 USAID contribution, \$11,254,000 will be funded with Mission appropriated funds and \$3,666,000 with USAID/W Global Support Funds. Of the \$11,254,000, the Mission expects to make OYB transfers totalling \$902,000 for Global Support technical assistance services and contraceptives. Thus, obligations made by USAID/Honduras will total \$10,352,000 (see Annex 3 for greater detail on these figures).

Table 3: ILLUSTRATIVE SUMMARY LOP COST ESTIMATE (US\$ 000)

PROJECT ACTIVITIES	USAID/HONDURAS FUNDS		Total USAID	Counterpart Funds	TOTAL
	LC	FX			
I. ASHONPLAFA	7,664.3	408.3	8,072.6	13,369.7	21,442.3
II. Other PVOs	1,540.0	0.0	1,540.0	0.0	1,540.0
III. Training and Local TA	739.4	902.0*	1,641.4	0.0	1,641.4
Subtotal	9,943.7	1,310.3	11,254.0	13,369.7	24,623.7
	USAID/WASHINGTON GLOBAL SUPPORT				
	LC	FX			
IV. TA	0.0	1,826.0	1,826.0	0.0	1,826.0
V. Contraceptives	0.0	1,590.0	1,590.0	0.0	1,590.0
VI. Evaluations	0.0	250.0	250.0	0.0	250.0
Subtotal	0.0	3,666.0	3,666.0	0.0	3,666.0
Total	9,943.7	4,976.3	14,920.0	13,369.7	28,289.7

* Planned OYB transfers for Global Support Technical Assistance services.

Table 4: ILLUSTRATIVE DETAILED FIRST YEAR (CY96) BUDGET (US\$ 000)

PROJECT ACTIVITIES	USAID FUNDS		Total USAID Funds	Counterpart Funds	TOTAL
	LC	FX			
ASHONPLAFA Coop. Agreement					
Medical Clinical	533.3	0.0	533.3	391.0	924.3
Community Services	132.9	0.0	132.9	374.9	507.8
Social Marketing	87.1	0.0	87.1	178.8	265.9
Planning, Evaluation & Investigation	192.9	0.0	192.9	117.2	310.1
Training	97.7	20.9	118.6	67.1	185.7
Communication	285.2	0.0	285.2	285.5	570.7
Administration	145.9	0.0	145.9	872.6	1,018.5
Equipment	0.0	0.0	0.0	0.0	0.0
Audits	5.7	0.0	5.7	0.0	5.7
Subtotal	1,480.7	20.9	1,501.6	2,287.1	3,788.7
PVO Grants	220.0	0.0	220.0	0.0	220.0
Technical Assistance (TA)					
USAID/W TA	0.0	599.0	647.0	0.0	647.0
Local TA	143.1	0.0	143.1	0.0	143.1
Contraceptives ASH & PVOs	0.0	250.0	250.0	0.0	250.0
Evaluations	0.0	0.0	0.0	0.0	0.0
TOTAL	1,843.8	869.9	2,713.7	2,287.1	4,999.5

b. Planned Obligation Actions and Instruments

Project funds will be obligated through several instruments. First, USAID will sign a Cooperative Agreement which will give ASHONPLAFA overall responsibility for achievement of results with substantial involvement of USAID.⁵⁵ The USAID grant funds expected to be obligated under this instrument are \$8,072,600.

Second, USAID plans to sign approximately five grant agreements with PVOs, selected from the review of proposals to be received in response to an RFA. An estimated total of \$1,540,000 in USAID grant funds will be obligated through these agreements. The funds to

⁵⁵ In accordance with USAID's "Principles for Award of Assistance Instruments to PVOs and NGOs for Development and Humanitarian Assistance", substantial involvement by USAID should be limited to those few elements which are essential to meet program requirements and assure achievement of mutual program objectives (i.e. approval of annual work plans; designation of key positions and approval of key personnel; and approval of monitoring and evaluation plans, and monitoring progress toward the achievement of program objectives during the course of the cooperative agreement).

be obligated under each of these five grants will likely vary between \$50,000 for the smaller PVOs to \$500,000 or more for the larger PVOs.

Third, USAID plans to obligate funds under individual obligation instruments (i.e., contracts, purchase orders, travel authorizations, and project implementation orders for participant training) totalling \$739,400. These funds will be used by USAID to procure local technical assistance, evaluation and audit services; fund local/foreign training; and fund Mission personal services contracts (100% funding of an FSN PSC Project Liaison Officer; 50% funding of an FSN PSC Population Advisor; and 100% funding of an FSN Administrative Assistant, and 40% funding of a US PSC Financial Officer).

Fourth, it is estimated that USAID/W will obligate \$3,666,000 from Global Support Funds and \$902,000 from Mission OYB transfers for the provision of technical assistance and the procurement of contraceptives.

See budgets included in Annex 3 for greater detail on these planned obligation instruments.

c. Recurrent Costs to ASHONPLAFA

ASHONPLAFA's recurrent costs needed to continue activities beyond the life of the project (LOP) are currently estimated at US\$4.8 million per year. USAID and ASHONPLAFA's projections indicate that ASHONPLAFA will generate resources to cover only US\$3.2 million per year, or 65.7% of the total annual recurrent costs, after the year 2000. Therefore, ASHONPLAFA will need to look for other donor support to cover the remaining 34.3% of its recurrent costs (see Annex 3 for greater detail on recurrent costs).

2. Human Resource Requirements

Within USAID: USAID project management responsibility will rest with the Office of Human Resources Development's Health Population and Nutrition Division (HRD/HPN) with participation of other members of the SO No. 3 Team. The Health, Population, and Nutrition US Direct Hire Officer will provide general technical and administrative oversight and will manage the project for results with assistance from a project-funded Western Consortium Fellow, a US PSC Financial Officer, a FSN PSC Project Liaison Officer, a FSN PSC Population Advisor, a FSN PSC Administrative Assistant, and a Population Council resident technical advisor. This group of professionals will work with ASHONPLAFA and other PVOs to facilitate project implementation, identify and resolve problems, and monitor progress toward achievement of planned results and the use of resources to that end.

Within ASHONPLAFA: ASHONPLAFA, the leader in providing family planning services in Honduras, will be the primary implementing agency for this project. Based on experience with the Private Sector Population II Project (522-0369), the Mission has determined that ASHONPLAFA has the administrative, technical and infrastructure capability and financial

accountability necessary to manage USAID project resources for achievement of planned results.

Within other participating PVOs: Based on experience with PSP II, USAID/H has determined that PLAN, CARE and Save the Children have the technical, administrative, and financial capability to manage USAID resources for achievement of planned results. RENAFE and CDJF will need technical assistance in data collection and reporting.

B. USAID Management Costs (in terms of money and people)

Position	Source of Funding	% Time	Cost LOP (US\$)
HPN Officer, Direct Hire	OE Funds	45%	24,948
FSN Project Secretary	OE Funds	60%	2,628
FSN Population Advisor	Program Funds	50%	110,500
FSN Population Liaison	Program Funds	100%	232,500
FSN Administrative Assistant	Program Funds	100%	91,000
US PSC Financial Officer	Program Funds	40%	180,000
Western Consortium Fellow	Global Field Support Funds, OYB Transfer	100%	940,000
Population Council Resident Advisor	Global Field Support Funds, OYB Transfer	50%	657,333
TOTAL			2,238,909

C. Measures to Ensure the Prudent Stewardship of USAID Resources

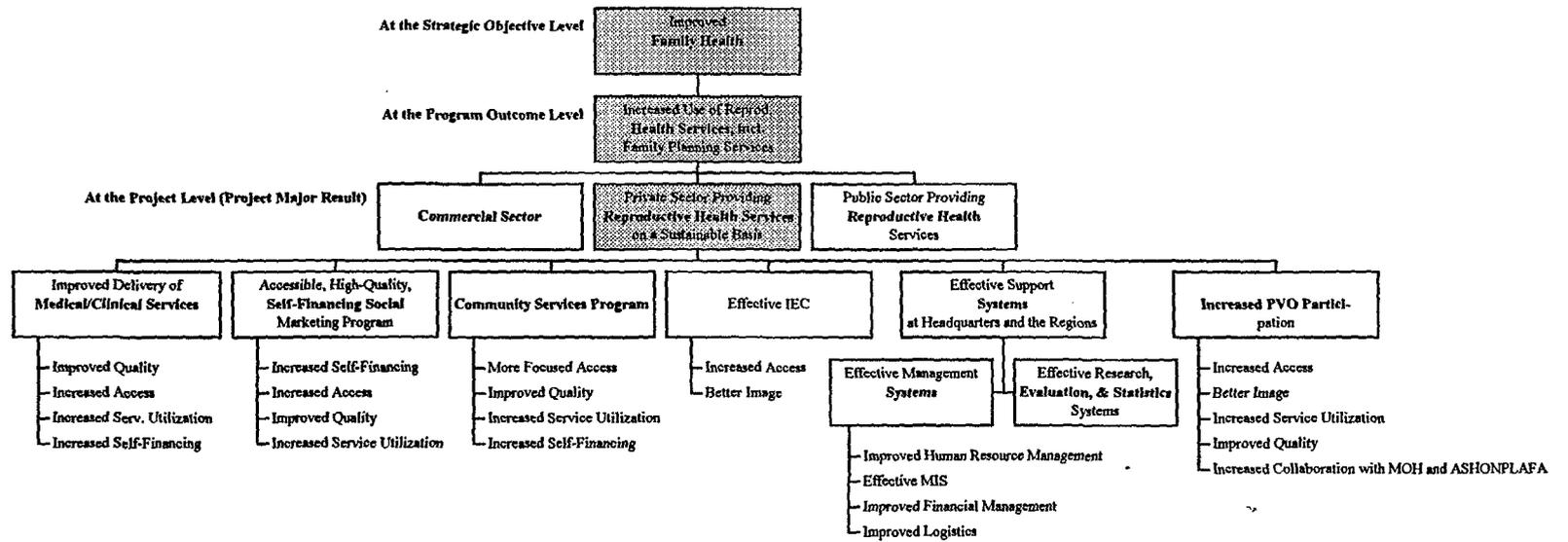
ASHONPLAFA has long proven its ability to manage USAID funds in a prudent manner. USAID will assure that ASHONPLAFA prospective PVOs have adequate internal control and financial systems in place (e.g., through financial reviews performed by the Office of the Controller/FARS) prior to disbursing USAID grant funds to them. In addition, the Mission will continue to finance audits under the Recipient Contracted Audit Program to monitor the financial management practices of these organizations.

Annexes:

- Annex 1: Key Background Data**
- Annex 2: Private Sector Population III Results Framework:**
 - A. Objectives Tree**
 - B. Intermediate Results Indicators**
 - C. Intermediate Results Benchmarks**
- Annex 3: Financial Plan**
- Annex 4: Definition of and Projected Impact on Project's Customers**
- Annex 5: Economic Analysis**
- Annex 6: Environmental Threshold Decision**
- Annex 7: Statutory Checklist**

Objectives Tree

Private Sector Population III Project



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ANNEX 1

PRIVATE SECTOR POPULATION III PROJECT - KEY BACKGROUND DATA

- o Basic Data: ASHONPLAFA Access and Service Utilization
- o Baseline Data: 1994 CYPs Provided by ASHONPLAFA's Service Delivery Department
- o Map: Prevalence of the Use of Modern Contraceptives by Health Region

	Region 1 Tegu	Region 2 SPS	Region 3 Choluteca	Region 4 La Ceiba	Region 5 Santa Rosa	Region 6 Juticalpa	Total
WRA (in 1000s)	435	276	116	139	152	94	
square kilometers (sq.km.) of region	25	15	6	32	10	23	
Average coverage of ASHONPLAFA clinics and affiliated clinical providers in sq. km.	2	3	6	7	10	23	
991 CPR - all methods	50%	65%	44%	46%	37%	37%	47%
991 CPR - modern methods	38%	50%	31%	38%	19%	27%	35%
991 CPR - traditional methods	12%	10%	13%	8%	18%	10%	12%
SP # of promoters and (# of consejeras) # of consejeras per promoter	8 (530) 66	7 (462) 66	3 (215) 71	5 (408) 81	3 (266) 88	2 (141) 70	28 (2022) 72
994 CYP - ASHONPLAFA CSP ¹	15,974	12,884	4,795	9,849	4,991	3,215	51,717
MCP:							
# of ASHONPLAFA regional clinics	1	1	1	1	1	1	6
Clinica de la Mujer	1	1	1	1			4
Clinica del Hombre	1	1					2
Cytology lab	1	1					2
Clinical lab	1	1					2
MCP:	4	1		2	1		8
Affiliated clinics (MD)	X	X		X			
Affiliated private hospitals							
994 CYP - ASHONPLAFA MCP except VSC	19,999	7,574	2,074	2,270	1,115	2,565	35,595
994 CYP - VSC in ASHONPLAFA MCP	19,570	22890	9,120	7,740	8,430	7,480	75,230
994 CYP - VSC in affiliated clinics and hospitals	14,030	10,970			7,450		32,450
Planned new clinics de la mujer					1	1	2
Planned new clinics for men			1	1	1	1	4
Planned rural brigades					X	X	
Planned FP satellite clinics staffed with nurse			X	X	X		
Planned new affiliations with private clinics							
Planned community clinics - private MDs	X	X		X			
NGOs working in area on significant scale	SAVE, CDJF ²	PLAN, CDJF, CARE	SAVE, CDJF, CARE	CDJF, CARE	CARE, PLAN, CDJF in Santa Barbara	PLAN	

¹ Additionally, ASHONPLAFA reports 25,560 CYP from the SMP, reported from Tegucigalpa, Region 1.

² CDJF (Centro de Desarrollo Juvenil y de Familia) is a small Honduran NGO, with largely European funds, which directly provides family planning services in 10 (13) clinics. It has 4 clinics in La Ceiba, 1 in Puerto Cortes, 1 in SPS, 1 in Tegucigalpa, 2 in Choluteca, 1 in Santa Barbara and a general hospital in La Lima. CDJF has never received USAID funds.

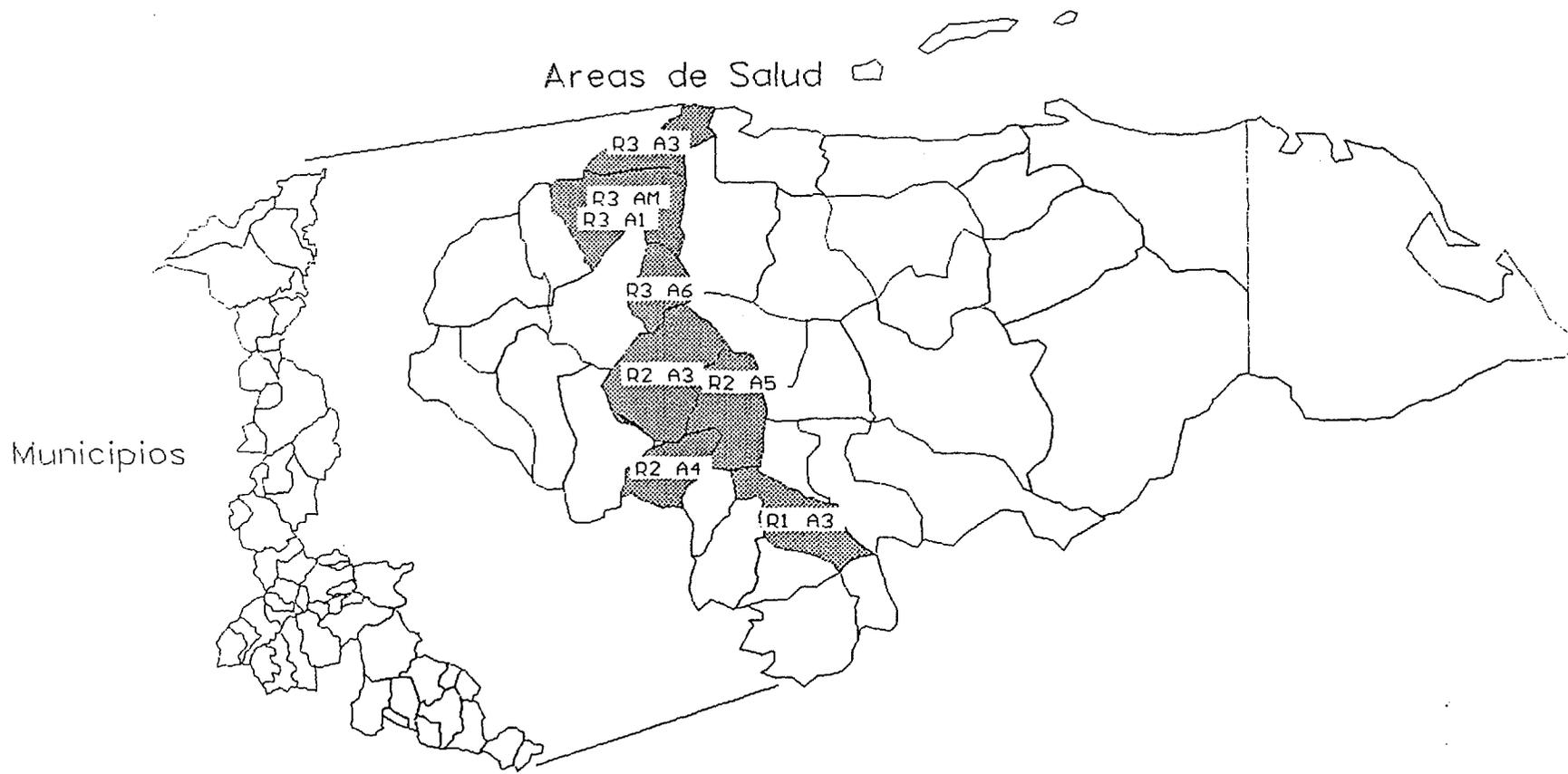
The 1991 ENESF identified seven reasons why sexually active WRA who were not pregnant, and did not desire to become pregnant, were not using contraception. They are: fear, lack of knowledge, partner opposes use, cost, religious reasons, medical reasons, and others. Each of these reasons can be viewed as an access barrier; the group of seven can be collapsed into four access barriers: lack of knowledge, cost, religious reasons, and partner opposes use³. Additionally, family planning literature has identified a fifth barrier: distance from services. The following TABLE presents these five barriers as indicators of access, by ASHONPLAFA region.

Access Indicator	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
Distance from services: % of WRA who must travel 2 hours or more to reach any FP clinic (1991)	19.5%	7.0%	14.0%	9.9%	26%	43.1%	
# of WRA (000) per ASHONPLAFA clinic (# of WRA/# of ASHONPLAFA clinics and affiliated clinics) (1995)	40	56	116	28	152	94	
Lack of information % of WRA who cite lack of knowledge or knowledge-related factors as reasons for not using contraception (1991)	14.6%	5.6%	13.7%	11.2%	11.6%	15.3%	12.0%
Cost % of WRA who cite cost as a reason for not using contraception (1991)	.4%		.5%	.8%		.4%	.3%
% of annual client income needed to pay for IUD services in first year (1995)	0.8%	1%	1.6%	1.2%	1.8%	0.8%	
Religious reason % of WRA who cite religious reasons for not using contraception (1991)	1.3%		.5%	.4%	1.2%	2.2%	1.0%
Partner opposes % of WRA who cite their partner's opposition for not using contraception (1991)	1.6%	.8%	2.8%	2.4%	2.8%	4.8%	2.2%

CYPs 1994 (BASELINE DATA)
SERVICE DELIVERY DEPARTMENT

REGIONAL CLINICS							
	I	II	III	IV	V	VI	TOTAL
1) MEDICAL CLINICAL							
A) <u>ASHONPLAFA Clinics</u>							
Oral	159	62	48	22	12	18	321
Condoms	27	15	8	2	1	1	54
IUDs	19813	7497	2018	2246	1102	2546	35222
Female VSC	18940	22500	9120	7740	8330	7480	1110
Male VSC	630	390			90		1020
B) <u>Private Clinics</u>							
CEMENE, Danli:							
Female VSC	5560						5560
Male VSC	70						70
Evangelico, Siguatepeque	2200						2200
Montes, Comayagua	4960						4960
Enamorado, Santa Barbara		4000					4000
Progreseña, El Progreso		210					210
CEMECO, Tocoa		5110		4070			9180
S.M.Q. Olanchito				2580			2580
2) SOCIAL MARKETING PROGRAM							
Commercial sells, 1994:							
Oral	16267						16267
Condoms	4892						4892
3) COMMUNITY SERVICE PROGRAM							
Oral	14852	12041	4462	9,282	4,594	3,066	48297
Condoms	1118	840	326	566	397	149	3396
TOTAL	89488	52665	15982	26,508	14,526	13,260	88400

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Area de Enfoque del Proyecto Sector Salud II

1996 - 1998

LISTA DE LAS MUNICIPALIDADES INCLUIDAS EN EL AREA DE ENFOQUE DEL
PROYECTO SECTOR SALUD II (SEGUN MAPA ANTERIOR)

NUMERO	NOMBRE DE LA REGION
01	Ajuterique
02	Alubaren
03	Cabañas La Paz
04	Cane
05	Chinacla
06	Choloma
07	Curaren
08	Guajiquire
09	Humuya
10	Jesús de Otoro
11	La Lima
12	La Paz
13	La Venta
14	Lamani
15	Las Vegas
16	Lejamani
17	Lepaterique
18	Marcala
19	Masaguara
20	Meambar
21	Nueva Armenia
22	Ojojona
23	Omoa
24	Opatoro
25	Pimienta
26	Potreros Cortes
27	Puerto Cortés
28	Reitoca
29	Sabanagrande
30	San Antonio De Cortes
31	San Buenaventura
32	San Francisco de Yojoa
33	San Isidro Intibuca
34	San José de Comayagua
35	San José La Paz
36	San Manuel Cortes
37	San Pedro de Tutule
38	San Pedro Sula
39	San Sebastian Comayagua
40	Santa Ana, Fco. Morazán
41	Santa Ana La Paz
42	Santa Cruz de Yojoa
43	Santa Elena
44	Santa María La Paz
45	Santia de Puringla
46	Siguatepeque
47	Taulabe
48	Texiguat
49	Vado Ancho
50	Villa de San Antonio
51	Villanueva
52	Yarula

ANNEX 2

PRIVATE SECTOR POPULATION III PROJECT RESULTS FRAMEWORK

The three tables presented in this Annex –

- o Intermediate Results Indicators;
- o Intermediate Results Benchmarks; and
- o Objectives Tree

– together constitute the Results Framework for the Private Sector Population III Project. The first sets forth how USAID and its partners will assess, at the end of the project, whether or not they have achieved the Intermediate Results planned. The second provides annual benchmarks (or checkpoints) by which USAID and its partners will measure progress toward these Intermediate Results. In some cases, these benchmarks will represent intermediate results in and of themselves (e.g., increases of 5% by the end of Year One in the total number of CYPs provided by the Community Services Program); in others, they simply represent intermediate actions (e.g., the completion of a baseline study or an assessment) that must be completed by a certain point if progress toward the end-of project intermediate objective is to remain on track. The third illustrates schematically the relationship between, and hierarchy of, planned results.

It should be noted that, wherever possible, these matrices set forth quantitative targets for each result (or, more properly, for each indicator by which progress toward results will be measured). The targets included here represent the best present estimates of USAID and its partners as to what is achievable by what dates. All these quantitative estimates, however, are subject to revision pending the outcome of baseline data-gathering studies.

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS INDICATORS**

Result I: Improved Delivery of Medical Clinical Services	Means of Verification
<p>1.1 Improved Quality of MCP Services MCP is providing safe, effective and high quality services.</p> <p>a. Indicators related to <u>choice of methods</u>:</p> <ul style="list-style-type: none"> ▶ # of contraceptive methods available in each clinic ¹ <p>b. Indicators related to <u>information given to client</u>:</p> <ul style="list-style-type: none"> ▶ % of counseling sessions with new acceptors in which provider gives accurate, unbiased overview of all methods ▶ % of counselors giving accurate, relevant information on methods accepted (i.e. how to use, advantages and disadvantages, primary and secondary precautions, complications requiring follow-up, resupply) <p>c. Indicators related to <u>technical competence</u>:</p> <ul style="list-style-type: none"> ▶ % of medical and paramedical personnel demonstrating skill at providing clinical procedures according to guidelines ▶ rate of complications <p>d. Indicators related to <u>Quality Assurance (QA)</u> norms and specifications (to be established):</p> <ul style="list-style-type: none"> ▶ # of problems identified for which a solution was promptly found <p>e. Indicators related to <u>interpersonal relations</u>:</p> <ul style="list-style-type: none"> ▶ % of clients reporting sufficient time with provider ▶ % of clients who reported: <ul style="list-style-type: none"> - feeling at ease asking questions - treated with respect/politeness by providers 	<p>a: ASHONPLAFA statistics</p> <p>b-c: Special Quality of Services study done by ASHONPLAFA (1996 & 1999) and ASHONPLAFA statistics</p> <p>d: ASHONPLAFA QA records</p> <p>e: Yearly exit interviews conducted by ASHONPLAFA at each region</p>
<p>1.2 Increased Access to MCP Services Medical clinical services will be more accessible in terms of distance and cost, particularly in rural areas.</p> <p>a. % of women of reproductive age (WRA) who must travel two hours or more to reach clinical services</p> <p>b. % of WRA who cite cost as a reason for not using contraception</p> <p>c. % of annual family income needed to pay for IUD services in first year (not to exceed 2%)</p> <p>d. % of monthly family income needed to pay for VSC (male/female, not to exceed 2%)</p>	<p>a-b: Population-based survey (1995 & 1999) ²</p> <p>c-d: ASHONPLAFA statistics</p>
<p>1.3 Increased Utilization of MCP Services During the last 4 years of the project, CYPs provided by the CSP increase an average of 7% a year.</p> <p>a. CYPs (by year, region, clinic, method, gender, age, direct ASHONPLAFA service delivery or through affiliated program)</p>	<p>a: ASHONPLAFA statistics</p>

¹ Each clinic will have IUDs, injectables, orals, condoms and teach natural methods.

² This is the National Epidemiology and Family Health Survey (EFHS) or a similar population-based study carried out by ASHONPLAFA and the Ministry of Health.

<p>1.4 Increased Self-Financing of MCP Total level of self-sufficiency of Medical Clinical Program exceeds 50%. a. % of costs recovered (by clinic)</p>	a. ASHONPLAFA data.
Result II: Accessible, High Quality Self-Financing Social Marketing Program	
<p>2.1 Increased Self-Financing of SMP SMP 110% self-sufficient and USAID provision of commodities for SMP ceases. a. % of total costs, including costs of contraceptives, recovered</p>	a. ASHONPLAFA cost accounting records
<p>2.2 Increased Access to SMP Products in the Commercial Market SMP products accessible to low and middle income in 95% of pharmacies, 75% of supermarkets and 20% of pulperías. a. One cycle of the lowest priced pill will cost not less than 1.5% and not more than 2% of the monthly minimum wage b. % of pharmacies in which Social Marketing Program (SMP) orals are sold c. % of pharmacies, supermarkets, and "pulperías" in which SMP condoms and orals are sold</p>	a: ASHONPLAFA statistics b-c: Special market study (1996 & 1999).
<p>2.3 Improved Quality of SMP Women and men are more knowledgeable about and satisfied with the SMP contraceptive they have purchased: its correct use, contraindications, and its use in preventing STDs/HIV/AIDS. a. % of women buying SMP orals who know how to use them correctly b. % of women buying SMP orals who know the indications and contraindications c. % of women buying SMP orals who know about the use of condoms to prevent STDs/HIV/AIDS. d. % of men buying SMP condoms who know the importance of using them for protection against STDs/HIV/AIDS (as well as for family planning) e. % of men buying SMP condoms who know how to use them correctly f. % of salespeople who give mystery clients full and accurate information g. % of persons (women, men, adolescents) buying SMP contraceptives who express satisfaction with SMP product and service received while buying it</p>	a-e: Special quality of services study (1996 & 1999) done by ASHONPLAFA f: Mystery client study g: Exit interviews at pharmacies
<p>2.4 Increased Utilization of SMP On average, sales will have increased at least 4% per year.</p>	ASHONPLAFA statistics.
Result III: Focused, High Quality Community Services Program (CSP)	
<p>3.1 More Focused Access to CSP in Peri-Urban and Rural Areas CSP more accessible in terms of distance and cost in rural and peri-urban areas. a. <i>Cost:</i> % of minimum wage needed to pay for one cycle of oral contraceptives and condoms, per region (not to exceed 1%) b. <i>Distance:</i> # of CSP rural posts established within target areas that: ▶ have no more than 2,000 inhabitants ▶ are at least 20 kilometers away from an urban setting ▶ have no CSP posts or pharmacies already serving population c. <i>Distance:</i> # of CSP posts established in peri-urban areas which are no less than two kilometers from a pharmacy or other CSP post.</p>	a: ASHONPLAFA statistics b-c: ASHONPLAFA statistics

<p>3.2 Improved Quality of CSP Services³ "Consejeras" offering higher quality services to CSP clients</p> <ul style="list-style-type: none"> a. Variety of method six "consejera" offers to clients and potential clients (this would include, Billings, IUD and VSC referrals) b. % of counseling sessions with new acceptors in which consejera gives accurate, unbiased overview of all methods c. % of consejeras giving accurate, relevant information on method accepted (i.e. how to use, advantages and disadvantages, primary and secondary precautions, complications requiring follow-up, resupply) d. % of CBD clients who express satisfaction with service e. % of CBD posts which have in stock all temporary methods 	<ul style="list-style-type: none"> a. Quality of Services study (1996 & 1999) and Consejera's Records b-d. Quality of Services and Customer Satisfaction study (1997 & 2000) e. Periodic site visits and reviews of contraceptive stocks.
<p>3.3 Increased Utilization of CSP Services in Periurban and Rural Areas Utilization of CBD services will increase by 6% annually in rural areas and by 5% annually in urban and peri-urban areas during the last four years of the project.</p> <ul style="list-style-type: none"> a. Number of CYPs in peri-urban areas and urban areas and # of CYPs in rural areas (by region and method) b. Number of confirmed references made by "consejeras" for surgical methods and other ASHONPLAFA reproductive health services⁴ 	<p>a-b: ASHONPLAFA statistics</p>
<p>3.4 Increased Self-Financing of Community Services Program The CSP will be at least 70% self-sufficient, and urban and periurban posts will generate an annual average of 50 CYPs.</p> <ul style="list-style-type: none"> a. % costs recovered b. CYP/post ratio (disaggregated by urban, peri-urban and rural) 	<p>a-b: ASHONPLAFA statistics and cost-accounting records</p>

³ ASHONPLAFA will set targets for indicators 3.2 a-e upon completion of its baseline study (at the end of year two).

⁴ ASHONPLAFA will set targets upon completion of its OR study which will test alternative "consejera" incentives program (at the end of year three).

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Result IV: Effective Information, Education and Communications (IEC)	Means of Verification
<p>4.1 Increased Access⁵ Women, men, and adolescents well-informed about reproductive health:</p> <p>Indicators related to <u>all target groups</u> (WRA, men, adolescents):</p> <p>a. % of target population exposed to family planning messages b. % of target population which correctly understands family planning messages c. % of target population that knows why, how and when to use temporary and permanent methods d. % of target population which knows reproductive risk factors e. % of target population which knows how to prevent STDs/HIV infection f. % of target population that knows the hours, location, and variety of services provided at ASHONPLAFA</p> <p>Indicator related to <u>WRA</u>:</p> <p>g. % of target population (WRA) which knows why, how, how frequently and when to begin and continue getting pap tests</p> <p>Indicators related to <u>adolescents</u>:</p> <p>h. % of adolescents who know how to avoid an undesired pregnancy i. % of adolescents who know how to use at least two contraceptive methods j. % of adolescents who know why to postpone sexual involvement</p> <p>Indicators related to <u>men</u>:</p> <p>k. % of target population which knows male methods l. % of target population which knows the benefits of a vasectomy and knows where to get procedure done m. % of target population which knows the benefits of condom use</p>	<p>a-m: Knowledge, Attitudes and Practices (KAP) Population-based study (1996 & 1999)</p>
<p>4.2 Better Image⁶ Women, men, and adolescents have an improved image of family planning and ASHONPLAFA.</p> <p>a. % of target population (WRA, men, adolescents) which supports family planning b. % of target population which has a favorable opinion of ASHONPLAFA</p>	<p>a-b: KAP Population-based study (1996 & 1999)</p>

⁵ ASHONPLAFA will set targets for IEC indicators upon completion of the KAP baseline survey (at the end of year one).

⁶ ASHONPLAFA will set targets for indicators on image upon completion of the KAP baseline survey (at the end of year one).

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Result V: Effective Support Systems at Headquarters and the Regions	Means of Verification
<p>5.1 Effective Management Systems</p> <p>a) Indicators related to <u>improved human resource management</u>: ASHONPLAFA personnel motivated and capable of achieving institutional goals; ASHONPLAFA appropriately and sustainably staffed to achieve planned results.</p> <p>i. Programs and departments appropriately staffed to achieve planned results.</p> <p>ii. ASHONPLAFA responsible for 60% of the salary and benefits line items.</p> <p>iii. Competitive, motivating, and sustainable compensation (including incentives).</p>	<p>i: ASHONPLAFA's staffing assessment, personnel records.</p> <p>ii. Review of ASHONPLAFA budget's Strategic Plan and yearly workplans</p> <p>iii: ASHONPLAFA's personnel records and market study.</p>
<p>b) Indicators related to <u>effective management information systems (MIS)</u>: The MIS presents accurate and relevant information on finance, service utilization, and quality, and this data is used for decision making.</p> <p>i. % of regional offices which routinely have timely and accurate data on all administration and service statistics essential to managing their programs.</p> <p>ii. % of regional offices with cost accounting systems presenting monthly data on income and expenditures, and levels of financial self-sufficiency (by service delivery programs, clinics, labs, and other activities in the region)</p> <p>iii. At headquarters, MIS producing consolidated and disaggregated data on all finance, administration and service statistics by service delivery programs, clinics, labs, and other activities.</p> <p>iv. A new Strategic Plan (2000-2005) developed outlining results and strategies for ASHONPLAFA's continued growth in sustainability and impact.</p>	<p>i-iii: ASHONPLAFA's statistical and financial reports.</p> <p>iv. Review of Strategic Plan.</p>
<p>c) Indicators related to improved <u>financial management</u>: ASHONPLAFA has effective cost accounting system in place and is 63% self-sufficient.</p> <p>i. Cost accounting system includes all income generated and direct expenses incurred plus administrative costs.</p> <p>ii. ASHONPLAFA funding 63% of operating costs with its own revenues.</p>	<p>i-ii: Cost accounting records and financial reports.</p>
<p>d) Indicators related to <u>improved logistics</u>: ASHONPLAFA will provide adequate quantities of high quality contraceptives to the right service delivery points, in a timely manner.</p> <p>i. % of storage capacity (at each region and central warehouse) meeting acceptable standards.</p> <p>ii. 80% of warehouses and distribution points at regions and clinic levels, plus 60% at community level, have 80% of commodities within minimum stocking level throughout the year.</p>	<p>i-ii: ASHONPLAFA statistics; surprise site visits.</p>

<p>5.2 Effective Research, Evaluation and Statistics Systems</p> <p>a. Indicators related to <u>statistics</u>: ASHONPLAFA enjoys complete service and programmatic statistics system that is timely, accurate, standardized, provides comparative analysis and is widely used.</p> <p>i. Production and circulation of consistent, timely, relevant and accurate institutional statistics at the regional and central level.</p>	<p>i: Review of statistical bulletins and reports and interviews with staff.</p>
<p>b. Indicators related to <u>research and evaluation</u>: ASHONPLAFA uses timely and accurate research and evaluation results for decision making and for program modification.</p> <p>i. Evaluation unit completes quality and client satisfaction baseline studies for MCP and SMP.</p> <p>ii. Evaluation unit completes national baseline KAP survey.</p> <p>iii. Department and program managers and regional directors cognizant of the principal conclusions and recommendations of evaluations.</p> <p>iv. By EOY 4, Evaluation Unit completes EFHS survey.</p> <p>v. By early year 5, Evaluation Unit completes KAP impact survey.</p>	<p>i-iv: Receipt of copies of surveys and evaluation; interviews with ASHONPLAFA and USAID officials.</p>
<p>Result VI: Increased PYO Participation⁷</p>	

⁷ USAID will set indicators for Result VI upon the Mission's receipt of specific grant proposals.

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
I. IMPROVED MEDICAL CLINICAL SERVICE DELIVERY					
1.1 Improved Quality of MCP Services	<p>A Quality Assurance (QA) system established and operating in all MCP clinics.</p> <p>Baseline Quality of Services and Customer Satisfaction studies completed.</p>	<p>QA system established in any new service before such a service is initiated.</p> <p>Exit interviews indicate that 95% of family planning users are satisfied with services received.</p>	<p>Exit interviews indicate 98% of users are satisfied with services (family planning or other) received.</p> <p>Mid-term evaluation indicates that ASHONPLAFA provides safe, effective and high quality services as defined by Intermediate Result Indicators.</p>	<p>Exit interviews indicate that 98% of the users of all services are satisfied with services received.</p> <p>Endline Quality of Services and Customer Satisfaction studies completed.</p>	<p>Final evaluation indicates that MCP is providing safe, effective and high quality services.</p>
1.2 Increased Access to MCP Services	<p>Pricing strategy completed and implemented by end of CY. Strategy must ensure that cost not be a barrier to access, but that prices approximately cover costs.</p>	<p>Rural brigades completed in rural areas of Santa Rosa.</p> <p>Men's services offered in at least two regions other than TGA and SPS.</p> <p>Satellite clinics opened in small cities.</p>	<p>Specialized counseling for adolescents made available in all clinics.</p>		<p>Medical clinical services will be more accessible in terms of distance and cost, particularly in rural areas.</p>
1.3 Increased Utilization of MCP Services	<p>Total CYPs provided by MCP increase 5% over 1995.</p>	<p>Total CYPs provided by MCP increase by 7% over 1996 and by 10% over 1996 in Regions 5 and 6.</p> <p>New users of non-family planning services increase by 10%</p> <p>Male VSC increased by 200%.</p>	<p>Total CYPs provided by MCP increase by 7% over 1997 and by 10% over 1997 in Regions 5 and 6.</p> <p>New users of non-family planning services increase by 10%</p> <p>Male VSC increased by 25%.</p>	<p>Total CYPs provided by MCP increase by 7% over 1998 and by 10% over 1998 in Regions 5 and 6.</p> <p>New users of non-family planning services increase by 10%</p> <p>Male VSC increased 25%.</p>	<p>During the last 4 years of the project, Couple Years of Protection provided by the Community Services Program increase an average of 7% a year.</p>

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
1.4 Increased Self-Financing of MCP	<p>Pricing policy initiated in 1995 maintained throughout Year 1 to keep up with inflation.</p> <p>All clinics will generate at least 85% of their projected income for the year, or be subject to a change in hours of operation, reduction in budget, or transfer of operations to another organization.</p> <p>Based on marketing studies, 1 to 3 laboratories will be opened with contracted personnel and with an incentive plan.</p>	<p>Pricing policy maintained throughout Year 2 to keep up with inflation.</p> <p>All clinics will generate at least 85% of their projected income for the year, or be subject to a change in hours of operation, reduction in budget, or transfer of operations to another organization.</p> <p>By mid-year 2, reduce hours, stop payments to, or close those clinics not operating with at least at 25% self-sufficiency.</p> <p>Family Clinics opened in at least two regions.</p> <p>2 clinics initiated in existing facilities using contracted personnel with incentive plans.</p>	<p>Pricing policy maintained throughout Year 3 to keep up with inflation.</p> <p>All clinics will generate at least 85% of their projected income for the year, or be subject to a change in hours of operation, reduction in budget, or transfer of operations to another organization.</p> <p>Continue to reduce hours, stop payments to, or close those clinics not operating with at least 25% self-sufficiency.</p> <p>2 diversification programs implemented.</p>	<p>Pricing policy maintained throughout Year 4 to keep up with inflation.</p> <p>All clinics will generate at least 85% of their projected income for the year, or be subject to a change in hours of operation, reduction in budget, or transfer of operations to another organization.</p> <p>Continue to reduce hours, stop payments to, or close those clinics not operating with at least 25% self-sufficiency.</p> <p>2 diversification programs implemented.</p>	<p>Total level of self-sufficiency of Medical Clinical Program exceeds 50% by end of project.</p>

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**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
II. ACCESSIBLE, HIGH QUALITY, SELF-FINANCING SOCIAL MARKETING PROGRAM					
2.1 Increased Self-Financing of SMP	<p>Program is 110% self-sufficient.</p> <p>Pricing policy initiated in 1995 maintained throughout Year 1 to at least keep up with inflation.</p> <p>SMP generating at least 85% of its projected income for year.</p> <p>SMP develops 5-year plan and implementation plan for Year One by 3/96.</p> <p>SMP launches Duo-Fem and relaunches Protector by 4/96.</p>	<p>Program is 110% self-sufficient.</p> <p>Pricing policy maintained throughout Year 2 to at least keep up with inflation.</p> <p>SMP generating at least 85% of its projected income for year.</p>	<p>Program is 110% self-sufficient.</p> <p>Pricing policy maintained throughout Year 3 to at least keep up with inflation.</p> <p>SMP generating at least 85% of its projected income for year.</p> <p>Two new SMP products – oral and condom (commodities purchased by ASHONPLAFA) launched.</p>	<p>Program is 110% self-sufficient and volume of commodities provided by USAID reduced by 50%.</p> <p>Pricing policy maintained throughout Year 4 to at least keep up with inflation.</p> <p>SMP generating at least 85% of its projected income for year.</p> <p>One more oral SMP product (commodities purchased by ASHONPLAFA) launched.</p>	<p>Social Marketing Program is 110% self-sufficient and USAID provision of commodities for SMP ceases at end of year.</p>

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**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
2.2 Increased Access to SMP Products	SMP products accessible to low and middle income clients in 95% of pharmacies. . Pricing strategy developed by end of CY 1995 and implemented early in CY 1996.	SMP products accessible to low and middle income clients in 95% of pharmacies. Assessment of potential distributors other than MANDOFER.	SMP products accessible to low and middle income clients in 95% of pharmacies and some supermarkets and pulperías. Contracts signed with additional distributors.	SMP products accessible to low and middle income clients in 95% of pharmacies and some supermarkets and pulperías.	SMP products accessible to low and middle income clients in 95% of pharmacies, 75% of supermarkets and 20% of pulperías.
2.3 Improved Quality of SMP	Baseline Quality and Customer Satisfaction studies completed, and yearly targets set.	Increased % of women and men knowledgeable about the contraceptive purchased (targets to be set when baseline data have been analyzed.) Increased customer satisfaction (male and female) with product and purchase of product (targets to be established when data has been analyzed).	Increased % of women and men knowledgeable about the contraceptive purchased. Increased customer satisfaction (male and female) with product and purchase of product in pharmacy/super market etc.	Increased % of women and men knowledgeable about the contraceptive purchased. Increased customer satisfaction (male and female) with product and purchase of product in pharmacy/supermarket etc. Endline Quality of Services and Customer Satisfaction studies conducted.	Women and men are more knowledgeable about and satisfied with the SMP contraceptive they have purchased: its correct use, contraindications, and its use in preventing STDs/HIV/AIDS.
2.4 Increased Utilization of SMP Services	Sales will not increase over 1995 levels due to phase-out of Noriday and phase-in of Duo-Fem (1995 CYP total expected to be about 21,150).	Volume of sales likely to continue to be flat for orals. Sales of Protector increased by 300% over Year 1 level.	Volume of sales increased due to increased distribution (levels to be determined).	Volume of sales increased by a to-be-determined percentage over the 1995 level.	On average, sales will have increased at least 4% per year.

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PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
III: FOCUSED, HIGH QUALITY COMMUNITY SERVICES PROGRAM (CSP)					
3.1 More Focused Access to CSP in Peri-Urban and Rural Areas		<p>Pricing policy maintains costs of one cycle of oral contraceptives and condoms at not more than 1% of minimum wage per region.</p> <p>Recruitment and training of 20 consejeras and subsequent opening of CSP posts in rural and un/underserved areas of Ocotepeque, Santa Barbara, Lempira, Copán, Santa Rosa, La Paz and Olancho.</p> <p>Recruitment and training of 10 consejeras and subsequent opening of CSP posts in periurban areas where pharmacies are not accessible.</p>	<p>Pricing policy maintains costs of one cycle of oral contraceptives and condoms at not more than 1% of minimum wage per region.</p> <p>Recruitment and training of 20 consejeras and subsequent opening of CSP posts in rural and un/underserved areas of Ocotepeque, Lempira, Copán, Santa Rosa, La Paz, Santa Barbara and Olancho.</p> <p>Recruitment and training of 10 consejeras and subsequent opening of CSP posts in periurban areas where pharmacies are not accessible.</p>	<p>Pricing policy maintains costs of one cycle of oral contraceptives and condoms at not more than 1% of minimum wage per region.</p> <p>Recruitment and training of 20 consejeras and subsequent opening of CSP posts in rural and un/underserved areas of Ocotepeque, Lempira, Copán, Santa Rosa, La Paz, Santa Barbara and Olancho.</p> <p>Recruitment and training of 10 consejeras and subsequent opening of CSP posts in periurban areas where pharmacies are not accessible.</p>	Community Services Program will be more accessible in terms of distance and cost in rural and peri-urban areas.

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**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
3.2 Improved Quality of CSP Services		<p>Completion of baseline Quality of Care and Client Satisfaction studies. EOP targets set.</p> <p>Recommendations from the needs assessment of the CSP implemented in all six regions.</p> <p>Re-structured consejera training program in place.</p>	<p>Incentives/referrals plan for consejeras nationwide will be in place.</p> <p>Increased percentage of CBD posts stocking all CBD temporary methods.</p>	<p>Incentive/referral plan results in an increase in consejera referrals to the Medical Clinical Program for clinical methods and reproductive health services.</p> <p>Variety of method mix offered by consejeras expands.</p> <p>Increased percentage of CBD posts stocking all CBD temporary methods.</p> <p>Completion of impact evaluation surveys on quality of care and client satisfaction</p>	<p>"Consejeras" will offer higher quality services to CSP clients in terms (1) greater method mix, (2) complete and unbiased overview of all methods, (3) complete information on chosen contraceptive, and (4) client satisfaction.</p>
3.3 Increased Utilization of CSP Services in Periurban and Rural Areas		<p>Total CYP increased by 6% in rural areas, and by 8% in rural areas of Regions 5 and 6.</p> <p>Total CYPs increased by 5% in periurban and urban areas, and by 8% in Regions 5 and 6.</p>	<p>Total CYP increased by 6% in rural areas and by 8% in rural areas of Regions 5 and 6.</p> <p>Total CYPs increased by 5% in periurban and urban areas and by 8% in Regions 5 and 6.</p>	<p>Total CYPs increased by 5% in periurban and urban areas and by 8% in Regions 5 and 6.</p>	<p>Utilization of CBD services will increase by 6% annually in rural areas and by 5% annually in urban and peri-urban areas during the last four years of the project.</p>

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
3.4 Increased Self-Financing of Community Services Program	<p>CSP generates at least 85% of its projected annual income.</p> <p>Policy of maintaining constant real prices of CSP contraceptives initiated in 1995 and maintained throughout Year 1.</p> <p>Posts in urban, periurban and rural areas with low CYP productivity levels closed.</p>	<p>CSP generates at least 85% of its projected annual income.</p> <p>Real prices of CSP contraceptives maintained.</p> <p>Posts in urban, periurban and rural areas with low CYP productivity will be closed.</p>	<p>CSP generates at least 85% of its projected annual income.</p> <p>Real prices of CSP contraceptives maintained.</p> <p>Posts in urban, periurban and rural areas with low CYP productivity will be closed.</p>	<p>CSP generates at least 85% of its projected annual income.</p> <p>Real prices of CSP contraceptives maintained.</p> <p>Posts in urban, periurban and rural areas with low CYP productivity will be closed.</p>	<p>The CSP will be at least 70% self-sufficient, and urban and periurban posts will generate an annual average of 50 CYPs.</p>
IV: EFFECTIVE INFORMATION, EDUCATION AND COMMUNICATION (IEC)					
4.1 Increased Access to Information on Reproductive Health Services	<p>One national baseline KAP survey will be completed. End-of-project results will be established upon completion of baseline KAP survey and availability of data.</p> <p>Strong, timely promotional campaign for SMP launch of Duo-Fem & relaunch of Protector.</p>	<p>One national <u>reproductive health</u> campaign (with male component) completed.</p>	<p>One national <u>men's</u> campaign completed.</p>	<p>One national <u>adolescent</u> reproductive health campaign completed.</p> <p>Completion of national KAP impact survey.</p>	<p>Women, men, and adolescents well informed on family planning, cytology, STDs/HIV prevention, reproductive risk, contraceptive technology, the advantages of postponing initiation of sexual relations, and ASHONPLAFA services.</p>
4.2 Better Image of Family Planning	See above: 4.1	See above: 4.1	See above: 4.1	See above: 4.1	<p>Women, men, and adolescents have an improved image of family planning and ASHONPLAFA.</p>

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**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
V: EFFECTIVE SUPPORT SYSTEMS AT HEADQUARTERS AND REGIONS					
<i>5.1 Effective Management Systems</i>					
5.1.a Improved Human Resources Management (HRM)	<p>HRM begins to "right-size" and develop performance-based incentives and training programs.</p> <p>ASHONPLAFA assumes responsibility for 50% of the salary and benefits line items.</p> <p>Written semi-annual review/evaluation process of all personnel implemented. All annual salary increases will be directly related to these workplans.</p>	<p>HRM plan ("right-sizing," performance-based training and performance-based incentive plan) completely implemented by EOY 2.</p> <p>By EOY 2, two of the agreed-upon incentive plans for clinics and incentive plans for social marketing, administration and community services will be initiated.</p> <p>ASHONPLAFA assumes responsibility for 52% of the salary and benefits line items.</p>	<p>At least 70% of clinics will be on one of the agreed-upon incentive plans. This will remain true throughout remainder of the project.</p> <p>ASHONPLAFA assumes responsibility for 54% of the salary and benefits line items.</p>	<p>ASHONPLAFA assumes responsibility for 56% of the salary and benefits line items.</p>	<p>ASHONPLAFA personnel motivated and capable of achieving institutional goals; ASHONPLAFA appropriately and sustainably staffed to achieve planned results.</p>

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
5.1.b Effective Management Information System (MIS)	In each regional office and in Headquarters, a computerized MIS, including SAC, SIES, SCI and cost accounting is functioning smoothly, integrating, consolidating and presenting accurate and reliable monthly service and financial data to relevant users.	MIS will continue to present timely, accurate, reliable and relevant data to ASHONPLAFA relevant users. The MIS incorporates Quality Assurance standards, procedures and techniques for the MCP and CSP.	Consistent, accurate, timely data available from each program in each region on self-sufficiency, access, quality, and progress achieving the results of this project.		The MIS presents accurate and relevant information on finance, service utilization, and quality, and this data is used for decision making.
5.1.c Improved Financial Management	In first month of 1996, finance department implements cost center accounting at clinic and program levels and ensures that a monthly budget variance analysis is produced. ASHONPLAFA 45% self-sufficient by EOY 1996.	Finance department continues to send out individual programs and clinics monthly budget variance reports and comparative reports. ASHONPLAFA 48% self-sufficient by EOY 1997.	Finance department continues to send out to individual programs and clinics monthly budget variance reports and comparative reports. ASHONPLAFA 52% self-sufficient by EOY 1998.	Finance department continues to send out to individual programs and clinics monthly budget variance reports and comparative reports. ASHONPLAFA 57% self-sufficient by EOY 1999.	ASHONPLAFA has effective cost accounting system in place and is 63% self-sufficient.
5.1.e Improved Logistics	100% of all clinics and programs (except CSP) have established minimum and maximum levels by EOY 1. An inventory control software implemented at all regional centers by EOY 1.	At least 80% of all warehouse and distribution points at the regional and clinical levels will have 80% of commodities at minimum stocking levels throughout the year.	By EOY 3, 80% of warehouses and distribution points at regions and clinic levels, plus 50% at community levels (CSP) will have 80% of commodities within minimum stocking level throughout the year.	By EOY 4, 80% of warehouses and distribution points at regions and clinic levels, plus 55% at community levels (CSP) will have 80% of commodities within minimum stocking level throughout the year.	ASHONPLAFA will provide adequate quantities of high quality contraceptives to the right service delivery points, in a timely manner.

**PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS**

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RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
5.2 Effective Research, Evaluation and Statistics Systems					
5.2.a Statistics	Statistics department has functional information and statistics system in place at central office and in all regions.	Statistics department has incorporated programmatic statistics into database. Statistics department producing bulletins on a quarterly, semi-annual and annual basis.	All performance reviews include an appropriate statistical component. All facility and programmatic monitoring includes an appropriate statistical component.		ASHONPLAFA enjoys complete service and programmatic statistics system that is timely, accurate, standardized, provides comparative analysis and is widely used.
5.2.b Effective Research and Evaluation Systems	Research unit completes 4-to-6 special purpose studies, and contracts out 2-to-4 special purpose studies. Evaluation unit completes quality and client satisfaction baseline studies for MCP and SMP. Evaluation unit completes national baseline KAP survey.	Research department completes 4-to-6 special purpose studies, and contracts out 2-to-4 special purpose studies and one operations research (OR) study. Evaluation unit completes quality and client satisfaction CSP baseline study.	Research department completes 4-to-6 special purpose studies, and contracts out 2-to-4 special purpose studies and one OR study. By Mid-Term evaluation, ASHONPLAFA will increasingly use evaluation and research results as a decision making tool in program modification.	Research department completes 4-to-6 special purpose studies, and contracts out 2-to-4 special purpose studies and one OR study. By EOY 4, Evaluation Unit completes EFHS survey. Completion of the SMP, MCP, and CSP endline studies. Completion of KAP impact survey.	ASHONPLAFA uses timely and accurate research and evaluation results for decision making and for program modification.

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PRIVATE SECTOR POPULATION III PROJECT (522-0389)
INTERMEDIATE RESULTS BENCHMARKS

RESULTS	YEAR 1 (CY 1996)	YEAR 2 (CY 1997)	YEAR 3 (CY 1998)	YEAR 4 (CY 1999)	YEAR 5 (CY 2000)
<i>cont.</i> 5.2.b Effective Research and Evaluation Systems	By EOY 1, Evaluation unit publishes and circulates the 1995 EFHS Family Planning/Demographics Report. ASHONPLAFA technical committee, and USAID will review and discuss all evaluation and research results and make programming accordingly.				
VI: Increased PVO Participation ¹					

¹ USAID/Honduras will set benchmarks for result VI upon the Mission's receipt of specific grant proposals.

ANNEX 3

PRIVATE SECTOR POPULATION III PROJECT (No. 522-0389)

FINANCIAL PLAN

FINANCIAL TABLES:

- TABLE A: FINANCIAL PLAN SUMMARY
- TABLE B: PLANNED OBLIGATION INSTRUMENTS
- TABLE C: ESTIMATED USAID LIFE OF PROJECT (LOP) OBLIGATIONS BY FISCAL YEAR
- TABLE D: ILLUSTRATIVE LOP BUDGET OF USAID EXPENDITURES BY CALENDAR YEAR
- TABLE E: ILLUSTRATIVE LOP BUDGET OF ASHONPLAFA'S COUNTERPART EXPENDITURES BY CALENDAR YEAR
- TABLE F: ILLUSTRATIVE LOP BUDGET OF PVO EXPENDITURES BY CALENDAR YEAR (USAID FUNDS)
- TABLE G: LOP BUDGET OF USAID/W TECHNICAL ASSISTANCE (GLOBAL SUPPORT)
- TABLE H: LOP BUDGET OF ESTIMATED TRAINING AND LOCAL TECHNICAL ASSISTANCE EXPENDITURES BY CALENDAR YEAR (USAID FUNDS)
- TABLE I: ANALYSIS OF ASHONPLAFA'S RECURRENT COSTS
- TABLE J: DETAILED FIRST YEAR (CY96) EXPENDITURES BUDGET (USAID AND ASHONPLAFA COUNTERPART FUNDS)
- TABLE K: ILLUSTRATIVE DETAILED BUDGETS OF ASHONPLAFA EXPENDITURES (USAID FUNDS) BY CALENDAR YEAR:
- TABLE K1: MEDICAL CLINICAL; COMMUNITY SERVICES; SOCIAL MARKETING; AND PLANNING, EVALUATION AND INVESTIGATION
- TABLE K2: TRAINING; COMMUNICATION; AND ADMINISTRATION
- TABLE L: ILLUSTRATIVE DETAILED BUDGETS OF ASHONPLAFA EXPENDITURES (ASHONPLAFA COUNTERPART FUNDS) BY CALENDAR YEAR:
- TABLE L1: MEDICAL CLINICAL
- TABLE L2: COMMUNITY SERVICES
- TABLE L3: SOCIAL MARKETING
- TABLE L4: PLANNING, EVALUATION AND INVESTIGATION; AND TRAINING
- TABLE L5: COMMUNICATION
- TABLE L6: ADMINISTRATION

ANNEX 3

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389 FINANCIAL PLAN

The total life of project (LOP) funding is \$14,920,000 in USAID funds and \$13,369,700 in ASHONPLAFA counterpart funds, for a total cost of \$28,289,700. Of the \$14,920,000 USAID contribution, \$11,254,000 will be funded with Mission appropriated funds and \$3,666,000 with USAID/W Global Support funds. Of the \$11,254,000, the Mission expects to make OYB transfers totalling \$902,000 for Global Support technical assistance (TA).

These financial estimates are considered reasonable. ASHONPLAFA's commitment to provide the required counterpart funds will be included in its Program Proposal to be submitted to the Mission.

The planned methods of financing project inputs include direct disbursements to ASHONPLAFA under a Handbook 13 Cooperative Agreement; direct disbursements to other to-be-selected PVOs through Handbook 13 Grant Agreements; direct disbursements made by USAID/Honduras through individual obligation instruments for the procurement of technical assistance, training, evaluation and audit services, and hiring of Mission Personal Services Contractors (PSC); and direct provision of technical assistance and contraceptives through USAID/W Global support.

ASHONPLAFA has received regular financial audits without significant findings. The Mission's O/Controller/FARS will perform financial reviews of the internal control and financial systems of ASHONPLAFA and other to-be-selected PVOs. These reviews will be conducted prior to disbursing USAID funds to each PVO.

The following exchange rates were used to convert Lempiras costs to US dollars in this Financial Plan:

	1996	1997	1998	1999	2000
Lempiras equivalent to US\$1.00	L.10.5	L.11.5	L.12.5	L.13.5	L.14.5

ILLUSTRATIVE SUMMARY COST ESTIMATE (US\$ 000 or equivalent)

Project Activities	USAID/Honduras Funds		Total USAID	Counterpart	Total
	LC	FX	Funds	Funds	
ASHONPLAFA Coop. Agreement	7664.3	408.3	8,072.6	13,369.7	21,442.3
Other PVO Grants	1,540.0	0.0	1,540.0	0.0	1,540.0
Training/Local TA	739.4	902.0 *	1,641.4	0.0	1,641.4
Subtotal	9,943.7	1,310.3	11,254.0	13,369.7	24,623.7
	USAID/Washington Funds				
TA	0.0	1,826.0	1,826.0	0.0	1,826.0
Contraceptives	0.0	1,590.0	1,590.0	0.0	1,590.0
Evaluations	0.0	250.0	250.0	0.0	250.0
Subtotal	0.0	3,666.0	3,666.0	0.0	3,666.0
TOTAL	9,943.7	4,976.3	14,920.0	13,369.7	28,289.7

* Planned OYB transfers for Global Support TA.

PRIVATE SECTOR POPULATION III PROJECT - PLANNED OBLIGATION INSTRUMENTS

A. USAID/HONDURAS OBLIGATIONS:

1.	ASHONPLAFA Coop. Agreement	Total (US\$ 000)
	Medical Clinical	3,042.3
	Community Services	851.8
	Social Marketing	262.9
	Planing, Evaluation & Investigation	611.7
	Training	504.8
	Communication	1,481.5
	Administration	900.4
	Procurement (Equipment)	387.4
	Audits	29.8
	Total	8,072.6
2.	PVO Grant Agreements	
	CARE	350.0
	PLAN EN HONDURAS	350.0
	SAVE THE CHILDREN	350.0
	RENAFE	45.0
	CDJF	235.0
	EQUIPMENT FOR PVOs	80.0
	OTHER PVOs	130.0
	Total	1,540.0
3.	USAID - Various Obligations	
	Mission PSCs	615.8
	Training	46.6
	Other Local TA	77.0
	Total	739.4
	TOTAL USAID/H OBLIGATIONS	10,352.0 *

B. USAID/W OBLIGATIONS:

GLOBAL FIELD SUPPORT	
Contraceptives	
- ASHONPLAFA	1,500
- Other PVOs	90
Subtotal	1,590.0
Technical Assistance	
- Global Support Funds	1,826
- Mission OYB Transfers	902
Subtotal	2,728.0
Evaluation	250.0
TOTAL USAID/W OBLIGATIONS	4,568.0
GRAND TOTAL	14,920.0

* This amount is equivalent to the authorization total of \$11,254,000 less \$902,000 for planned OYB transfers to USAID/W (see B. below).

TABLE C

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ESTIMATED USAID LOP OBLIGATIONS BY FISCAL YEAR
(US \$000)

	FY 95	FY 96	FY97	FY 98	FY99	FY00	TOTAL
MISSION - Projected							
75% Budget Levels	2,261.0	1,623.0	942.0	1,784.0	1,856.0	1,886.0	10,352.0
OYB Transfers	250.0	425.0	177.0	20.0	30.0	0.0	902.0
TOTAL	2,511.0	2,048.0	1,119.0	1,804.0	1,886.0	1,886.0	11,254.0
GLOBAL	599.0	538.0	843.0	843.0	843.0	0.0	3,666.0
GRAND TOTAL	3,110.0	2,586.0	1,962.0	2,647.0	2,729.0	1,886.0	14,920.0

TABLE D

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE LOP BUDGET OF USAID EXPENDITURES
BY CALENDAR YEAR
(US \$000 or equivalent)

PROJECT ACTIVITIES	CY 96		CY 97		CY 98		CY 99		CY 00		TOTAL		GRAND	
	LC	FX	TOTAL											
ASHONPLAFA Cooperative Agreement														
Medical Clinical	533.3	0.0	566.0	0.0	618.6	0.0	641.1	0.0	683.3	0.0	3,042.3	0.0	3,042.3	
Community Services	132.9	0.0	148.3	0.0	173.8	0.0	190.2	0.0	206.6	0.0	851.8	0.0	851.8	
Social Marketing	87.1	0.0	68.1	0.0	52.6	0.0	34.4	0.0	20.7	0.0	262.9	0.0	262.9	
Planing, Evaluation & Invest.	192.9	0.0	60.0	0.0	62.9	0.0	65.9	0.0	230.0	0.0	611.7	0.0	611.7	
Training	97.7	20.9	121.3	0.0	106.2	0.0	95.7	0.0	63.0	0.0	483.9	20.9	504.8	
Communication	285.2	0.0	282.7	0.0	292.7	0.0	304.5	0.0	316.4	0.0	1,481.5	0.0	1,481.5	
Administration	145.9	0.0	160.6	0.0	176.2	0.0	197.1	0.0	220.6	0.0	900.4	0.0	900.4	
Equipment 1/	0.0	0.0	0.0	90.0	0.0	90.0	0.0	90.0	0.0	117.4	0.0	387.4	387.4	
Audits	5.7	0.0	5.7	0.0	5.6	0.0	5.9	0.0	6.9	0.0	29.8	0.0	29.8	
Subtotal	1,480.7	20.9	1,412.7	90.0	1,488.6	90.0	1,534.8	90.0	1,747.5	117.4	7,664.3	408.3	8,072.6	
PVO Grants														
	220.0	0.0	340.0	0.0	350.0	0.0	350.0	0.0	280.0	0.0	1,540.0	0.0	1,540.0	
Technical Assistance (TA)														
USAID/W TA - ASH & PVOs	0.0	599.0	0.0	673.0	0.0	570.0	0.0	518.0	0.0	368.0	0.0	2,728.0	2,728.0	
Local TA	143.1	0.0	153.1	0.0	153.1	0.0	143.1	0.0	147.0	0.0	739.4	0.0	739.4	
USAID/W Contraceptives - ASH & PVOs														
	0.0	250.0	0.0	290.0	0.0	325.0	0.0	345.0	0.0	380.0	0.0	1,590.0	1,590.0	
Evaluations														
		0.0		0.0		125.0		0.0		125.0	0.0	250.0	250.0	
Total	1,643.8	869.9	1,905.8	1,053.0	1,991.7	1,110.0	2,027.9	953.0	2,174.5	990.4	9,943.7	4,976.3	14,920.0	
Total by CY		2,713.7		2,958.0		3,101.7		2,980.9		3,164.9		14,920.0	14,920.0	

1/ To be procured by USAID/Honduras.

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TABLE E

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE LOP BUDGET OF ASHONPLAFA'S COUNTERPART
EXPENDITURES BY CALENDAR YEAR
(US\$ 000)

PROJECT ACTIVITIES	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
ASHONPLAFA Coop. Agreement						
Medical Clinical	391.0	443.1	533.5	578.7	643.0	2,589.3
Community Services	374.9	358.0	426.6	467.9	503.1	2,130.5
Social Marketing	178.8	168.2	222.7	222.4	272.7	1,064.8
Planning, Evaluation & Investigation	117.2	111.6	136.1	139.8	140.7	645.4
Training	67.1	57.8	60.4	36.6	21.6	243.5
Communication	285.5	301.8	341.5	372.2	413.7	1,714.7
Administration	872.6	1,124.4	1,039.7	969.7	975.1	4,981.5
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Audits	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal	2,287.1	2,564.9	2,760.5	2,787.3	2,969.9	13,369.7
PVO Grants	0.0	0.0	0.0	0.0	0.0	0.0
Technical Assistance (TA)						
USAID/W TA	0.0	0.0	0.0	0.0	0.0	0.0
Local TA	0.0	0.0	0.0	0.0	0.0	0.0
Contraceptives ASH & PVOs	0.0	0.0	0.0	0.0	0.0	0.0
Evaluations	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	2,287.1	2,564.9	2,760.5	2,787.3	2,969.9	13,369.7

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE LOP BUDGET OF PVO EXPENDITURES (USAID FUNDS)
BY CALENDAR YEAR
(US \$000)

PVO	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
PVO Grants						
CARE	50.0	75.0	75.0	75.0	75.0	350.0
PLAN EN HONDURAS	50.0	75.0	75.0	75.0	75.0	350.0
SAVE THE CHILDREN	50.0	75.0	75.0	75.0	75.0	350.0
RENAFE	0.0	15.0	15.0	15.0	0.0	45.0
CDJF	40.0	50.0	50.0	50.0	45.0	235.0
EQUIPMENT FOR PVOs	0.0	20.0	30.0	30.0	0.0	80.0
OTHER PVOs	30.0	30.0	30.0	30.0	10.0	130.0
Subtotal	220.0	340.0	350.0	350.0	280.0	1,540.0
Contraceptives (USAID/W)	0.0	15.0	25.0	20.0	30.0	90.0
TOTAL	220.0	355.0	375.0	370.0	310.0	1,630.0

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
LOP BUDGET OF USAID/W TECHNICAL ASSISTANCE (GLOBAL SUPPORT)
BY CALENDAR YEAR
(US \$000)

TECHNICAL ASSISTANCE (TA) I/	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
AVSC	0.0	40.0	21.0	10.0	0.0	71.0
WESTERN CONSORTIUM	200.0	144.0	144.0	154.0	154.0	796.0
FPLM	45.0	30.0	20.0	0.0	0.0	95.0
FPMD	75.0	65.0	75.0	75.0	60.0	350.0
QA I/II PROJECT	0.0	113.0	40.0	30.0	10.0	193.0
PRIME	0.0	50.0	50.0	34.0	0.0	134.0
SOMARC	125.0	65.0	45.0	35.0	21.0	291.0
PCS	0.0	50.0	75.0	30.0	0.0	155.0
INOPAL	154.0	116.0	100.0	150.0	123.0	643.0
TOTAL	599.0	673.0	570.0	518.0	368.0	2,728.0

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
LOP BUDGET OF ESTIMATED TRAINING AND LOCAL TECHNICAL
ASSISTANCE EXPENDITURES (USAID FUNDS) BY CALENDAR YEAR
(US \$000)

TRAINING AND LOCAL TECHNICAL ASSISTANCE (TA)	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Local TA (PSCs):						
Financial Officer (US)	34.0	35.0	36.0	37.0	38.0	180.0
Population Advisor (FSN)	22.5	22.5	22.5	22.5	22.5	112.5
Population Liaison (FSN)	46.5	46.5	46.5	46.5	46.5	232.5
Administrative Assistant (FSN)	18.2	18.2	18.2	18.2	18.0	90.8
subtotal	121.2	122.2	123.2	124.2	125.0	615.8
Other Local TA	11.0	20.0	19.0	8.0	19.0	77.0
Local/Foreign Training	10.9	10.9	10.9	10.9	3.0	46.6
TOTAL	143.1	153.1	153.1	143.1	147.0	739.4

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ANALYSIS OF ASHONPLAFA'S RECURRENT COSTS

ASHONPLAFA's recurrent costs needed to continue activities beyond the life of the project (LOP) are currently estimated at US\$4.8 million per year. USAID and ASHONPLAFA's projections indicate that after year 2000, ASHONPLAFA will generate resources to cover only US\$3.2 million per year or 65.7% of these costs. Therefore, ASHONPLAFA will need to look for other donor support to cover the remaining 34.3% of its recurrent costs.

ILLUSTRATIVE BUDGET OF ASHONPLAFA'S RECURRENT COSTS
(USAID AND ASHONPLAFA COUNTERPART FUNDS)
(US \$000)

Project Activities	Total LOP Costs	Total CY 2000 Costs	Total Yearly Recurrent Costs
ASHONPLAFA Coop. Agreement			
Medical Clinical	5,631.6	1,326.3	1,141.4
Community Services	2,982.3	709.7	694.2
Social Marketing	1,327.7	293.4	291.8
Planing, Evaluation & Investigation	1,257.1	370.7	368.9
Training	748.3	84.6	79.3
Communication	3,196.2	730.1	687.8
Administration	5,881.9	1,195.7	1,112.6
Equipment	387.4	117.4	0.0
Audits	29.8	6.9	0.0
Contraceptives	1,500.0	350.0	380.0
PVO Grants (including contraceptives)	1,630.0	310.0	0.0
Technical Assistance	3,467.4	515.0	0.0
Evaluations	250.0	125.0	0.0
TOTAL	28,289.7	6,134.8	4,756.0

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
DETAILED FIRST YEAR (CY96) EXPENDITURES BUDGET
(US\$ 000 or equivalent)

PROJECT ACTIVITIES	USAID FUNDS		Total USAID	Counterpart	TOTAL
	LC	FX	Funds	Funds	
ASHONPLAFA Coop. Agreement					
Medical Clinical	533.3	0.0	533.3	391.0	924.3
Community Services	132.9	0.0	132.9	374.9	507.8
Social Marketing	87.1	0.0	87.1	178.8	265.9
Planning, Evaluation & Investigation	192.9	0.0	192.9	117.2	310.1
Training	97.7	20.9	118.6	67.1	185.7
Communication	285.2	0.0	285.2	285.5	570.7
Administration	145.9	0.0	145.9	872.6	1,018.5
Equipment	0.0	0.0	0.0	0.0	0.0
Audits	5.7	0.0	5.7	0.0	5.7
Subtotal	1,480.7	20.9	1,501.6	2,287.1	3,788.7
PVO Grants	220.0	0.0	220.0	0.0	220.0
Technical Assistance (TA)					
USAID/W TA	0.0	599.0	599.0	0.0	599.0
Local TA	143.1	0.0	143.1	0.0	143.1
Contraceptives ASH & PVOs	0.0	250.0	250.0	0.0	250.0
Evaluations	0.0	0.0	0.0	0.0	0.0
TOTAL	1,843.8	869.9	2,713.7	2,287.1	7,714.5

TABLE K1

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGETS OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
USAID FUNDS
(US \$000)

MEDICAL CLINICAL	CY 96	CY97	CY 98	CY 99	CY 00	TOTAL
Salaries	309.5	324.4	350.1	361.1	374.9	1,720.0
Travel & Per Diem	8.6	5.1	3.1	3.2	3.3	23.3
Private Hospitals	100.9	121.7	143.9	154.6	180.0	701.1
Medicines	114.3	114.8	121.5	122.2	125.1	597.9
TOTAL	533.3	566.0	618.6	641.1	683.3	3,042.3

COMMUNITY SERVICES	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	81.3	85.4	90.2	95.6	101.8	454.3
Educational Activities	42.0	51.7	67.7	70.2	71.9	303.5
Printing Forms	9.6	11.2	15.9	24.4	32.9	94.0
TOTAL	132.9	148.3	173.8	190.2	206.6	851.8

SOCIAL MARKETING	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Packing Materials	18.6	15.9	11.2	5.8	6.0	57.5
Advertising & Promotion	68.5	52.2	41.4	28.6	14.7	205.4
TOTAL	87.1	68.1	52.6	34.4	20.7	262.9

PLANING, EVALUATION & INVESTIGATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	40.5	42.6	45.0	47.6	50.7	226.4
Evaluation	152.4	17.4	17.9	18.3	179.3	385.3
TOTAL	192.9	60.0	62.9	65.9	230.0	611.7

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGETS OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
USAID FUNDS
(US \$000)

TRAINING	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	14.2	15.5	17.1	19.0	21.3	87.1
Travel & Per Diem	40.9	40.7	33.8	31.1	7.6	154.1
Equipment	1.9	1.7	1.8	0.6	0.5	6.5
Communication & Mail	0.3	0.3	0.3	0.2	0.2	1.3
Printing Forms	0.2	0.2	0.2	0.1	0.1	0.8
Vehicle Maintenance	0.5	0.5	0.5	0.3	0.2	2.0
Educational Materials	2.9	3.1	3.4	1.9	1.4	12.7
Data Processing	0.8	0.7	0.8	0.5	0.4	3.2
Office Supplies	0.6	0.6	0.7	0.4	0.3	2.6
Transportation	3.2	3.3	2.9	4.0	3.4	16.8
International Training	52.9	54.5	44.3	37.3	27.6	216.6
Miscellaneous	0.2	0.2	0.4	0.3	0.0	1.1
TOTAL	118.6	121.3	106.2	95.7	63.0	504.8

COMMUNICATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	161.2	159.3	168.2	178.4	189.8	856.9
Travel & Per Diem	87.4	86.8	87.9	89.5	91.0	442.6
Promotion and Advertising	36.6	36.6	36.6	36.6	35.6	182.0
Medical Uniforms	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	285.2	282.7	292.7	304.5	316.4	1,481.5

ADMINISTRATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	145.9	160.6	176.2	197.1	220.6	900.4
Reserve for Project Diversification	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	145.9	160.6	176.2	197.1	220.6	900.4

TABLE L1

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGET OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

MEDICAL CLINICAL	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	165.3	210.7	272.9	331.1	398.6	1,378.6
Travel & Per Diem	5.8	9.4	12.2	12.7	13.0	53.1
Equipment	23.9	26.1	40.0	22.2	13.8	126.0
Communication/Mail	9.7	9.8	10.3	10.7	11.0	51.5
Shipping & Postage	0.9	0.9	1.1	1.0	1.0	4.9
Office Rent	3.2	3.2	3.4	3.5	3.6	16.9
Professional Fees	4.1	4.1	4.4	4.5	4.6	21.7
Printing Forms	10.8	10.8	11.5	11.9	12.2	57.2
Cleaning Supplies	1.3	1.3	1.3	1.4	1.4	6.7
Vehicle Maintenance	3.7	3.7	3.9	4.1	4.2	19.6
Building Maintenance	31.8	31.9	33.8	33.5	34.1	165.1
Equipment Repair	7.6	7.7	8.1	8.4	8.6	40.4
Medical Supplies	85.8	86.1	91.1	92.5	94.8	450.3
Data Processing	2.7	2.7	2.9	3.0	3.1	14.4
Office Supplies	5.1	5.2	5.5	5.7	5.8	27.3
Advertising & Promotion	0.6	0.7	0.7	0.7	0.7	3.4
Reception Expenses	4.3	4.4	4.6	4.8	4.9	23.0
Insurance	1.4	1.4	1.4	1.5	1.5	7.2
Custom Services	0.2	0.2	0.3	0.3	0.3	1.3
Utilities/Public Services	13.5	13.6	14.3	14.8	15.3	71.5
Transportation	0.7	0.7	0.7	0.7	0.8	3.6
Medical Uniforms	7.6	7.6	8.1	8.4	8.6	40.3
Miscellaneous	1.0	0.9	1.0	1.3	1.1	5.3
TOTAL	391.0	443.1	533.5	578.7	643.0	2,589.3

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PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGET OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

COMMUNITY SERVICES	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	88.0	100.3	114.8	132.1	152.6	587.8
Travel & Per Diem	77.8	78.1	82.6	85.7	87.7	411.9
Contraceptives	40.1	26.4	55.1	59.8	65.8	247.2
Equipment	11.9	7.7	12.2	9.7	9.8	51.3
Vehicle	57.1	43.5	50.0	57.8	59.2	267.6
Communication/Mail	6.2	6.2	6.6	6.9	7.0	32.9
Shipping & Postage	1.8	1.8	1.9	2.0	2.0	9.5
Office Rent	3.3	3.8	4.3	5.0	5.9	22.3
Supplies	3.9	3.5	3.4	3.2	6.8	20.8
Vehicle Repair	29.1	29.2	30.9	32.8	32.9	154.9
Equipment Repair	0.4	0.3	0.4	0.4	0.4	1.9
Office Supplies	4.9	5.1	8.1	12.5	12.8	43.4
Advertising & Promotion	17.0	17.1	18.1	18.7	19.3	90.2
Reception Expenses	11.0	12.5	14.4	16.7	15.5	70.1
Insurance	10.0	10.1	10.7	11.1	11.7	53.6
Custom Services	1.6	1.6	1.7	1.7	1.8	8.4
Utilities/Public Services	8.6	8.6	9.1	9.4	9.7	45.4
Transportation	0.2	0.2	0.2	0.2	0.2	1.0
Miscellaneous	2.0	2.0	2.1	2.2	2.0	10.3
TOTAL	374.9	358.0	426.6	467.9	503.1	2,130.5

TABLE L3

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGET OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

SOCIAL MARKETING	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	40.9	44.8	49.4	54.9	61.4	251.4
Travel & Per Diem	25.8	25.7	27.1	28.1	28.8	135.5
Educational Activities	2.5	2.9	3.1	3.2	3.3	15.0
Contraceptives	39.0	47.5	45.5	43.8	42.4	218.2
Equipment	2.8	1.0	1.0	1.0	1.1	6.9
Vehicle	28.6	0.0	28.0	0.0	27.6	84.2
Communication/Mail	0.2	0.3	0.3	0.3	0.3	1.4
Shipping & Postage	0.4	0.4	0.4	0.4	0.4	2.0
Office Rent	0.3	0.3	0.4	0.4	0.4	1.8
Supplies	3.1	3.5	3.7	3.8	3.9	18.0
Printing Forms	0.4	0.4	0.5	0.5	0.5	2.3
Vehicle Repair	4.8	5.4	5.8	6.0	6.1	28.1
Equipment Repair	0.3	0.4	0.4	0.4	0.4	1.9
Office Supplies	4.6	10.6	16.8	23.3	23.8	79.1
Advertising & Promotion	1.0	1.0	1.1	1.1	1.2	5.4
Office Supplies	0.8	1.0	1.0	1.0	1.1	4.9
Insurance	7.6	13.0	27.6	42.9	58.6	149.7
Reception	0.2	0.3	0.3	0.4	0.4	1.6
Custom Services	3.0	3.4	3.6	3.7	3.8	17.5
Utilities	0.4	0.4	0.5	0.5	0.5	2.3
Transportations	0.4	0.4	0.4	0.4	0.4	2.0
Investigations	11.4	5.3	5.6	5.8	5.9	34.0
Miscellaneous	0.3	0.2	0.2	0.5	0.4	1.6
TOTAL	178.8	166.2	222.7	222.4	272.7	1,064.8

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGETS OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

PLANING, EVALUATION & INVESTIGATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	43.9	50.0	57.2	65.8	76.1	293.0
Travel & Per Diem	4.8	4.8	5.1	5.2	5.4	25.3
Equipment	13.8	1.0	0.4	0.7	0.8	16.7
Communication & Mail	0.1	0.0	0.1	0.1	0.1	0.4
Office Rent	0.4	0.4	0.5	0.4	0.4	2.1
Professional Fees	24.6	24.7	25.4	25.9	27.6	128.2
Printing Forms	2.1	2.4	2.6	2.9	3.2	13.2
Vehicle Maintenance	3.1	3.8	3.7	3.6	3.6	17.8
Data Processing	1.4	1.5	1.4	1.4	1.3	7.0
Office Supplies	1.1	0.7	0.8	0.9	1.0	4.5
Reception Expenses	1.1	1.2	1.1	1.1	1.1	5.6
Transportation	1.8	1.9	2.1	2.2	2.2	10.1
Investigation	19.0	19.2	35.7	29.6	17.9	121.4
TOTAL	117.2	111.6	136.1	139.8	140.7	645.4

TRAINING	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Professional Fees	40.2	34.8	38.5	27.9	13.8	155.2
Office Rent	15.5	13.4	14.8	3.9	3.4	51.0
Reception Expenses	11.4	9.6	7.1	4.8	4.4	37.3
TOTAL	67.1	57.8	60.4	36.6	21.6	243.5

TABLE L5

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGET OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

COMMUNICATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	164.2	187.0	214.0	246.4	284.7	1,096.3
Equipment	7.3	0.4	6.5	0.5	0.5	15.2
Communication/ Mail	1.1	1.1	1.1	1.2	1.2	5.7
Shipping & Postage	1.5	1.5	1.6	1.6	1.7	7.9
Office Rent	0.3	0.3	0.3	0.3	0.3	1.5
Supplies	0.1	0.1	0.1	0.1	0.1	0.5
Professional Fees	4.8	4.8	5.1	5.2	5.4	25.3
Printing Forms	3.7	3.7	4.0	4.1	4.2	19.7
Vehicle Maintenance	6.0	6.0	6.4	6.6	6.8	31.8
Equipment Repair	0.5	0.5	0.5	0.5	0.5	2.5
Educational Supplies	12.5	12.6	13.3	13.8	14.1	66.3
Data Processing	0.8	0.8	0.8	0.8	0.8	4.0
Office Supplies	7.3	7.3	7.8	8.1	8.3	38.8
Advertising & Promotion	65.6	65.9	69.7	72.4	74.1	347.7
Reception Expenses	5.5	5.5	5.9	6.1	6.2	29.2
Reception with Helper	1.0	1.0	1.0	1.0	1.1	5.1
Custom Services	0.3	0.3	0.3	0.3	0.3	1.5
Transportation	1.7	1.7	1.8	1.9	1.9	9.0
Medical Uniforms	0.3	0.3	0.3	0.3	0.3	1.5
Miscellaneous	1.0	1.0	1.0	1.0	1.2	5.2
TOTAL	285.5	301.8	341.5	372.2	413.7	1,714.7

PRIVATE SECTOR POPULATION III PROJECT No. 522-0389
ILLUSTRATIVE DETAILED BUDGET OF ASHONPLAFA
EXPENDITURES BY CALENDAR YEAR
COUNTERPART FUNDS
(US \$000)

ADMINISTRATION	CY 96	CY 97	CY 98	CY 99	CY 00	TOTAL
Salaries	328.0	367.3	401.2	439.8	494.8	2,031.1
Travel & Per Diem	38.1	38.3	40.5	42.0	43.0	201.9
Equipment	57.1	21.7	36.0	22.2	34.5	171.5
Communication/Mail	15.7	15.7	16.6	15.8	17.7	81.5
Shipping & Postage	5.3	5.4	5.7	5.9	6.0	28.3
Office Rent	2.2	2.2	2.3	2.4	2.5	11.6
Supplies	1.1	1.0	1.0	1.0	1.1	5.2
Professional Fees	2.2	0.9	0.8	0.8	1.7	6.4
Printing Forms	7.8	7.8	8.3	8.6	8.8	41.3
Incentive to Production	28.6	87.0	64.0	66.7	69.0	315.3
Building Improvement	57.1	173.9	72.0	92.6	41.4	437.0
Cleaning Supplies	17.3	17.4	18.4	19.1	19.6	91.8
Vehicle Maintenance	29.5	29.7	31.4	32.6	34.0	157.2
Building Maintenance	28.6	28.7	29.0	29.6	30.3	146.2
Equipment Repair	19.0	22.6	24.8	23.7	23.4	113.5
Data Processing	16.2	16.3	17.2	17.0	17.4	84.1
Office Supplies	15.2	15.2	15.2	15.0	15.2	75.8
Advertising & Promotion	2.1	2.1	2.2	2.3	2.4	11.1
Reception Expenses	7.1	6.8	6.8	7.1	7.2	35.0
Meeting Volunteers	8.6	8.3	8.0	7.8	7.6	40.3
Insurance	11.6	11.6	12.3	12.8	13.0	61.3
Custom Services	0.9	0.9	1.0	1.0	1.0	4.8
Utilities	19.0	19.1	20.2	21.0	21.5	100.8
Transportation	2.2	2.2	2.3	2.4	2.5	11.6
Technical Assistance	5.7	5.7	4.0	3.7	3.4	22.5
Building Security	40.5	40.7	43.0	43.0	44.0	211.2
Reserve for Project Diversification	95.2	165.2	144.0	22.2	0.0	426.6
Miscellaneous	10.7	10.7	11.5	11.6	12.1	56.6
TOTAL	872.6	1,124.4	1,039.7	969.7	975.1	4,981.5

ANNEX 4

PRIVATE SECTOR POPULATION III PROJECT - DEFINITION OF AND PROJECTED IMPACT ON PROJECT'S CUSTOMERS

The customers of this project are women, men and adolescents of fertile age in Honduras. More than previous projects, this project is targeting the un- and underserved populations who are interested in planning their families but who do not do so due to a lack of information or fear, as well as those who use ineffective traditional methods. These are women, men, and adolescents primarily in rural and periurban areas. Adolescents and men have been identified as un- and underserved groups by the results of a recent a Knowledge, Attitudes and Practices (KAP) study. Though not nationally representative, the study suggests that one of the constraints to increased utilization of modern contraception is lack of male involvement in family fertility decisions. Further, only the minority of sexually active adolescents interviewed have ever used contraception, and even a smaller percentage used contraception during first intercourse. Lack of information and poor planning are the two primary reasons adolescents cited for not using contraception. The study results also suggest that among adolescents there may be gender differences. Of those adolescents interviewed, male adolescents initiated sexual activity at a much earlier age, but were more likely than sexually active females to have used at least one method of contraception in their lives.¹ Gender differences in adolescents and men and women will be examined more closely in the baseline KAP study scheduled for Year 1 of this project. Interventions for all target groups which acknowledge gender differences will be designed once the national KAP study results are made available.

ASHONPLAFA's Medical Clinical Program (MCP), Community Services Program (CSP) and Social Marketing Program (SMP) serve overlapping yet distinct market segments and women/men at different points in their reproductive lives. Through this project ASHONPLAFA will assist its MCP, CSP and SMP to serve those populations better. The MCP traditionally has served women and men who are first-time users seeking temporary methods (spacers) or those seeking long-term or permanent methods (limiters). Most have been from urban and periurban areas; relatively few have been rural customers. Over the next five years, the MCP, with the utterly critical support of the Information, Education and Communications (IEC) unit and the support of PVOs, will serve more rural women and men, particularly limiters, in the ASHONPLAFA regions of Santa Rosa de Copán. Additionally, as a result of new quality assessment and quality assurance interventions and customer satisfaction monitoring, the MCP will serve all customers, rural and urban, limiters and spacers, with a higher level of quality than it is currently providing.

In rural and underserved areas, the CSP serves women and men who wish to space their children through provision of orals and condoms and serves women and men who wish to

¹ MULTI/MARKETING, 1995, *Conocimientos, Actitudes y Prácticas de Adolescentes, Hombres y Mujeres.*

limit the size of their families through referral to ASHONPLAFA or Ministry of Health (MOH) clinics for clinical procedures. CSP posts should bridge an access gap – due to distance, cost, or lack of knowledge. In fact, the ASHONPLAFA CSP has served these customers imperfectly for two reasons: too much of its effort has been directed to easily-reached urban and periurban customers; and CSP community *consejeras*, not wanting to lose the income from sales, have referred very few customers to ASHONPLAFA for clinical procedures.² One result of this project will be that the CSP program will more fully serve the customers it was established to serve: rural and underserved women and men seeking both to space and to limit their families.

Customers of the SMP are urban and periurban men and women who wish to space their families and have the income to pay all or partial cost of orals and condoms. They are assumed to buy from a pharmacy after consultation with medical personnel elsewhere (in the case of oral contraceptives) or are knowledgeable enough about contraception to buy contraceptives without the immediate need for counseling that the MCP or CSP would provide. Again, the SMP has served these customers imperfectly. Contraceptive prices have been very low, resulting in an unsustainable SMP market niche.³ Secondly, many customers are buying SMP products without sufficient knowledge to use them in a safe and effective way.⁴ This project will address both issues.

By reducing fertility rates, the project will have a direct impact on maternal mortality reduction and an indirect impact on children born to women who avoid high risk births (i.e. births that are too closely spaced, births to women too young or too old, or births to women who already have three or more children).

All of the above will impact the lives of the customers' families. By lowering fertility rates, families will be smaller and will have more resources to divide among fewer people for investments in nutrition, health care, education, etc.

² Joseph Burke, Community Services Program Analysis, July 1995.

³ Joseph Burke, Social Marketing Program Analysis, July 1995.

⁴ *Perfil de Usuaris del Programa de Mercadeo Social*, ASHONPLAFA, Department of Research and Statistics, June 1994.

ANNEX 5

Economic Analysis

An integral aspect of the economic analysis of this family planning project is the identification of economic benefits. Ostensibly the benefits are those that would be realized if the proposed project proves effective in reducing the number of unwanted births. An important measurable benefit is those budgetary costs that will not be incurred as a result of the project's success in reducing unwanted births.

The first step in deriving economic benefits is to compute the number of births averted by the proposed project. That is a relatively straight-forward exercise. The proposed project seeks to reduce the total fertility rate from what it is today -- 4.7 in 1995 -- to 3.0 by 2015 with the intervening goal of reduction to 4.2 in the year 2001. Using the Rapid IV model the number of births over the 1996-2015 period were calculated on an annual basis assuming that the fertility rate declines from 4.7 to 3.0 during the period. The Rapid IV model also was used to calculate births per annum, given that today's fertility rate of 4.7 remains unchanged over the 1996-2015 period. The difference in births under the two scenarios becomes the measure of births averted.

Births Averted

<u>Year</u>	<u>Births Without the Project</u>	<u>Births With the Project</u>	<u>Births Averted</u>
1996	202,982	195,646	7,336
1997	208,936	198,723	10,213
1998	215,261	201,725	13,536
1999	221,847	204,579	17,268
2000	228,584	207,215	21,369
2001	235,548	209,670	25,878
2002	242,813	211,990	30,823
2003	250,264	214,122	36,142
2004	257,788	216,007	41,781
2005	265,271	217,590	47,681
2006	273,483	218,957	54,526
2007	282,500	220,146	62,354
2008	291,167	221,026	70,141
2009	298,330	221,470	76,860
2010	302,835	221,348	81,487
2011	304,728	220,553	84,175
2012	304,778	219,170	85,608
2013	302,917	217,361	85,556
2014	299,076	215,286	83,790
2015	293,186	213,103	80,083

The second step is to determine the economic value of an averted birth. This is far more problematic. Traditionally, the most common approach is to take as the principal economic benefit to society of an averted birth the net present value of the discounted consumption stream of an unborn child. The net benefit of an averted birth would be the present value of the difference between lifetime production and lifetime consumption.

However, this approach suffers from defects. It leads to the implausible outcome that a birth rate not far from zero is economically the most desirable in all countries at all periods of time. This is a consequence of discounting which places a greater value on economic costs and benefits incurred in the near term than in the medium and longer term. (For instance, one would always prefer to have \$10 today than \$10 a year from now; the \$10 today could be invested say in a time deposit to yield more than \$10 a year from now.) The benefits of a birth averted -- consumption foregone -- begin at birth, while the costs -- production foregone -- begin 10 to 15 years later when the individual begins to work. The process of discounting places a far greater value on consumption foregone -- the economic benefits from averting a birth -- than production foregone -- the economic costs of averting birth. This approach yields the result that it is in the best interests of society from the perspective of economic costs and benefits to always avert births. By implication, this would mean that parents are acting irrationally from an economic perspective when they have children. Yet, children provide benefits to their parents such as support in old age, unpaid labor for the family farm, and simply enjoyment.

Given the defects in the approach equating the net benefits of an averted birth with the present value of the difference between lifetime consumption and production and its implication for desired birth rates from an economic standpoint, our analysis will focus on other economic benefits. The most significant benefit that can be measured is the Government of Honduras (GOH) budgetary savings from averting a birth, those expenditures that the GOH will not have to make.

One item in the budget that will be directly affected by the reduction in births is the primary education budget which should be less than it otherwise would be owing to less births and correspondingly less children attending primary school. The primary education budget totaled lempiras 699 million in 1995 or \$73.6 million (using an exchange rate of L9.5 = \$1). Given that there are 1,035,821 Honduran children attending primary school, the figure works out to \$71 per child. To calculate the budgetary savings, we multiplied the births averted in a given year by the budgetary allocation per child. In Honduras, children cannot legally attend primary school until they are 6 1/2 years old. Consequently, the births averted say in 1996 do not begin to produce budgetary savings until the year 2003 and so on. Please consult Table A for a list of such benefits.

Budgetary savings also will accrue from the reduction in overall population size induced by the births averted. The following table provides projections of reductions in population size, utilizing the Rapid IV model and assuming project success in reducing the overall fertility rate from 4.7 in 1995 to 3.0 by year 2015.

Population Size Reductions

<u>Year</u>	<u>Population Size Without project (Thousands)</u>	<u>Population Size With Project (Thousands)</u>	<u>Population Size Reductions (Thousands)</u>
1996	5,624	5,620	4
1997	5,787	5,777	10
1998	5,956	5,938	18
1999	6,131	6,101	30
2000	6,314	6,267	47
2001	6,506	6,436	70
2002	6,704	6,608	96
2003	6,910	6,783	127
2004	7,123	6,960	163
2005	7,343	7,137	206
2006	7,570	7,316	254
2007	7,804	7,496	308
2008	8,046	7,678	368
2009	8,295	7,860	435
2010	8,551	8,042	509
2011	8,822	8,223	599
2012	9,108	8,406	702
2013	9,398	8,588	810
2014	9,680	8,767	913
2015	9,942	8,941	1001

We held discussions with the Economic Advisor in the Ministry of Finance. Those ministerial budgetary allocations that are sensitive to population size -- that is, would be greater with more people and less with less people -- include (a) the entire allocation of the Ministry of Health, (b) the investment budgets in the Ministries of Public Works and Transport and Natural Resources, (c) transfers to the municipalities which is a line item in the budget for the Ministry of Governance and Justice, and (d) social transfers such as the urban transport subsidy and allocations for the two safety net programs -- PRAF and FHIS.

**GOH Budgetary Allocations in 1995
Sensitive to Population Size**

	<u>Lempiras</u> <u>(Million)</u>	<u>U.S. \$ ^{1/}</u> <u>(Million)</u>
Social Transfers	<u>284.1</u>	<u>29.9</u>
Urban Transport Subsidy	100.0	10.5
PRAF	28.5	3.0
FHIS	155.6	16.5
Ministry of Health	<u>1,071.5</u>	<u>112.8</u>
Ministry of Public Works and Transport Investment Budget	<u>795.8</u>	<u>83.8</u>
Ministry of Natural Resources Investment Budget	<u>186.9</u>	<u>19.7</u>
Ministry of Governance and Justice Transfers to the Municipalities	<u>201.6</u>	<u>21.2</u>
Total	<u>2,539.9</u> = = = =	<u>267.4</u> = = = =

^{1/} Using an exchange rate of L9.5 = \$1.

These budgetary allocations, which totaled lempiras 2,539.9 million or \$267.4 million in 1995, work out to \$49 per person, assuming a population of 5,466,000 in 1995. Budgetary savings were computed by multiplying the allocation per head of the summed total of those budgetary items sensitive to population size -- the \$49 per person -- by the reduction in population size by year. (Please see Table A).

To assess the economic viability of the Private Non-Profit Sector Population III, we computed economic benefits and costs. Economic benefits consist of the summation of the budgetary savings from births averted and reduced population size. Economic costs consist of (a) USAID assistance to ASHONPLAFA -- both operating budget support and in kind, (b) USAID help to participating PVOs, and (c) ASHONPLAFA's own resources. Utilizing a 20 year benefit-cost stream and a discount rate of 15%, a benefit-cost ratio of 2.04 was computed, suggesting that the project is an economically viable proposition.

Actually, the 2.04 benefit-cost ratio understates the value of the project. In addition, to the budgetary savings, the project will be producing other economic benefits that are more difficult to quantify. These include increases in labor productivity, greater private savings, and improvements in health. If these other benefits could be quantified, we suspect that the benefit-cost ratio would be considerably higher than the 2.04 we calculated.

Table A

**Private Non-Profit Sector Population III:
Economic Benefits and Costs
(U.S. \$)^{1/}**

Year	Economic Benefits		Economic Costs
	Budgetary Savings from Reduced Primary School Enrollment	Budgetary Savings from those Items Sensitive to Population Size	
1996		195,600	4,245,204
1997		489,000	5,136,623
1998		880,200	5,194,592
1999		1,467,000	5,004,707
2000		2,298,300	4,340,237
2001		3,423,000	2,356,237
2002		4,694,400	2,356,237
2003	520,856	6,210,300	2,356,237
2004	725,123	7,970,000	2,356,237
2005	961,056	10,073,400	2,356,237
2006	1,226,028	12,420,600	2,356,237
2007	1,517,199	15,061,200	2,356,237
2008	1,837,338	17,995,200	2,356,237
2009	2,188,433	21,271,500	2,356,237
2010	2,566,082	24,890,100	2,356,237
2011	2,966,451	29,291,100	2,356,237
2012	3,385,351	34,327,800	2,356,237
2013	3,852,176	39,609,000	2,356,237
2014	4,427,134	44,645,700	2,356,237
2015	4,980,011	48,948,900	2,356,237

^{1/} Constant dollars.

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Table B

**Private Non-Profit Sector Population III:
Discounted Economic Benefits and Costs
(U.S. \$)**

Year	Discount Rate	Economic Benefits		Economic Costs
		Budgetary Savings from Reduced Primary School Enrollment	Budgetary Savings from those Items Sensitive to Population Size	
1996	.87		170,172	3,693,327
1997	.76		371,640	3,903,833
1998	.66		580,932	3,428,430
1999	.57		836,190	2,852,682
2000	.50		1,149,150	2,170,118
2001	.43		1,471,890	1,013,181
2002	.37		1,736,928	871,807
2003	.33	171,882	2,049,399	777,558
2004	.28	203,034	2,231,796	659,746
2005	.25	240,264	2,518,350	589,059
2006	.21	257,466	2,608,326	494,809
2007	.19	288,268	2,861,628	447,685
2008	.16	293,974	2,879,232	376,997
2009	.14	306,381	2,978,010	329,873
2010	.12	307,930	2,986,812	282,748
2011	.11	326,310	3,222,021	259,186
2012	.09	304,682	3,089,502	212,061
2013	.08	308,174	3,168,720	188,498
2014	.07	309,899	3,125,199	164,936
2015	.06	<u>298,801</u>	<u>2,936,934</u>	<u>141,374</u>
		3,617,065	42,972,831	22,857,908
		=====	=====	=====
Total Economic Benefits:		46,589,896		
Total Economic Costs:		22,857,908		
Economic Benefit-Cost Ratio:		2.04		

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U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

LAC-IEE-95-41

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Honduras

Project Title : Private Sector Population III Project

Project Number : 522-0389

Funding : \$11,254,000

Life of Project : FY 95-01

IEE Prepared by : Albert Merkel, MEO
USAID/Honduras

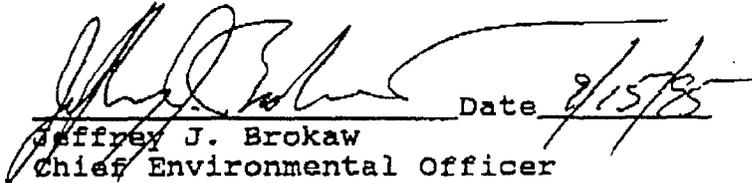
Recommended Threshold Decision: Categorical Exclusion for TA,
procurement, and studies

Negative Determination for
medical waste

Bureau Threshold Decision : Concur with Recommendation

Comments

Mitigation measures shall be incorporated into the project design, and implemented as described in the attached IEE.


Date 8/15/95
Jeffrey J. Brokaw
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

Copy to : Elena Brineman, Mission Director
USAID/Honduras

Copy to : Albert Merkel, MEO

Copy to : Wayne Williams, REA/CEN
USAID/Guatemala

**ENVIRONMENTAL THRESHOLD
DECISION (cont'd.)**

LAC-IEE-95-41

Copy to : Kraig Baier, LAC/CEN
Copy to : Jean Meadowcroft, LAC/SPM-CAC
Copy to : IEE Files

INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Honduras
Project Title : Private Sector Population III Project
Project Number : 522-0389
Funding : \$11,254,000
Life of Project : FY 95 - 01
IEE Prepared by : Albert L. Merkel, USAID/Honduras Mission Environmental Officer
Recommended Threshold Decision : Categorical Exclusion for all project activities including TA, procurement, and studies.
Negative Determination for medical waste disposal.



MISSION DIRECTOR'S DECISION

Approved: 
Date: 9/12/95

LAC CHIEF ENVIRONMENTAL OFFICER'S REVIEW

Concurred: _____
Date: _____

Clearance: O/ANR(E) (In draft)
HPN (In draft)
DF 
DMD LOK

INITIAL ENVIRONMENTAL EXAMINATION Private Sector Population III Project

Project Description

This new project is a follow-on to the Private Sector Population II (PSP II) Project scheduled to end in mid-FY 1996. Although the PSP II Project has supported significant increases in reproductive health service utilization and improved access to reproductive health services throughout the country, continued efforts to these areas, alongside efforts to improve quality of services and self-financing are necessary to ensure a private sector able to provide reproductive health services on a sustainable basis.

The Project purpose is to promote the sustainable provision of reproductive health services, including family planning services, by the private non-profit sector. A five year/4 months implementation period beginning in FY 1995 and ending in FY 2001 is proposed. The Project will contribute to the achievement of USAID/Honduras' Strategic Objective No. 3, "Improved Family Health", primarily by reducing fertility rates. The project will increase the access of un- and underserved rural women, men and adolescents to reproductive health services; improve the quality of services of the Asociación Hondureña de Planificación de Familia (ASHONPLAFA, the International Planned Parenthood affiliate in Honduras) and other Private Voluntary Organizations (PVOs); increase ASHONPLAFA self-financing; and increase the client volume of ASHONPLAFA and other PVO reproductive health services.

Project-funded activities will lead to six intermediate results. The first five of these are related to ASHONPLAFA; the sixth will be a consequence of activities with international and Honduran PVOs:

- Improved Delivery of Medical and Clinical Services;
- Accessible, High-Quality, Self-Financing Social Marketing Program;
- Focused, High Quality; Community Services Program;
- Effective Information, Education, and Communication Strategy;
- Effective Support Systems at the Headquarters and Regions; and
- Increased PVO participation in reproductive health.

Description of the Environmental Impacts

The project will result in significant positive impacts on the health of Honduran citizens, and a corresponding increase in productivity associated with improved family health.

The only potential negative environmental impact is that of small amounts of medical wastes generated during project implementation, which, if not properly

disposed of, may contribute to contamination of the environment. The waste will consist of used bandages, rubber gloves, syringes, paper products, tape, cotton, and needles. Each of the eleven sites in the project will produce about one pound of waste each day. The clinics are located throughout the country. The waste is now disposed of by burning on site. These small quantities require only a container for burning and some inflammable source of combustion such as kerosine.

The small quantities of waste produced and the dispersed locations of the clinics will result in no significant accumulation of waste at any particular site. For this reason, a negative determination is appropriate based on the HB 3 definition of "significant environmental impact."

Mitigation Measures

Mitigating environmental impact is a high priority in this and all other USAID undertakings. For this reason the Private Sector Population III Project will undertake several mitigation measures to insure that environmental concerns about medical waste are addressed.

These measures include:

- Periodic measures of the quantity of medical waste generated in the clinics which receive funding from the project. These quantities will be reported in the Quarterly Reports submitted to USAID. The Project Officer will evaluate the quantities and if significant changes are seen, will report this to the Mission Environmental Office for action.
- Provision of written instructions to the clinics about how to handle medical wastes.
- Training of all personnel in the clinics on proper handling and disposal of medical wastes.
- Provision of appropriate waste containers and needle disposal systems to the clinics.
- Each planned Project Evaluation shall have instructions included to evaluate the quantity medical waste produced and the disposal procedures at each clinic. The results will be clearly presented in the evaluation findings. The findings shall be reviewed by the Mission Environmental Officer, who will propose additional mitigation measures if needed.

All mitigation procedures in this IEE will be incorporated into the Project design with support from the budget. The mitigation measures shall be included in appropriate project documents, including budgets, and agreements.

When the final U.S. Environmental Protection Agency rules on medical waste disposal are published, the project shall comply with those regulations.. If unable to comply, Mission Environmental Officer shall submit justification to LAC/RSD/E Chief Environmental Officer for approval.

Relevant Honduran Legislation

The Environmental Law, passed in June 1993, created the National Environmental Impact System. The regulations for this have been published and have a minimum set of requirements for the "Environmental Impact Assessment" on all projects. Consultation with the Ministry of Environment has shown that there are no specific requirements on treatment of medical waste under the National Environmental Law.

Recommended Environmental Threshold Decision

Categorical Exclusion (22 CFR 216.2(c) (viii) for project activities, including TA, procurement, and studies.

Negative Determination (22 CFR 216.3(a)(2) for medical waste disposal.

Albert Merkel@RD@TEGUCIGALPA

From: Jeffrey Brokaw@LAC.DR@AIDW
Subject: re: IEE for POP III Project
Date: Wednesday, September 6, 1995 14:01:43 LOC
Attach:
Certify: Y
Forwarded by:

1,

read the subject IEE and think the Mission's approach to addressing the issues of medical waste is highly commendable. This is an area that USAID has not paid enough attention to and we are interested in learning from your experience of your project in order to develop a protocol that other projects could use. Please, therefore ~~would~~ keep us informed about what the Mission develops in the way of safety precautions, procedures, etc. and how they work.

We will send a concurring threshold decision as soon as we receive an IEE signed by the Mission Director.

Regarding the Threshold decision, you need to make the decision in the text consistent with that on the cover sheet. I think that the cover sheet is correct in that it recommends a Categorical Exclusion for TA, studies and a negative determination for the medical waste disposal. The text only recommends a Categorical Exclusion.

Hope that all goes well with you.

Regards,

Jeff.

1/2

HONDURAS - 1995

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics Certification

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of nonagricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 522 of the FY 1995 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries, and programs identified in section 547 of that Act and other provisions of law that have similar notwithstanding authority.) If the recipient is a "major illicit drug producing country" (defined as a country in which during a year at least 1,000 hectares of illicit opium poppy is cultivated or harvested, or at least 1,000 hectares of illicit coca is cultivated or harvested, or at least 5,000 hectares of illicit cannabis is cultivated or harvested) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the March 1 International Narcotics Control Strategy Report (INCSR) determined and certified to the Congress (without Congressional enactment, within 30 calendar days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

Yes. The President is expected to certify by March 1, 1995 that Honduras has cooperated fully with the U.S. If not certified assistance will be suspended accordingly.

(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on March 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

Not Applicable.

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No.

3. **Seizure of U.S. Property** (Foreign Relations Authorization Act, Fiscal Years 1994 and 1995, Sec. 527): If assistance is to a government, has it (including any government agencies or instrumentalities) taken any action on or after January 1, 1956 which has the effect of

No.

nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without (during the period specified in subsection (c) of this section) either returning the property, providing adequate and effective compensation for the property, offering a domestic procedure providing prompt, adequate, and effective compensation for the property, or submitting the dispute to international arbitration? If the actions of the government would otherwise prohibit assistance, has the President waived this prohibition and so notified Congress that it was in the national interest to do so?

4. **Communist and other countries** (FAA Secs. 620(a), 620(f), 620D; FY 1995 Appropriations Act Secs. 507, 523): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided directly to Cuba, Iraq, Libya, North Korea, Iran, Serbia, Sudan or Syri? Will assistance be provided indirectly to Cuba, Iraq, Libya, Iran, Syria, North Korea, or the People's Republic of China? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

Honduras is not a communist country.

5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

Honduras has fully compensated the U.S.G. for damages from the April 1988 mob action. They have taken adequate measures to prevent such incidents.

6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to

No.

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enter into an investment guaranty agreement with OPIC?

7. Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

No.

8. Loan Default (FAA Sec. 620(q); FY 1995 Appropriations Act Sec. 512 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1995 Appropriations Act appropriates funds?

Yes. Honduras is presently in default as defined in FAA SEC. 620 (q) and the Brooke Amendment by virtue of their default on a Paris Club rescheduling agreement. Before obligation of FY95 funds the arrears will be paid or rescheduled. (Both 620(q) sanctions and Brooke Alexander were lifted effective July 11, 1995)

9. Military Equipment (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes. Taken into account by the Administrator at the time of approval of the FY 1995 OYB.

(N/A)

10. Diplomatic Relations with U.S. (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

11. U.N. Obligations (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the

Honduras is not in arrears to the U.N. to the extent described in Article 19 of the U.N.

country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

charter. Other arrearages in general were taken into account by the Administrator at the time of approval of the FY 199 OYB.

12. International Terrorism

a. **Sanctuary and support** (FY 1995 Appropriations Act Sec. 529; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No.

b. **Airport Security** (ISDCA of 1985 Sec. 552(b)): Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No.

c. **Compliance with UN Sanctions** (FY 1995 Appropriations Act Sec. 538): Is assistance being provided to a country not in compliance with UN sanctions against Iraq, Serbia, or Montenegro and, if so, has the President made the necessary determinations to allow assistance to be provided?

No.

13. **Countries that Export Lethal Military Equipment** (FY 1995 Appropriations Act Sec. 563): Is assistance being made available to a government which provides lethal military equipment to a country the government of which the Secretary of State has determined is a terrorist government for purposes of section 40(d) of the Arms Export Control Act?

No.

14. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin

No.

or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

15. Nuclear Technology (Arms Export Control Act Secs. 101, 102): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E(d) permits a special waiver of Sec. 101 for Pakistan.) No.

16. Algiers Meeting (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.) Yes. Taken into account by the Administrator at the time of approval of the FY 1995 OYB.

17. Military Coup (FY 1995 Appropriations Act Sec. 508): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? No.

18. Exploitation of Children (FAA Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to No.

protect children from exploitation, abuse or forced conscription into military or paramilitary services?

19. **Parking Fines (FY 1995 Appropriations Act Sec. 564):** Has the overall assistance allocation of funds for a country taken into account the requirements of this section to reduce assistance by 110 percent of the amount of unpaid parking fines owed to the District of Columbia as of August 23, 1994?

The unpaid parking fines owed to the District of Columbia as of August 23, 1994 will reduce the obligations for FY 1995 by 110 percent of such amount.

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

Human Rights Violations (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No.

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

No.

LAC/CEN:KBaier/chklist.hon/1/11/95:7-9555

Clearances:

LAC/CEN:Kellis	<i>[Signature]</i>	Date:	<u>7 Feb 95</u>
LAC/SAM:TKellerman	<i>[Signature]</i>	Date:	<u>2/2/95</u>
LAC/SPM:DLoudis	<i>[Signature]</i>	Date:	<u>20/Jan/95</u>
LAC/DPB:EZallman	<i>[Signature]</i>	Date:	<u>2/2/95</u>
LAC/GC:AAdams	<i>[Signature]</i>	Date:	<u>2/6/95</u>
ARA/CEN:Lallison	<i>[Signature]</i>	Date:	<u>19 Jan 95</u>
State/IO/S/B:DLeis	<i>[Signature]</i>	Date:	<u>26 Jan 95</u>
State/INM/P:XBryson	<i>[Signature]</i>	Date:	<u>24 Jan 95</u>
State/HA//BA:MCurtain	<i>[Signature]</i>	Date:	<u>20 Jan 95</u>
State/M/OFM/VTC:GMonica	<i>[Signature]</i>	Date:	<u>24 Jan 95</u>

artin
correct
pelling

Jorge Cintron

VPL - first initial is K
not A.

14. PVO Assistance

a. **Auditing and registration (FY 1995 Appropriations Act Sec. 560):** If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

ASHONPLAFA is the local IPPF affiliate locally registered with USAID, and is in good standing.

b. **Funding sources (FY 1995 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"):** If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A. ASHONPLAFA is a local PVO.

15. **Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)):** Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

This Agreement is below the \$25 million threshold established for implementing Case-Zablocki.

16. **Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy):** Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically

Yes

available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

17. Abortions (FAA Sec. 104(f); FY 1995 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? (Note that the term "motivate" does not include the provision, consistent with local law, of information or counseling about all pregnancy options including abortion.) No

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) Yes

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer No

only natural family planning? (As a legal matter, DA only.)

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No

18. **Cooperatives (FAA Sec. 111):** Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? No

19. **U.S.-Owned Foreign Currencies**

a. **Use of currencies (FAA Secs. 612(b), 636(h); FY 1995 Appropriations Act Secs. 503, 505):** Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. The U.S. owns no excess Honduran currencies.

b. **Release of currencies (FAA Sec. 612(d)):** Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No

20. **Procurement**

a. **Small business (FAA Sec. 602(a)):** Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? N/A

b. U.S. procurement (FAA Sec. 604(a): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?

Yes

c. Marine insurance (FAA Sec. 604(d): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Honduras does not so discriminate.

d. Insurance (FY 1995 Appropriations Act Sec. 531): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. insurance companies have a fair opportunity to bid for insurance when such insurance is necessary or appropriate?

N/A

e. Non-U.S. agricultural procurement (FAA Sec. 604(e): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

f. Construction or engineering services (FAA Sec. 604(g): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

N/A

g. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b)

No. The Project Authorization complies with the terms of section 901(b) of the Merchant

of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

Marine Act of 1936, as amended.

h. Technical assistance

Yes

(FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

i. U.S. air carriers

Yes

(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

j. Consulting services

Yes

(FY 1995 Appropriations Act Sec. 559): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

k. Metric conversion

Yes

(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually

to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. Competitive Selection Yes
Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

m. Notice Requirement (FY 1995 Yes
Appropriations Act Sec. 568): Will project agreements or contracts contain notice consistent with FAA section 604(a) and with the sense of Congress that to the greatest extent practicable equipment and products purchased with appropriated funds should be American-made?

21. Construction

a. Capital project (FAA Sec. N/A
601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

b. Construction contract (FAA N/A
Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

c. Large projects, Congressional N/A
approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

22. U.S. Audit Rights (FAA Sec. 301(d)): N/A
If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

23. Communist Assistance (FAA Sec. 620(h)). Yes
Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

24. Narcotics

a. Cash reimbursements (FAA Sec. 483): Yes
Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

b. Assistance to narcotics traffickers (FAA Sec. 487): Yes
Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

25. Expropriation and Land Reform (FAA Sec. 620(g)): Yes
Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?

26. Police and Prisons (FAA Sec. 660): Yes
Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

27. **CIA Activities (FAA Sec. 662):** Will assistance preclude use of financing for CIA activities? Yes
28. **Motor Vehicles (FAA Sec. 636(i)):** Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes
29. **Export of Nuclear Resources (FY 1995 Appropriations Act Sec. 506):** Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? Yes
30. **Publicity or Propaganda (FY 1995 Appropriations Act Sec. 554):** Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No
31. **Exchange for Prohibited Act (FY 1995 Appropriations Act Sec. 533):** Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? No
32. **Commitment of Funds (FAA Sec. 635(h)):** Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? No

33. Impact on U.S. Jobs (FY 1995 Appropriations Act, Sec. 545):

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? No

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? No

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1995 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be N/A

expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

2. Tied Aid Credits (FY 1995 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

No

4. Indigenous Needs and Resources (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

There is appreciable unmet demand for family planning services and for improved maternal and child health. This has been documented in the last Epidemiology Family Health Survey.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes. Improved maternal and child health and reduced population growth rates are key to sustainable economic growth.

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the

(a) Beneficiaries under PSP III will include periurban and rural poor who are interested in planning their families but who do not do so due to a lack of information (b) N/A (c) By reducing population growth rate, PSP III will support Honduras' own development efforts (d) The PSP III Project will include women who are interested in planning their families (e) PSP

self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

III will not have activities related to regional cooperation.

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

PSP III beneficiaries will for the most part be members of the poor majority.

9. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

10. Disadvantaged Enterprises (FY 1995 Appropriations Act Sec. 555): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The Mission intends to comply with the Gray Amendment to the maximum extent possible. However, since PSP III technical assistance will for the most part be obtained through the use of Personal Services Contracts and buy-ins to centrally funded projects, the opportunities for use of disadvantaged enterprises will depend on previously competed contracts.

11. **Biological Diversity (FAA Sec. 119(g):** Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? (Note new special authority for biodiversity activities contained in section 547(b) of the FY 1995 Appropriations Act.)

No

12. **Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):**

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support

No

training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the

No

construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

Yes

13. **Energy (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

14. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation,

N/A

(h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

15. Deobligation/Reobligation (FY 1995 Appropriations Act Sec. 510): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

16. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A

17. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

See B.6 above.

18. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers:

N/A

If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to

This activity is not related to the efforts being carried out under FAA Section 104.

improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

9. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

20. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management

This activity will contribute to improved food security at the household level by lowering fertility rates which will result in smaller families. Smaller families will have more resources to divide among fewer people for investments in food, health care, education, etc.

The PSP III Project specifically targets rural poor, and especially women of reproductive age through support to ASHONPLAFA's Community Service Program (CSP). The CSP runs distribution posts which distribute oral contraceptives and condoms at subsidized prices. In addition, the PSP III Project supports voluntary clinical contraception at 11 clinics nationwide and a Social Marketing Program which distributes orals and condoms at more than 600 pharmacies and health posts nationwide.

(a) The PSP III Project will support private voluntary organizations in the delivery of specialized family planning education services.

capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(b) N/A

21. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

The assistance is not related to the energy sector.

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development organizations;

The Mission plans to support family planning activities through several PVOs, including two U.S. PVOs.

c. research into, and evaluation of, economic development processes and techniques;

N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

The project is not intended to provide disaster relief.

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

PSP III builds upon the experience and infrastructure of two successful USAID projects in the area of population.

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

N/A

22. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

N/A

ACTION MEMORANDUM TO THE MISSION DIRECTOR

DATE: September 22, 1995

FROM: Marcela Moya, DF

THRU: Leon S. Waskin, DF 

SUBJECT: Authorization of the Private Sector Population III (PSP III) Project (522-0389)

ACTION REQUESTED: You are requested to (1) sign the Project Data Sheet for the PSP III Project Paper, thereby approving the PSP III Project design; and (2) sign the Project Authorization, thereby authorizing the PSP III Project.

BACKGROUND: The PSP III Project builds upon the successful experiences and lessons learned from the ongoing Private Sector Population II (PSP II) Project (522-0369). PSP II, scheduled to end in FY 1996, has been a significant success in terms of meeting its planned objectives of increasing reproductive health service utilization and improving access to reproductive health services throughout the country. However, Honduras remains a "plateau country" where the use of modern methods of contraception has grown slowly, while the use of traditional methods has grown considerably.

The Mission decided to start a new project rather than adding this year's planned obligation of population funds to extending PSP II for several reasons:

- The new project will use a new approach by focussing on results rather than activities, and will hold the *Asociación Hondureña de Planificación de Familia* (ASHONPLAFA, the International Planned Parenthood Federation affiliate in Honduras) and other Private Voluntary Organizations (PVOs) accountable for progress toward those results;
- PSP III will emphasize the use of modern methods but also respond to the evident demand for natural family planning methods;
- PSP III will coordinate more effectively with the other major actors in the sector, the PVO community and the Ministry of Health; and
- PSP III will begin an effort to make significant progress toward ASHONPLAFA's financial self-sufficiency.

DISCUSSION: The PSP III Project is designed to promote the sustainable provision of reproductive health services, including family planning services, by the private non-profit sector. A five year, 4 months implementation period beginning in FY 1995 (September 1995) and ending in FY 2001 (December 2000) is proposed. The project will contribute to the achievement of USAID/Honduras' Strategic Objective No. 3, "Improved Family Health", primarily by reducing fertility rates. Activities funded under PSP III will increase the access of un- and underserved rural women, men and adolescents to reproductive health services; improve the quality of services of ASHONPLAFA and other PVOs; increase

ASHONPLAFA's financial self-sufficiency; and increase the client volume of ASHONPLAFA and other PVO reproductive health services.

Project-funded activities will lead to six intermediate results. The first five of these are related to ASHONPLAFA; the sixth will be a consequence of activities carried out by international and Honduran PVOs:

- Improved Delivery of Medical Clinical Services;
- Accessible, High-Quality, Self-Financing Social Marketing Program;
- Focused, High-Quality Community Services Program;
- Effective Information, Education, and Communication Strategy;
- Effective Support Systems at the Headquarters and in the Regions; and
- Increased PVO participation in reproductive health.

Although there will be an overlap between PSP II and PSP III, the Mission will not allow duplication between these two projects. During the overlap period, POP II funds will be used to finance ASHONPLAFA's operating costs through December 1995. After this date, PSP II funds will finance only the procurement of medical clinical equipment and vehicles and construction costs of the San Pedro Sula clinic. With the exception of Global Bureau Field Support funds, no PSP III funds will be used before January 1, 1996. After January 1, 1996 PSP III funds will begin to finance the USAID-funded portion of ASHONPLAFA operating costs.

USAID AND COUNTERPART CONTRIBUTIONS: The total cost of the PSP III Project is estimated at \$28,289,700, with USAID providing \$14,920,000 in grant funding and ASHONPLAFA providing a counterpart contribution of \$13,369,700.

Of the \$14,920,000 USAID contribution, \$11,254,000 will be authorized by the Mission and funded with Development Assistance resources from the Mission's OYB and \$3,666,000 will be funded with USAID/W Global Bureau Field Support funds and authorized/obligated by USAID/W. Of the \$11,254,000, the Mission expects to make OYB transfers totalling \$902,000 for Global Bureau Field Support technical assistance.

Project funds will be obligated through several instruments. First, USAID will sign a Cooperative Agreement with ASHONPLAFA for a total of \$8,072,600 in USAID funding. Second, USAID plans to sign approximately five grant agreements with PVOs, selected from the review of proposals to be received in response to a Request For Applications (RFA). An estimated total of \$1,540,000 in USAID grant funds will be obligated through these agreements. Third, USAID plans to obligate some \$739,400 under individual obligation instruments (i.e., contracts, purchase orders, travel authorizations, and Project Implementation Orders for Participant Training). These funds will be used by USAID to procure local technical assistance; fund local/foreign training; and fund Mission personal services contracts. Fourth, it is estimated that USAID/W will obligate \$3,666,000 from Global Bureau Field Support funds and \$902,000 from Mission OYB transfers for the provision of technical

assistance and the procurement of contraceptives.

CONSISTENCY WITH DESIGN GUIDANCE: The attached Project Paper is consistent with the Interim Project Development Directive issued by USAID/W in November 1994 and with the emerging principles of operations reengineering. The document sets forth a clear set of results, and was prepared by the internal USAID Project Team in close coordination with ASHONPLAFA and in consultation with other PVOs potentially interested in participating in the project. Further, this PP:

- o Explicitly identifies, and discusses how the project is to meet the needs of, its customers (Section I.C and Annex 4);
- o Assesses the feasibility of planned activities and the risks that might imperil achievement of intended results (Section VI);
- o Identifies and explains how the project will complement and interact with the efforts of other donors and of other USAID projects (Section VI.A.2); and
- o Describes how the Mission and its partners will assure the prudent stewardship of USAID resources (Section VIII.C).

ISSUES: Attached to this Action Memorandum is a summary of the issues considered by the Project Design Committee in a meeting with the Front Office on August 30, 1995 and of how those issues were resolved.

SUSTAINABILITY: As noted in the attached Project Paper, increasing the financial self-sufficiency of ASHONPLAFA, and thus ensuring its ability to continue to provide reproductive health services in the absence of continued USAID support following the completion of this project, will be a major intermediate result of the Private Sector Population III Project. Achieving this result will in turn depend on improving the quality of, and the utilization of, all ASHONPLAFA service delivery systems.

It is important to note, however, that even if all our assumptions prove true and all planned activities are implemented as expected, ASHONPLAFA will cover no more than 63% of its costs by the December 31, 2000 PACD. Achievement of 63% financial self-sufficiency would be a major success, for this would be approximately the same level as that reached by the most successful (in these terms) USAID-assisted family planning association in the world, Colombia's PROFAMILIA.

Nonetheless, even this level would not provide the Association with full financial independence from continued donor support. If ASHONPLAFA is to continue to provide reproductive health services, and thus if Honduras is to maintain the contraceptive prevalence levels expected to be reached by the end of PSP III, further donor assistance in this sector will still have to be provided following the completion of this project.

ENVIRONMENTAL THRESHOLD DECISION: On September 15, 1995, the LAC Bureau's Chief Environmental Officer issued a Categorical Exclusion for PSP III activities including technical assistance, procurement, and studies; and a Negative Determination for medical waste disposal.

As stated in the attached Project Paper, ASHONPLAFA and other PVOs participating in PSP III will undertake several mitigation measures to insure that environmental concerns for medical waste disposal are addressed. These include: (1) periodic measures of the quantity of medical waste generated, (2) provision of written instructions to the clinics on how to handle and dispose of medical wastes; (3) training of all personnel in clinics on proper handling and disposal of medical wastes; (4) provision of appropriate waste containers and needle disposal systems to the clinics; and (5) provision that each planned Project Evaluation shall evaluate the quantity of medical waste produced and the disposal procedures at each clinic.

NOTIFICATION: The Congressional Notification for PSP III expired on August 16, 1995 (see attached copy of STATE 197640).

AUTHORITY: The AA/LAC has delegated to all LAC Missions, under revised Delegation of Authority No. 752, dated September 14, 1992, the authority to approve Project Authorizations executed by any USAID official, if the Project does not exceed \$50 million over the life of the project; does not exceed a ten year life; does not present significant policy issues; and does not require issuance of a waiver that may only be approved by the Administrator or Assistant Administrator. None of these exceptions applies in this case. You may therefore authorize this project.

RECOMMENDATION: That you sign the attached Project Data Sheet and Project Authorization, thereby approving the project design and authorizing the project.

Attachments:

1. Minutes of the Issues Meeting
2. Project Authorization
3. Project Data Sheet with Project Paper and Annexes

Clearance Page for Action Memorandum to the Mission Director recommending the signing of the Private Sector Population III Project Data Sheet and Project Authorization, thereby approving the project design and authorizing the project.

Cleared by: MAAnderson, HRD
DLosk, HRD
LSimard, DP
LGrizzard, CONT
TBeans, OCM
MWilliams, RLA
WNilsestuen, DMD

MAA 9/20/95
DLosk 9/20/95
(In-draft)
WJG 9/26/95
(In-draft)
(by E-mail)
WKN 9/26/95

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144

Clearance Page for Action Memorandum to the Mission Director recommending the signing of the Private Sector Population III Project Data Sheet and Project Authorization, thereby approving the project design and authorizing the project.

Cleared by: MAAnderson, HRD
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LGrizzard, CONT
TBeans, OCM
MWilliams, RLA
WNilsestuen, DMD

for CPT

(by E-mail)

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Clearance Page for Action Memorandum to the Mission Director recommending the signing of the Private Sector Population III Project Data Sheet and Project Authorization, thereby approving the project design and authorizing the project.

Cleared by: MAAnderson, HRD
DLosk, HRD
LSimard, DP
LGrizzard, CONT
TBeans, OCM
MWilliams, RLA
WNilsestuen, DMD

T. Beans 9-20-95

(by E-mail)

u:\dfpub\wpdata\projects\0389\action.mem

To: Marcela Moya@DF@TEGUCIGALPA
Leon Waskin@DF@TEGUCIGALPA
Cc:
Bcc:
From: Michael Williams@DIR@SAN SALVADOR
Subject: PSP III RLA clearance
Date: Tuesday, September 19, 1995 17:19:35 LOC
Attach:
Certify: N
Forwarded by:

RLA clears the packet of authorizing documents that you e-mailed to me for the PSP III project with the following comments:

1. Action Memo to the Director, page 3, delete the reference to FAA Section 110 and replace it with the appropriate refernce to Handbook 13. FAA 110 applies to grants to the host government and is not applicable here as a matter of law. You do have to comply with HB 13's requirement for a 25% NGO counterpart (or maybe the requirement is in what used to be HB 3). On the issues section, shouldn't you say that all issues have been satisfactorily resolved? To say that they have been partially resolved leaves the reader asking what happened to the part of the issue that was not resolved.

2. Project Authorization, looks fine, no comments.

3. Issues memo, looks fine. In my time, one recurring issue with ASHONPLAFA always was prestaciones and whether USAID would finance severance pay, especially in connection with the termination of one project and start-up of another. I am sure this issue was fleshed out during design.

4. Project Data Sheet, looks fine to me.

5. Annex 2, Results framework, looks fine, in fact it looks darned good.

6. Project paper, the parts that I read looked fine to me.

Please let me know if I can be of further assistance as this proceeds to obligation.

Mike

147

To: Marcela Moya@DF@TEGUCIGALPA
Cc:
Bcc:
From: Michael Williams@DIR@SAN SALVADOR
Subject: re: Clearance on FY95 Assistance Checklist for the PSP III Pro:
Date: Thursday, September 21, 1995 15:42:36 LOC
Attach:
Certify: Y
Forwarded by:

I reviewed the checklist and I don't see anything that needs to be changed.
It looks fine to me.

Mike

To: Michael Williams@DIR@SAN SALVADOR
Cc:
Bcc:
From: Marcela Moya@DF@TEGUCIGALPA
Subject: Clearance on FY95 Assistance Checklist for the PSP III Project
Date: Thursday, September 21, 1995 10:36:57 LOC
Attach: u:\dfpub\wpdata\projects\0389\annex7
Certify: Y
Forwarded by:

Mike,

Attached please the subject checklist (Annex 7 to the Private Sector
Population III Project) for your review/clearance. The Project Paper and
Authorization, which you already cleared by E-mail, are currently being
circulated for clearance in the Mission. Please let me know if you have any
comments/changes on the checklist ASAP. Thank you.

UNCLAS AIDAC

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ACTION: USAID-1
INFO: DCM-1 AMB-1 TOTAL-3 ECON-1

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E.O. 12356: N/A

TAGS:

SUBJECT: CORRECTION - CONGRESSIONAL NOTIFICATION ALERT

THE FOLLOWING CONGRESSIONAL NOTIFICATIONS EXPIRED WITHOUT
OBJECTION ON AUGUST 16, 1995. OBLIGATIONS MAY BE INCURRED
WHEN FUNDS ARE AVAILABLE.

522-0389 PRIVATE SECTOR POPULATION III - DOLS 2,309,000
DAF

TALBOTT
BT
#7640

NNNN

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PRIVATE SECTOR POPULATION III (PSP III)
(No. 522-0389)

Minutes of the August 30, 1995 Issues Meeting

1. ASHONPLAFA'S Corporate Culture and Leadership (ISSUE RESOLVED)

Background: The PP states (p. 4) that "If ASHONPLAFA is to become self-financing and sustainable, it must adopt additional values stressing productivity and efficiency, with the bottom line being an entrepreneurial mentality sensitive to opportunities for profit and loss. Such an organizational change is possible - with strong, determined and committed leadership from the Executive Director and the Board of Directors." It adds that "To achieve the results expected of this project, ASHONPLAFA needs senior executive staff with strong leadership, planning, finance and marketing skills. That staff needs to have both the charisma and authority to lead and command the synchronized implementation of many interdependent activities, as well as to make the hard decisions in human resource management which will be necessary as ASHONPLAFA focuses on performance and productivity."

Issue: Should the Cooperative Agreement to be signed with ASHONPLAFA include a clause for USAID's involvement on the designation of key positions and/or approval of key personnel in the Cooperative Agreement (designation of up to five individuals or five percent of employees, whichever is greater, is allowed under new procurement guidelines)?

Issues Meeting Resolution: It was decided that the Cooperative Agreement should not include such a clause for the following reasons:

- The politics of selecting or dictating any of ASHONPLAFA's key positions (i.e., Executive Director, Division Heads/Technical Council, and Directors of the Medical Clinical, Social Marketing, Community Services, and IEC Divisions) are too risky and potentially counterproductive to ASHONPLAFA's efforts to become sustainable;
- USAID expectations of this project are results-oriented not input-oriented (ASHONPLAFA will be evaluated on its progress towards meeting specific results, for which it should make its own personnel and other management decisions);
- USAID is not fully funding any of the key positions;
- USAID's involvement in the selection of candidates, approving scopes of work, or setting criteria for ASHONPLAFA's key positions would put the people currently occupying those key positions "at risk" and this could backfire on USAID.

However, the Mission should assure in its regular relationship with ASHONPLAFA that we would like to see the selection criteria for these positions.

2. Private Sector Population II (522-0369) Pipeline and PSP III FY 1995 Obligation (ISSUE RESOLVED)

Background: As of September 30, 1995, the pipeline of obligated but unexpended PSP II funds will be approximately \$2.4 million. The bulk of these funds will be devoted to ongoing expenditures of some \$1.0 million (including expenditures by PVOs) between that date and December 31, 1995. In addition, ASHONPLAFA expects to spend approximately \$400,000 in PSP II funds on the construction of a new regional clinic in San Pedro Sula, \$400,000 in PSP II funds on equipment, and \$50,000 on training by current PACD (March 31, 1996). Thus, there will be an unexpended balance of approximately \$550,000 by the current PACD.

Issue: Should PSP II be extended to finance PSP III activities for ASHONPLAFA and enable disbursing of PSP II pipeline? In preparing the PSP III budget, the pipeline for PSP II was not taken into account. If we extend the PSP II to finance PSP III activities we will have at least a pipeline of \$550,000. Should these monies go to PVOs?

Note: An extensive pipeline analysis has not been completed to date. Controllers and HRD will complete the analysis early next week and will have it for the Committee meeting on Wednesday, Aug. 30 at 11:00 am.

Issues Meeting Resolution: It was decided that the PSP II Project can be extended since it has not reached the 10-year limit. However, the Mission must be careful not to mix funds of both projects and should try to get PSP II "off the books" as soon as possible. HRD will prepare a proposal on how to best use this pipeline to be discussed with the Front Office.

Actions Taken After the Meeting: HRD and CONT have since performed a detailed pipeline analysis and have concluded that as of January 1, 1996 the PSP II pipeline will be \$1,400,000. Proposed expenditures after January 1, 1996 are as follows:

San Pedro Sula (SPS) Clinic	\$ 400,000
Medical Clinical Equipment (upgrading all clinics and equipping the SPS clinic)	600,000
Other Equipment (computers, xerox machines, etc.)	250,000
Vehicles	<u>150,000</u>
Total	1,400,000

Although there will be an overlap between PSP II and III, the Mission will not allow funding duplication during this overlap period. PSP II funds will be used to fund ASHONPLAFA operating costs through December 31, 1995. After this date, PSP II funds will only finance the above items. With the exception of USAID/W Global Bureau Field Support funds, no PSP III funds will be used until January 1, 1996. As of that date, all of ASHONPLAFA's operating costs will be funded with PSP III funds.

3. Private Sector Population II PACD Extension (ISSUE RESOLVED)

Background: PSP II was authorized on June 29, 1989 with an original PACD of June 30, 1994. The PACD was last amended to March 31, 1996. On November 7, 1994, the Mission Director signed an Action Memorandum which indicated his agreement with 1) the use of USAID project funding (\$400,000) to finance the construction of a new ASHONPLAFA clinic in San Pedro Sula, and 2) a PACD extension to March 31, 1996 to allow sufficient time for the clinic's construction, to spend existing obligated but unexpended funding, and to provide generous overlap between the project and the new POP III project.

As of this date, ASHONPLAFA recently completed the "pre-planos" for the San Pedro Sula clinic. Construction, however, has not yet begun and is not scheduled to begin for another two-to-three months. The most significant reason for the delay in the design and construction of the San Pedro Sula clinic was that ASHONPLAFA was unable to locate and consequently contract an architect with experience in design of hospital facilities. In May, 1995 ASHONPLAFA finally contracted such an architect, and since then progress in the design of the clinic has moved quickly. Construction of the San Pedro Sula Clinic will be completed no later than December 31, 1996.

Issue: In order to complete the construction of the San Pedro Sula Clinic with Private Sector Population II funds, the Mission will need to extend the current PACD from March 31, 1996 to December 31, 1996.

Issues Meeting Resolution: It was decided that for the construction purpose, the Mission should keep the pressure on ASHONPLAFA by extending PSP II only to September 1996.

4. Availability of Global Resources for PSP III (ISSUE PARTIALLY RESOLVED)

Background: The PSP III life of project (LOP) budget includes \$3.7 million of Global Bureau Resources (included in the Mission's 75% budget level projections). These resources will fund technical assistance (TA) from Cooperating Agencies (such as AVSC, POPTECH, Western Consortium, FPLM, FPMD, QA I Project, PRIME, PCS, SOMARC, and INOPAL) and contraceptives.

Issue: The Mission needs TA from FPLM, the QA I Project and PCS, but did not include them in the FY95 Global Field Support Request. Is procurement of these services an obstacle at this late date?

Issues Meeting Resolution: It was decided that HRD would follow-up on this question with the Cooperating Agencies. Also, it was decided that the Mission should consider using PSP II funds to procure TA through buy-ins (PIO/T) and verify if Global will accept buy-ins.

Actions Taken After the Meeting: Given rejection of an OYB transfer to the QA I Project

with FY95 funds, the Mission plans to make an OYB transfer to the follow-on project--QA II--with FY96 funds. PCS confirmed that an OYB transfer with FY95 funds is no longer possible and did not accept the option of a buy-in. PCS, however, is willing to advance funds for the provision of TA throughout FY96 provided that the Mission assures reimbursement of these funds with FY96 Field Support funds. Because of FPLM's PACD (December 31, 1995), FPLM will not accept a buy-in at this time. If the follow-on project (FPLM II) scheduled to begin on January 1, 1996 is authorized, the best option will be to request FPLM to advance funds for the provision of TA in FY96 provided that the Mission will reimburse it with FY96 Field Support funds (the same arrangement as with PCS), as opposed to a buy-in. A buy-in with PSP II funds would not be possible because the TA services to be provided will surpass the PSP II PACD.

5. Use of Incentives (ISSUE RESOLVED)

Background: The PP states that ASHONPLAFA will establish an institution-wide incentive plan to motivate its staff to increase productivity as well as cost efficiency. As stated on p. 26 of the PP, "Beginning in Year One, all ASHONPLAFA staff will have written semi-annual performance evaluations. For providers, a semi-annual quantitative minimum and maximum range of productivity target will be included. For key management, a quantitative level of self-sustainability for their respective departments will be included. All staff will receive their raises, which could be zero to the defined annual maximum, based on their achievement of the written semi-annual targets and goals."

Issue: Are there any USAID regulations that prohibit a USAID-funded family planning organization from using its own (counterpart) funds to support personnel incentive plans?

Issues Meeting Resolution: HRD informed that RLAs Clifford Brown and Michael Williams confirmed that there are no regulations prohibiting the proposed used of incentives. It was decided that the Mission should monitor the implementation of ASHONPLAFA's results-oriented incentive plan to ensure that there are no abuses in implementation. Operationally, this means that there are no material incentives being given to, nor coercion of, family planning beneficiaries.

6. ASHONPLAFA'S Rightsizing Efforts (ISSUE RESOLVED)

Background: In order to achieve the planned results under PSP III, ASHONPLAFA will need to assess its staffing levels, personnel qualifications, and past performance in each of its departments and programs. As stated in the PP (p. 24), ASHONPLAFA will have to present for USAID's approval, a plan for staffing, "rightsizing" and training to achieve the results of this project.

Issue: Should the Mission establish staffing ceilings for ASHONPLAFA to assure that staffing levels are compatible with the financial self-sufficiency targets?

Issues Meeting Resolution: It was decided that the Mission should stay out of personnel issues. The project's self-sufficiency targets and results should be the driving force. The personnel question should be tied to our yearly reviews of ASHONPLAFA's progress toward meeting those targets and results.

7. USAID's Funding Based on Results (ISSUE RESOLVED)

Background: As stated in the PP (p. 15), "USAID will decide whether to provide annual incremental funding to the Cooperative Agreement during its review of ASHONPLAFA's annual workplan and activity report (see Section V, "Monitoring and Evaluation", for full description of review process). These annual reviews will focus on progress toward planned results. USAID/Honduras will also provide extensive oversight of project implementation through joint monitoring, frequent consultations and formal external evaluations."

Issue: Is ASHONPLAFA fully aware and on board with this?

Issues Meeting Resolution: HRD informed the Committee that ASHONPLAFA staff is fully in agreement with this approach.

8. ASHONPLAFA'S Training Investment (ISSUE RESOLVED)

Background: USAID will fund technical assistance and training to ASHONPLAFA's staff in several areas, including Management Information Systems (MIS). The experience in other USAID-funded projects has shown that many times the investments made in training staff are lost because of personnel departures, changes in personnel, etc.

Issue: Should USAID require that ASHONPLAFA sign "training agreements" (similar to those signed by HOPS scholars) which require the staff to be trained to agree to work in ASHONPLAFA for a given period of time or repay the cost of the training?

Issues Meeting Resolution: HRD informed that ASHONPLAFA is already including this requirement in contracts. However, it was noted that this could be a double-edge sword because there may be a need to terminate someone's contract. A suggested solution was that the contracts refer only to "voluntary termination."

OTHER ISSUES DISCUSSED AT THE MEETING:

9. PSP III Impact on Maternal Mortality Reduction (ISSUE RESOLVED)

Background: The PP states (p. 1) that PSP III will contribute to reduce both Honduras' fertility rate (from 4.7 in 1995 to 4.2 by 2001) and Maternal Mortality Rate (no indicator is provided). Footnote No. 2 of the PP explains that the Mission uses maternal mortality ratio (maternal deaths per 100,000 live births) as the Strategic Objective No. 3 performance indicator and that this measure is not affected very much by reductions in fertility. The

footnote also states that it will not be possible to measure the impact of the project on maternal mortality during the life of the project.

Issue: Why does the PP mention that PSP III will contribute to the reduction of maternal mortality rate if, as the footnote clarifies, it will not be possible to measure the project's impact on that rate?

Issues Meeting Resolution: It was decided to clarify this issue upfront in the PP and eliminate the footnote. Also, it was decided that during the Action Plan preparation the Mission should determine whether there is a need to use the "maternal mortality rate" rather than "maternal mortality ratio", or both, as the performance indicator (s) of Strategic Objective No. 3. In the meantime, the Mission should assure that the Epidemiology and Family Health Survey (EFHS) includes both measurements.