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# USAID/HONDURAS: HIV/AIDS PREVENTION PROGRAMS EVALUATION

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## ACRONYM LIST

AHMF	Honduran Association for Women and Families
AIDS	Acquired immune deficiency syndrome
ASONAPVSI DAH	Honduran Association of People Living with HIV/AIDS
AIDSTAR	AIDS Support and Technical Assistance Resources
AED	Academy for Educational Development
ARV	Antiretroviral
AMDA	Asian Medical Doctors' Association
ANC	Antenatal clinic
ART	Antiretroviral therapy
BCC	Behavior change communication
BPHP	Business Planning for Health Program
BSS	Behavioral surveillance survey
CAI	Comprehensive care unit
CAS	Country Assistance Strategy
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CEPROSAF	Center for Health Promotion and Family Assistance
CHF	Community Housing Foundation
COMCAVI	Comunicando Cambio para la Vida Project (Communicating Change for Life Project)
COMISCA	Consejo de Ministros de Salud de Centroamérica (Council of Ministers of Health of Central America)
CONASIDA	National Commission on AIDS (Honduras)
CSW	Commercial sex workers
DHS	Demographic and health survey
ECOSALUD	Ecología y Salud (Ecology and Health)
ECVC	Encuesta Centroamericana de vigilancia de Comportamiento Sexual y Prevalencia de VIH e ITS (Central America Behavioral Surveillance and HIV/STI Prevalence Survey)
FP/RH	Family planning/reproductive health
FSW	Female sex worker
GFATM or Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOH	Government of Honduras
HIV	Human immunodeficiency virus
HIVOS	Humanist Institute for Development Cooperation
HSV	Herpes simplex virus
IAA	Interagency Agreement
IDUs	Intravenous drug users
IEC	Information, Education and Communication
IR	Intermediate Result

KAP	Knowledge, Attitudes, and Practices
KFW	German Cooperation Agency
LDP	Leadership Development Program
M&E	Monitoring and evaluation
MARPs	Most-at-risk populations
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MSM	Men who have sex with men
MSH	Management Sciences for Health
NGO	Non-governmental organization
PRODIM	Programas para el Desarrollo de la Infancia y la Mujer (Programs for the Development of Children and Mothers)
PSI	Population Services International
PASMO	Pan American Social Marketing Organization
PDI	Peer-driven interventions
PENSIDA I	First National HIV/AIDS Strategic Plan
PENSIDA II	Second National HIV/AIDS Strategic Plan
PENSIDA III	Third National HIV/AIDS Strategic Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PVO	Private voluntary organization
SOAG	Strategic Objective Grant Agreement
SOW	Scope of Work
STIs	Sexually transmitted infections
SW	Sex worker
TA	Technical assistance
ULAT	Unidad Local de Apoyo Técnico (Local Technical Assistance Unit)
UMIETS	Unidad de Manejo Integral de Enfermedades de Transmisión Sexual (Specialized Governmental STI Units)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNAH	National Autonomous University of Honduras
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
VICITS	Vigilancia Centinela de las ITS (Clinic-based STI services for testing and counseling/sexually transmitted infection control programs)

# EXECUTIVE SUMMARY

## PURPOSE OF THE EVALUATION

This evaluation was performed to:

- Determine the effectiveness of HIV/AIDS prevention programs for targeted beneficiaries;
- Document the degree to which program objectives have been met;
- Provide information about service delivery that will be useful to program staff and other audiences; and
- Enable program staff to make changes to improve program effectiveness.
- This effort focused on evaluating the impact of the following:
  - Behavior change communication (BCC) prevention activities
  - Sexually transmitted infection control programs (VICITS)
  - Condom social programming and marketing
  - Voluntary HIV counseling and testing programs
  - Local capacity building
  - Social mobilization for empowerment of men who have sex with men (MSM)

Evaluation results will be used by USAID/Honduras to make informed decisions about future HIV-prevention programming.

As part of the effort, the Evaluation Team (the Team) performed a desk review of documents, some provided by USAID, and data collected through internet searches, site visits and discussions with local counterparts. During a team planning meeting in Tegucigalpa, the evaluation framework discussed at an orientation meeting with USAID was drafted. The Team then met with the partners and other stakeholders identified by USAID and made site visits to projects both outside of and in Tegucigalpa. After an initial debriefing with USAID, the Team held separate discussion sessions with stakeholders and implementing agencies to share initial impressions from the field and receive further feedback. Primary information came largely from structured in-depth discussions with key informants and group discussions at various levels of the health system. Quantitative information came from a desk review of secondary data sources. In addition, the Team directly observed a number of education activities and met with clients in Tela, San Pedro Sula, Comayagua and Tegucigalpa, visited condom sales posts, checked stock for availability and pricing, and checked display materials in Garifuna villages and at high-risk points of sale. The Team also visited VICITS and Unidad de Manejo Integral de Enfermedades de Transmisión Sexual (UMIETS) in Tegucigalpa, San Pedro Sula, and La Ceiba.

Each of the five evaluation component areas—(1) behavior change communication activities, (2) sexually transmitted infection control programs, (3) condom social programming and marketing, (4) voluntary HIV counseling and testing programs, and (5) local capacity building of prevention programs—were assessed for relevance, effectiveness, efficiency, impact, and sustainability. At the USAID Mission’s request, the Team evaluated the social mobilization activities as a sixth component.

## BACKGROUND

The HIV epidemic in Honduras is both concentrated among certain population groups and generalized in some areas of the country, such as the north. The HIV epidemic is especially prominent among MSM, ethnic minorities, such as the Garifunas, male and female sex workers (FSWs), and prisoners.<sup>1</sup>

Beginning in 1995, USAID/Honduras stepped up its assistance for HIV/AIDS activities through the USAID/Washington AIDSCAP Project, which included a large non-governmental organization (NGO) sub-granting and strengthening component. This was followed by an umbrella grant to a local NGO, *Fundación para el Fomento en Salud*, formed by former AIDSCAP staff. A 1999 evaluation found the strategy of working through an HIV/AIDS network sound, but also found that the program needed to focus on high-risk groups. Changes were made accordingly.<sup>2</sup> In 2000, USAID invited Population Services International's (PSI) Central American affiliate organization, the Pan-American Social Marketing Organization (PASMO), to initiate a condom social marketing program for high-risk groups. The same year, the Population Communications Services Project also began work on a national media campaign.

In 2002, the Mission awarded a cooperative agreement to the Academy for Educational Development (AED), with PSI as a sub-contractor, to initiate the *Comunicando Vida* project, which, since that date, has been the primary umbrella model for its HIV/AIDS prevention efforts through NGO networks. Two years later, coinciding with the Mission's new Strategic Plan period, the Mission awarded a four-year cooperative agreement (2004 – 2008) to the same group for the *Comunicando Cambio para la Vida Project* (COMCAVI). COMCAVI's objectives were:

- Supporting NGO capacity to implement sustainable HIV/AIDS activities;
- NGO implementation of high-quality programs for the care of people living with HIV/AIDS;
- NGO implementation of effective HIV/AIDS interventions reaching most-at-risk populations (MARPs); and
- Coordination between NGOs in the COMCAVI program and other programs and institutions.

COMCAVI awarded three 13-15 month grant cycles, with 8 to 11 grantees participating in each cycle. An innovation beginning with the second grant cycle was the implementation of Voluntary Counseling and Testing (VCT) through NGOs under the technical supervision of the Ministry of Health (MOH). COMCAVI provided the NGOs technical assistance in monitoring and evaluation (M&E), including baseline and follow-up Knowledge, Attitude and Practices (KAP) studies. USAID extended the cooperative agreement for an additional year, through September 2009.

Current USAID/Honduras HIV activities are:

- PASMO/ABT: Condom distribution in high-risk outlets.
- AIDSTAR-Two/MSH: NGO BCC and VCT programs; development of a small-scale social mobilization program to address detrimental social norms that increase vulnerability among MARPs; and building of the capacity of local NGOs working to prevent HIV/AIDS among MARPs that receive United States Government (USG) funding, as well as those funded by the Global Fund.
- AIDSTAR-One/JSI: NGO care and support programs for people living with HIV/AIDS (PLWHA) and technical support to strengthen the national response to HIV/AIDS through improved provision of prevention, prevention of mother-to-child transmission (PMTCT), counseling and testing, treatment, and care and support services.

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<sup>1</sup> World Bank Global HIV/AIDS Program and Latin America and the Caribbean Region. "Planning for Results: The Case of Honduras," November 23, 2009.

<sup>2</sup> C. Cortez, et al. "Evaluation of the AIDS/STD Prevention and Control Project" (522-0216). USAID/Honduras.

- U.S. Centers for Disease Control and Prevention (CDC)/Interagency Agreement (IAA): Data collection and reporting systems related to the above; design and implementation of systems to measure national HIV sero-prevalence high-risk behaviors among high-prevalence groups; design and implementation of program monitoring and evaluation mechanisms; and strengthening of the sentinel surveillance (VICITS) of sexually transmitted infections (STIs) in sex workers and MSM.

## GENERAL OBSERVATIONS

USAID/Honduras and its international and local partners are to be lauded for implementing a country-appropriate and quality HIV/AIDS program and for maintaining services to high-risk and vulnerable populations through a difficult period, including the recent political upheaval. USAID's contribution is widely recognized and appreciated by stakeholders, partners and service clients, and USAID is a major player in national policy activities. Although attribution is always difficult, USAID's prevention program has probably made an important contribution to containing the spread of the epidemic. This report documents some of USAID's contributions and provides suggestions for improvements. However, the overall strategy and mix of program activities and services is sound and should be continued. One cross-cutting theme is the need to apply more sophisticated peer networking methods, interpersonal and electronic, for client recruitment to increase program coverage of hidden populations.

Currently, there is a national leadership vacuum in this area in Honduras, partly due to the recent political situation and partly due to a belief that the resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM or the Global Fund) have the problem under control. The National Commission on AIDS (Honduras) (CONASIDA) has been inactive as has the Information, Education and Communication (IEC) committee that instigated coordination and policy support for BCC efforts. The MOH National STI/AIDS Program has had a much lower profile than in previous years, and their intramural BCC actions appear weak. HIV/AIDS also appears to have dropped off of the interagency coordination radar screen. Leadership of some affected populations has not matured sufficiently to provide a unified and effective advocacy voice, often due to competing personal and institutional interests. Some important service delivery programs, such as VICITS, do not have a systematic client feedback mechanism for effective social auditing.

Data is being collected, but at present there is limited evidence of in-depth analysis or the use of strategic information for decision making. Best practices in prevention developed through USAID technical assistance and grants have not been sufficiently disseminated and adapted by other projects. Capacity building among the multiplicity of NGOs receiving HIV/AIDS grants has not been sufficiently strengthened through GFATM umbrella organizations.

There have been some very good examples of coordination, but more can be done in this area. AIDSTAR-Two worked closely with the Community Housing Foundation (CHF) to avoid duplication of grant activities, and its capacity-building technical assistance to GFATM sub-grantees has helped promote coordination. This model could be expanded to include prevention for GFATM grantees to promote best practices and harmonize messages. Cooperation could also be strengthened between the VICITS and the NGOs and between the Comprehensive Care Units (CAUs) and Honduran Association of People Living with HIV/AIDS (ASONAPVSI DAH). The result would be improved comprehensive care, including follow-up and extension of community-based palliative care and prevention services.

The USAID prevention activities are complementary, and the players know each other well. Some of the AIDSTAR-Two prevention NGOs coordinate well with PASMO, but others have less interest and appreciation of social marketing. NGOs need to consider diversifying suppliers and sources of revenue for funds in preparation for the time when condom donations and MARPs prevention activities diminish.

The transgender populations, the most affected group in terms of both HIV prevalence and social vulnerability, require further attention. The high-risk population about which the least is known is drug

users. The Central American Behavioral Surveillance Plus Studies (ECVC) data show alarming rates of injected drug use, with some users sharing syringes. Also alarming is the use of other dangerous drugs, such as crack.

Intervention efforts can have their effectiveness enhanced through improved strategic information, including further analysis and dissemination of program and study data. Quantitative data needs to be enriched by ethnographic studies. Other populations that could benefit from further ethnographic studies are the male sex workers (Zopes) who service men and women, transgender sex workers, transactional sex workers (waitresses, food vendors, etc., who do not consider themselves commercial sex workers [CSWs]), and the new generation of electronic networking sex workers.

There is a generally high level of satisfaction among the Garifuna, especially with the communications program, which they thought was effective in involving youth and changing their attitudes and behaviors, particularly in terms of mutual respect. They also had positive comments on the capacity-building activities for leadership development and the development of a business plan. FSW leaders and mentors also expressed satisfaction and gratitude, and several mentioned personal life changes, such as giving up alcohol and drugs (except when with clients). While in one sense the leaders-mentors activity can be considered a best practice, it is also labor intensive, costly, and difficult to scale up.

Nevertheless, the transgender community and MSM outside of the San Pedro Sula area both strongly expressed the opinion that they were not sufficiently attended to and/or involved in USAID-sponsored project activities. A variety of factors, including leadership problems and rivalries among the MSM community, halted the social mobilization process for policy advocacy for this group. There were also a number of questions raised about the transparency and fairness of the sub-granting process by non-recipients, so care needs to be taken in this area.

Honduras has been a leader in the development of trained professional HIV/AIDS human resources personnel who have left their positions to work for international development agencies. This migration creates the need for a constant upgrading of human resources, along with the adoption of policy instruments that transcend changes in personnel and governments.

Client ownership and organizational capacity are also important for sustainability. For the Garifuna, this means further community organization and strengthening of community governance, leadership, and conflict resolution under the health promotion model. For sexually diverse populations, it means further strengthening in leadership; advocacy and policy dialogue; proposal development and linkages with international sexual diversity advocacy groups; and conflict resolution. Another option to mitigate financial vulnerability may be to explore linkages between existing programs for credit and income-generation projects with key NGO MARPs partners as part of the capacity-building program. The PASMO condom social marketing program's commercial marketing activities are currently financially self-sufficient although the current level of support for the high-risk sales points is not. Sustainability of programs for FSWs is more problematic. The most effective approach may be to focus on mature organizations, programs and structures that best serve and represent their interests. Organizations that are affiliated with international Private Voluntary Organizations (PVOs) have an advantage in terms of accessing funds, and the Mission might want to consider promoting further partnering.

HIV/AIDS programs for MARPs are particularly vulnerable in the policy arena as well as in the financial one. The country has made strong commitments to universal access to anti-retroviral therapy (ART) and PMTCT. Without the injection of finances from the GFATM and agencies such as USAID, there will be no real pressure to maintain basic prevention services, such as the provision of condoms and Voluntary Counseling and Testing (VCT), much less Information, Education and Communication (IEC) and interpersonal prevention. Without international agency advocates at their side, MARPs will have little leverage when competing for scarce public health resources, much less for combating stigma and discrimination.

## I. BACKGROUND

The purpose of this evaluation is to determine the effectiveness of HIV/AIDS prevention programs for targeted beneficiaries by documenting the degree to which program objectives have been met; providing information about service delivery that will be useful to program staff and other audiences; and enabling program staff to make changes that improve program effectiveness.

The evaluation effort focused on the impact of prevention activities, inclusive of, but not limited to, mass media campaigns targeting most-at-risk populations (MARPs), theater groups, behavioral change communication (BCC) activities, social mobilization, condom social marketing, clinic-based sexually transmitted infections services for testing and counseling (VICITS) for MARPs, and local capacity building. The evaluation report includes a description and analysis of progress made in meeting program objectives, coordination of USAID-funded activities with the Ministry of Health (MOH) and other donor programs, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM or the Global Fund), and recommendations for further refining the program. The findings of this evaluation—which covers the most recent Mission HIV/AIDS Strategic Plan period that began in 2004 and continued to the present<sup>3</sup>—will be used by USAID/Honduras to make informed decisions about future HIV prevention programming in Honduras.

In June 2004, USAID/Honduras and the Government of Honduras (GOH) signed a Strategic Objective Grant Agreement (SOAG) for the Health Activity under the Mission’s Strategic Objective, “Investing in People.” The original completion date of the SOAG was September 30, 2009, which was subsequently extended through September 30, 2011. In collaboration with the MOH and civil society partners, the HIV-related component of the SOAG contributes to the achievement of the intermediate result, “HIV and Other Infectious Diseases Contained.”

To that end, the USAID HIV program provides assistance to (i) prevent the transmission of HIV; (ii) provide basic care and support services to people with HIV/AIDS; (iii) measure changes in the prevalence of HIV infection and risk-taking behavior; and (iv) increase the capacity of the National AIDS Program to monitor and evaluate HIV/AIDS activities. These activities have been carried out in those geographical areas (see below) with the highest prevalence of HIV/AIDS infection and focus on MARPs, namely commercial sex workers (CSWs), transgender people, men who have sex with men (MSM), the Garifuna Afro-Caribbean ethnic group, and people living with HIV/AIDS (PLWHA).

As follow-on to the SOAG, the Mission is in the process of developing a new Assistance Agreement with the GOH for implementation of its new Country Assistance Strategy (CAS) for the period 2009-2013. Under the CAS, the HIV component focuses on the improvement of the health status of CSWs, transgender people, MSM, the Garifuna, and PLWHA.

Under this new Strategy, the Mission aims to:

- i. Increase access to quality prevention services, especially for MARPs;
- ii. Increase access to quality clinical and community care and support services for HIV-infected adults and their families;
- iii. Strengthen the organizational and technical capacity of local NGOs to implement prevention activities and expand community-based HIV counseling and testing among MARPs;
- iv. Support mass media communication and community mobilization;
- v. Strengthen the MOH’s national HIV surveillance and monitoring and evaluation systems; and
- vi. Provide technical assistance to improve supply chain management for antiretroviral drugs.

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<sup>3</sup> Honduras HIV/AIDS Strategic Plan, 2004–2008, August, 2003.

Under its new Results Framework (currently pending approval in Washington), the Mission will seek to achieve Intermediate Result (IR) 4.3, “Use of Quality HIV/AIDS Services Expanded,” under Assistance Objective 4, “Health status for underserved and vulnerable populations improved.” This IR is supported by two Sub-IRs—Sub-IR 4.3.1: Access to quality prevention services for most-at-risk populations and Sub-IR 4.3.2: Quality of HIV/AIDS treatment and care and support services improved.

The focus of this evaluation is primarily on Sub-IR 4.3.1, Access to quality prevention services for most-at-risk populations. The associated HIV prevention indicators are as follows:

- i. Percentage of MARPs reporting use of condom with most recent partner (disaggregated by population);
- ii. Percentage of MARPs reporting reduction of partners during last 12 months (disaggregated by population);
- iii. Number of target population reached with individual and/or small group-level preventative interventions based on evidence;
- iv. Number of local organizations provided with technical assistance for HIV-related institutional capacity building; and
- v. Number of individuals who received counseling and testing for HIV and received their results.

In March 2010, the United States Government (USG) signed a Central American Regional HIV/AIDS Partnership Framework (the Framework) with COMISCA, the Central American Council of Ministers of Health. The Framework outlines the general strategy for USG assistance in the region. Although the Honduras program is bilateral, it must also fit within the general outlines of the Framework, which offers the USG the opportunity to partner with Central American governments, regional and national agencies, civil society, and other donors to influence and mitigate the impact of the HIV epidemic through focused technical assistance and capacity building of persons and health systems. In the case of bilateral missions such as Honduras, “activities under this regional Framework are intended to support, complement and coordinate with existing USG bilateral HIV programs to ensure that activities not managed through the USG regional HIV program contribute to supporting the major goals of the Framework.”

## **ANALYSIS OF THE HIV EPIDEMIC**<sup>4,5</sup>

The HIV epidemic is both concentrated among certain population groups and generalized in some regions of the country, such as the north, with HIV prevalence rates exceeding one percent among pregnant women.<sup>6</sup> The HIV epidemic is particularly severe among MSM,<sup>7</sup> ethnic minorities (such as the Garifunas), male and female sex workers, and prisoners.

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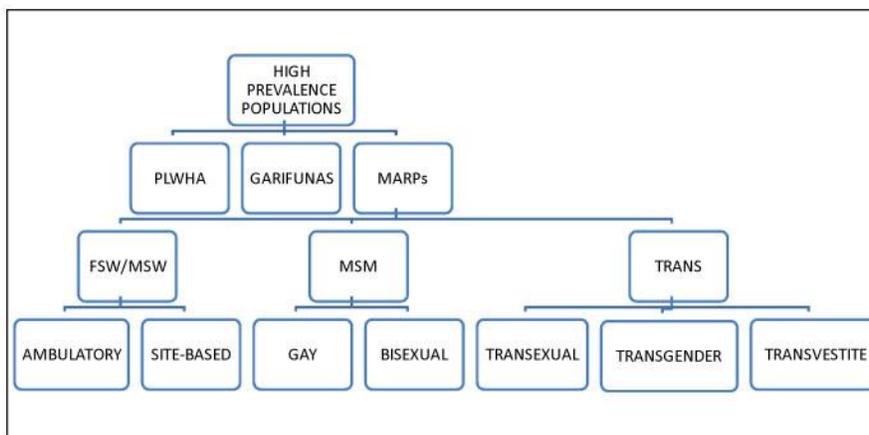
<sup>4</sup> Much of the data in what follows is derived from “III Plan Estratégico de Respuesta al VIH en Honduras: PENSIDA III (2008-2012),” Tegucigalpa, Honduras. December 2007.

<sup>5</sup> This section has been adapted and edited from the World Bank document, “Planning for Results, The Case of Honduras,” November 23, 2009. In some instances, parenthetical comments [ ] have been inserted.

<sup>6</sup> The following description is based on “Building on Evidence: A Situational Analysis of the HIV Epidemic and Policy Response in Honduras.” Global HIV/AIDS Program. World Bank. 2008.

<sup>7</sup> In the available data, the category MSM is exceptionally broad, comprising [gay] males, transvestites, transsexuals, [transgender], [some heterosexuals] and bisexuals.

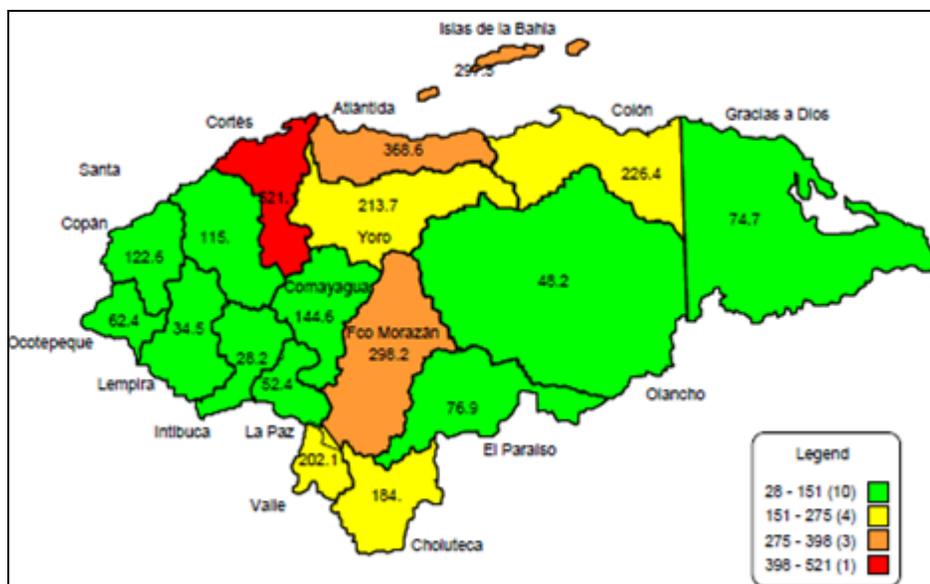
**Figure 1. High HIV-Prevalence Populations in Honduras**



### Geographical Distribution

All 18 departments of Honduras have reported some AIDS cases. However, as previously mentioned, the HIV epidemic in Honduras is a relatively concentrated phenomenon, that is, there is a strong geographical concentration of cases.

**Figure 2. Cumulative AIDS Cases per 100,000 Inhabitants (1985-2005)**



Source: Department of STIs/HIV/AIDS, Health Secretariat, Honduras

Reported cases of HIV are heavily concentrated by geographic area, reaching the status of a generalized epidemic along two axes, which together form a “T”: east-to-west along the northern Atlantic coast (Cortés, Atlántida) and the islands (Islas de Bahía) and north-to-south from Cortés to the capital Tegucigalpa (in Francisco Morazán) and continuing southward to Valle on the Pacific coast. Together, these regions constitute the vast majority (71%) of all reported AIDS cases since 1985. In contrast, relatively few AIDS cases have been reported in the eastern and the western part of the country.

A key factor in the geographical distribution of the epidemic has been its concentration in two urban areas—San Pedro Sula in Cortés and Tegucigalpa in Francisco Morazán. A key challenge is to determine whether the heavily urban character of AIDS in Honduras has to do primarily with the concentration of

sex workers or if other factors come into play. Other key concentrations are more easily explained by the prevalence of the Garifuna population in the islands and La Ceiba and in Atlántida, a major port and landing point from the islands. But some developing trends require further explanation. For example, recent data show that some cities in the southern department of Valle report a growing number of AIDS cases, suggesting a potentially worrying geographical shift, whose causes must be determined and confronted.

## **Age and Sex Distribution**

As in other countries, HIV in Honduras primarily affects younger, economically and reproductively active people, and since the onset of the epidemic in Honduras, those between 15 and 39 have constituted between 65 and 70% of all reported cases. While the analysis of the epidemic's age distribution is fundamental for policy-making purposes, even more suggestive of the epidemic trends is the significant shift seen in the infection ratio between men and women.

In 1994, this ratio was 1.7:1.0, suggesting an early prevalence among MSM and the exceedingly mobile male Garifuna population. But as the epidemic gained ground among sex workers and women in the Garifuna community, the ratio fell to 1.1:1.0 in 2005; among the newly infected cases, the vast majority are women, with a ratio of 0.6:1.0. *[It is not clear as to how much of this apparent shift is a reporting artifact due to increased contact of young women with health services such as the PMCT program].* However, current projections suggest that this new imbalance may have peaked and may begin to recede as the brunt of new infections is estimated to fall on the MSM populations and (largely male) clients of sex workers.

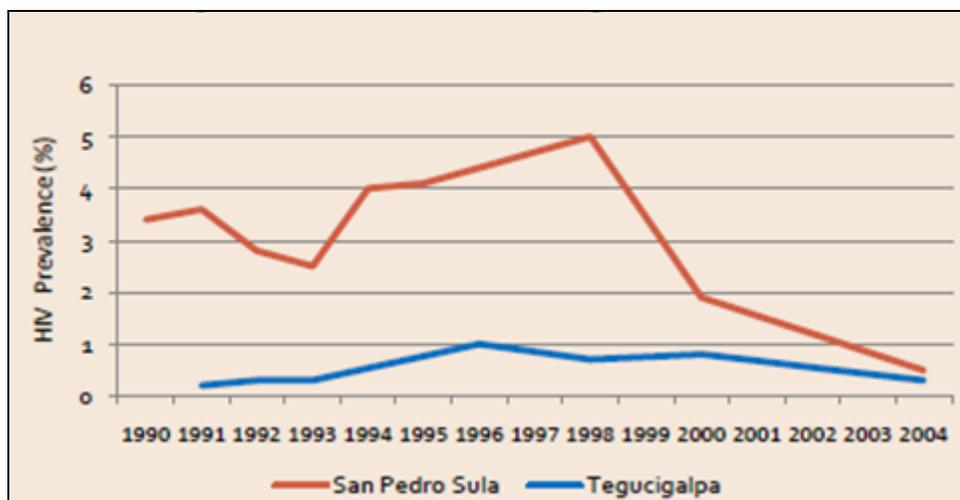
## **PREVALENCE IN SPECIFIC POPULATIONS**

### **Pregnant Women**

Early surveillance data showed an infection rate among pregnant women attending an antenatal clinic (ANC) in San Pedro Sula of 3.4% in 1990 and 4.1% in 1995, and in Tegucigalpa of 0.2% in 1991 and 1.0% in 1996. These data gave rise to projections that the HIV prevalence rate would reach double digit figures within the decade, suggesting the possibility of a spread of the epidemic throughout the population. However, newer data from the PMTCT program (prevention of mother-to-child transmission)—which came into force in 2001—has painted a more optimistic picture.

As shown in Figure 3, HIV prevalence in ANC clinics—rather than continuing to rise—appears to have declined in both major cities, and a broad, eight-city study carried out in 2004 showed a prevalence of just 0.46%. While the geographical expansion of the PMTCT program makes it difficult to identify clear causes for the statistical decline, prevention efforts and the PMTCT program may have played a significant role in reducing HIV prevalence among the general population.

**Figure 3. HIV Prevalence among ANC Attendees**

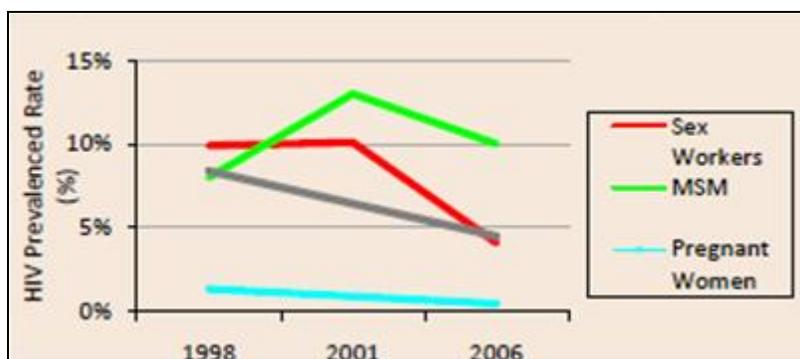


Source: Secretaría de Salud de Honduras, Various surveys conducted at ANC clinics.

### Sex Workers, Men Who Have Sex with Men, and Garifunas

As with pregnant women, the data suggest that HIV prevalence has decreased among these three most at-risk populations (Figure 4). The MSM population experienced a sharp increase—from 8% prevalence in 1998 to 13% in 2001—before dropping to 10% in 2006. The [rate among] the sex worker population [prevalence was steady] [increased] from 9.9 to 10.1% during the same years—but then declined sharply to 4.1% in 2006 [Encuesta Centroamericana de vigilancia de Comportamiento Sexual y Prevalencia de VIH e ITS - Central America Behavioral Surveillance (ECVC) Study]. The Garifuna population saw a steadier decline in HIV prevalence, from 8.4% in 1998 to 4.5% in 2006 [ECVC Study]. However, several qualifications are required. First, the decline is statistically significant only for sex workers. Second, as these data come from different studies with different methodologies, it is important to note that they are not necessarily comparable across time.

**Figure 4. HIV Prevalence Rate in Selected Populations**



Source: Studies of HIV Prevalence and Other STIs and Behavior. 1998 and 1999 Multicenter Study, Health Secretary/PASCA 2001. ECVC Secretary/CDC/GAP/CAP/USAID, 2007.

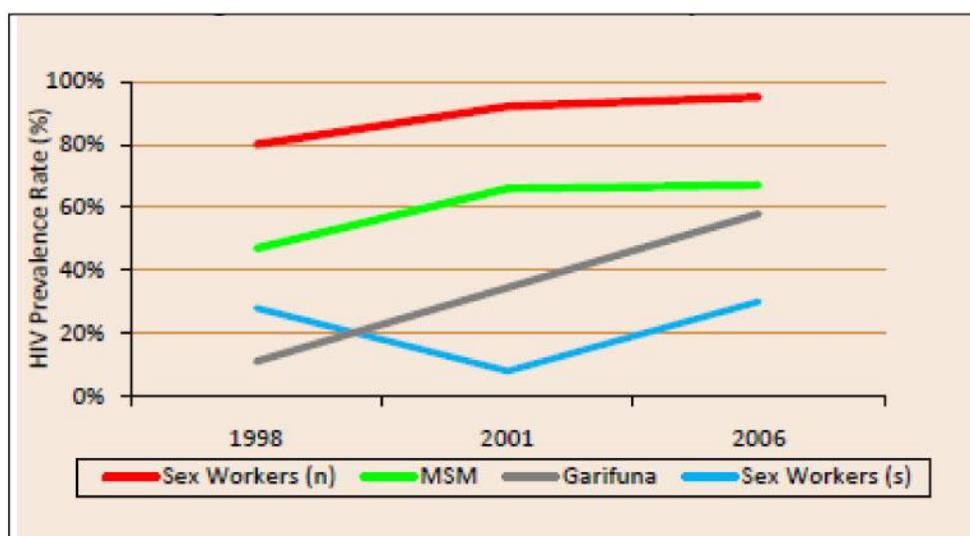
The persistence of HIV prevalence in the MSM population is of considerable concern, especially given increased condom use (see the next paragraph). It could suggest a contribution of further risk factors, most obviously sexually transmitted infections (STIs) such as syphilis, to the epidemic's intractability in that group. Another plausible explanation is that the high prevalence of multiple concurrent partners among this group that makes for a relatively large proportion of sexual contacts during the very highly

contagious acute stage of HIV infection. Furthermore, this persistence, alongside the sharp decline in HIV among sex workers, may suggest that current trends toward the feminization of the epidemic are occurring through *other* populations, such as the clients of sex workers transmitting HIV to their wives or other partners, and perhaps female sex partners of MSM who also have sex with women.

## Knowledge and Behavior

Awareness of HIV in Honduras is nearly universal—98% of women have heard of AIDS. Among that group, 89% know that AIDS can be avoided by having sex with only one uninfected partner, and 70% know that infections can be avoided by the use of condoms. The level of knowledge about HIV is higher among subpopulations at highest risk of infection (with the exception of PLWHA surveyed in 2006). For example, in 1998, 76% of MSM knew that condoms reduce the risk of HIV infection, and by 2001, the percentage had risen to 97%. Almost all sex workers (99%) knew that condom use reduces the probability of transmission of HIV. Better yet, condom use among at-risk population groups has increased in recent years (Figure 5) although it remains low [38 – 57% - see *Comparative Condom Use Tables 11 - 14*] among sex workers with regular partners.

**Figure 5. Condom Use in Selected Populations**



Source: Sierra M.A., Paredes C., Pinel R., Fernandez J., Mendoza S., Branson B., Soto RJ. “Estudio Seroepidemiológico de VIH, Sífilis y Hepatitis B en hombres que tienen sexo con hombres de Tegucigalpa y San Pedro Sula Honduras,” 1998. Secretaría de Salud de Honduras. Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y Comportamientos en Poblaciones específicas en Honduras,” 2003. CDC. “Versión preliminar de los informes de la Encuesta Centroamericana de Vigilancia de Comportamiento en Homres que tienen sexo con Hombres y de Trabajadoras Sexuales”, 2007.

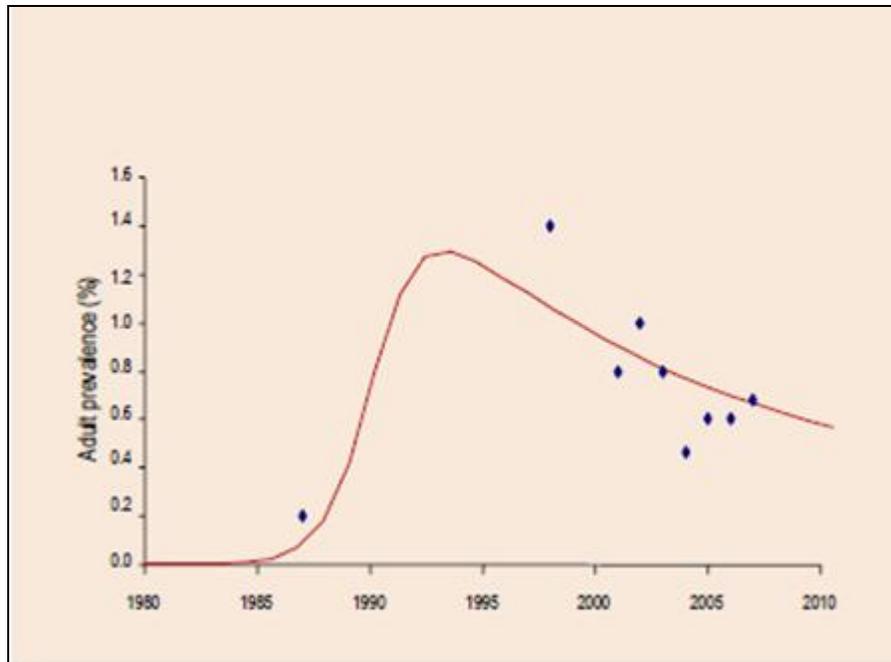
**Note:** The term sex workers (n) refers to condom use with new partners; sex workers (s) refers to stable partners.

## EVOLUTION OF THE HIV EPIDEMIC

One of the most important tasks of the [World Bank] planning team was to review the available evidence, revise the estimate of HIV prevalence, and predict future trends in Honduras. The analysis had an important conclusion: it showed that earlier predictions of rapid growth of the epidemic—possibly due to poor [or incomplete] data—were not accurate. Instead of increasing, the analysis of the data showed that the national HIV prevalence rate has steadily declined in recent years and reached 0.7% in 2007 (Figure 6). While it is too early to say for sure, several possible causes for the past and predicted

decline in HIV prevalence stand out. The natural course of the epidemic (and the death of people infected early in the epidemic) could have contributed to this trend. The picture is certainly complex, but it does suggest that improved knowledge and behavioral changes, and especially the significant shift in condom use in affected populations, could have helped to bring about the decline.

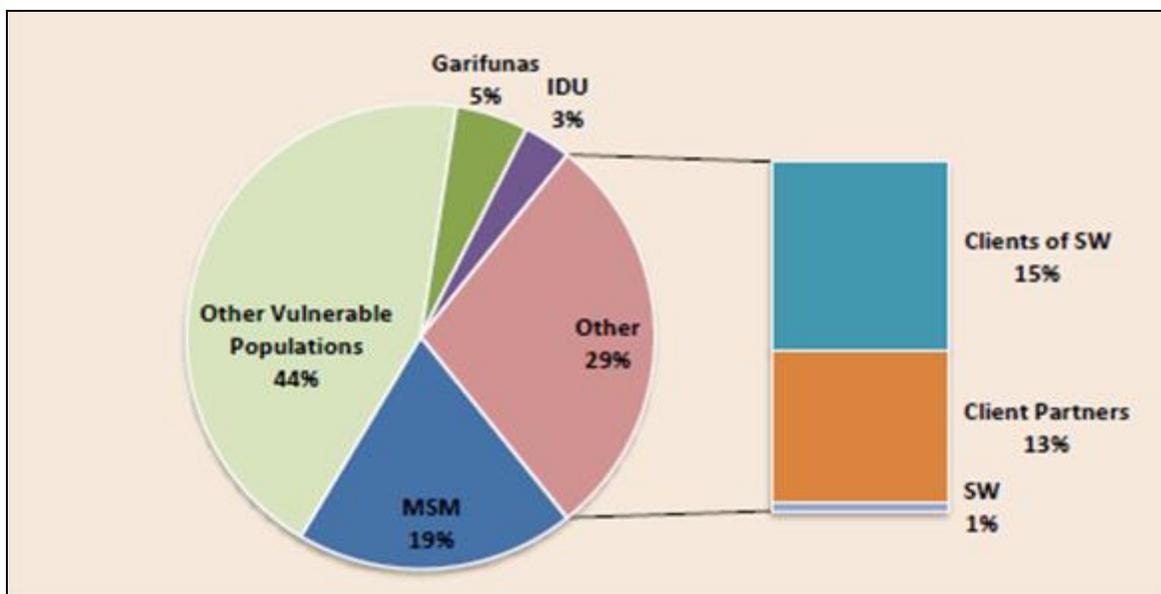
**Figure 6. HIV Protection, % Adult Prevalence (1980-2010)**



Another tool used by the [World Bank] team was the Modes of Transmission Model, which shed some light on the source of new infections (Figure 7). It was estimated that 1,500 new infections occurred in 2007. The Garifuna population contributed 5%, given their relatively small numbers, high use of condoms, and decline in HIV prevalence in recent years. MSM, sex workers, clients of sex workers and the wives of clients together accounted for 48% of new infections. The most striking result was that only 1% of new cases are expected to be among sex workers, but 15.3% of new cases would occur among their clients and 12.4% among the partners of those clients. This result showed clearly that it is not enough to target sex workers; efforts have to be directed at their sexual networks as well.

While the spread of HIV into the general population is important to recognize and address, it nonetheless remains critical to maintain a strong focus on those groups that continue to have the highest risk of infection. MSM and sex workers have HIV prevalence rates nearly 10 times higher than that of pregnant women. Their sexual partners may create a bridge for HIV to spread to the general population.

**Figure 7. Modes of Transmission**



## **THE RESPONSE TO HIV/AIDS IN HONDURAS<sup>8</sup>**

### **Government of Honduras**

The Honduran Government (GOH) has coordinated HIV/AIDS control efforts through a series of three National HIV/AIDS Strategic Plans (PENSIDA I, II and III). During PENSIDA I, the GOH formed the National AIDS Council (CONASIDA) with the mandate to coordinate national policies and programs. PENSIDA III (2008 – 2010), which featured an excellent analysis of the epidemic, emphasizes scaling up prevention efforts for most-at-risk populations and for preventing mother-to-child transmission. Considerable national resources are being dedicated to care, particularly on the North Coast.

According to key informants, including one member of CONASIDA, the National AIDS Council has been inactive due to recent political upheavals and tensions, but there are hopes that it will be reactivated and take a leadership role in the national coordination of the Three Ones. However, as constituted, it is a bit of an anachronism, with a very heavy weighting on the official sector. To be more effective and relevant, CONASIDA should find a way to broaden the participation of civil society and affected populations, possibly through a revision of its by-laws.

### **Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM or the Global Fund)<sup>9</sup>**

Honduras was awarded a Round I Global Fund HIV/AIDS grant, with the United Nations Development Programme (UNDP) serving as the Principal Recipient. The Global Fund approved continuing support on a rolling basis for an additional six years. Since May 2008, the Honduras Country Coordinating Mechanism (CCM) has chosen the Community Housing Foundation (CHF) as the country's Principal Recipient.

<sup>8</sup> R. Barber-Madden, et al, Evaluation of COMCAVI Umbrella Grants Program for HIV/AIDS Prevention Program in Honduras, GH Tech Project (Report No.08-001-84, 2008).

<sup>9</sup> Evaluation of the prevention component of USAID/Honduras's HIV/AIDS strategy, Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01.

The three main objectives of the Global Fund's program in Honduras are to:

- I. Promote and defend the human rights of PLWHA;
- II. Protect at-risk populations through adoption of risk-reducing behaviors; and
- III. Strengthen comprehensive, integrated services for PLWHA.<sup>10</sup>

Honduras received an initial HIV/AIDS allocation of \$27.3 million from the Global Fund for 2003-2008. At the Global Fund's invitation, Honduras submitted a proposal to extend this grant, and a \$47 million extension of the program to 2014 was approved. Under Objective 2, the Global Fund, through CHF as the Principal Recipient, has awarded over 45 grants to local non-governmental organizations (NGOs) to work with MARPs and vulnerable populations (youth). To channel such grants, four NGOs serve as an umbrella mechanism: Kukulkan; *Liga de la Lactancia Materna*; Asian Medical Doctors' Association (AMDA); and Center for Health Promotion and Family Assistance (CEPROSAF). In addition, the number of municipalities has increased from 39 to 69, allowing the extension of antiretroviral (ARV) therapy coverage and increased prevention activities among such high-risk groups as CSWs, MSM, prisoners, vulnerable youth, and the Garifuna. Recent coordination between USAID and CHF/the Global Fund to avoid redundancies has been quite successful. NGO proposals for USAID grants are reviewed by a CHF/AIDS Support and Technical Assistance Resources (AIDSTAR) Two inter-institutional committee, and USAID has provided important capacity-building technical assistance to Global Fund grantees working with CSWs and MSM through the AIDSTAR-Two project (see below).

Recently, the Global Fund approved a ninth round of an HIV/AIDS grant for a maximum of \$21.9 million over a five-year period to provide support to orphans and vulnerable children in 25 priority municipalities.

## **Other Multilateral and Bilateral Cooperation**

Outside of the Joint United Nations Programme on HIV/AIDS (UNAIDS) agencies, there are few international donors active in Honduras that lead an expanded Technical Group which facilitates policy dialogue, coordination and strategic planning. Other HIV/AIDS donors (including international private voluntary organizations [PVO]s) recently active in Honduras include the Swedish International Development Agency, Canadian International Development Agency, Department for International Development (United Kingdom), Humanist Institute for Development Cooperation, Christian Aid, Catholic Relief Services, German Cooperation Agency, Cooperative for American Relief Everywhere, Inc. (CARE), and the Red Cross.<sup>11</sup>

## **USAID's HIV/AIDS Activities in Honduras<sup>12</sup>**

Beginning in 1995, USAID/Honduras stepped up its assistance for HIV/AIDS activities through the USAID/Washington AIDSCAP Project, which included a large NGO sub-granting and strengthening component. This was followed by a grant to a local NGO, *Fundación para el Fomento en Salud*, created by former AIDSCAP staff. A 1999 evaluation found that the strategy of working through an HIV/AIDS network was sound, but that the program needed to increase its focus on the high-risk groups. Accordingly, changes were made.<sup>13</sup> In 2000, USAID invited the Population Services International (PSI) Central American affiliate organization, PASMO, to initiate a condom social marketing program for high-

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<sup>11</sup> Honduras, CCM. GFATM Proposal Form Rolling Continuation Channel, Phase III. July 2007.

<sup>11</sup> Aran, Daniel et al. Honduras National AIDS Spending Assessment, Secretary of Health/UNAIDS/World Bank 2006.

<sup>12</sup> R. Barber-Madden, et al, Evaluation of COMCAVI Umbrella Grants Program for HIV/AIDS Prevention Program in Honduras, GH Tech Project (Report No.08-001-84, 2008).

<sup>13</sup> C. Cortez, et al. "Evaluation of the AIDS/STD Prevention and Control Project" (522-0216). USAID/Honduras.

risk groups through the USAID/Washington AIDSMARK Project. The Population Communications Services Project also began work on a national media campaign that year.

In 2002, the Mission awarded a cooperative agreement to the Academy for Educational Development (AED), with PSI as a sub-contractor, to initiate the *Comunicando Vida* project, which has been the primary umbrella model for Mission HIV/AIDS prevention efforts through NGO networks since that date. The Project was re-bid after two years, and a four-year cooperative agreement (2004 – 2008), coinciding with the Mission's new Strategic Plan period, was awarded to the same group for the *Comunicando Cambio para la Vida* Project (COMCAVI), whose objectives were to:

- Strengthen NGO capacity to implement sustainable HIV/AIDS activities;
- Support NGO implementation of high-quality programs for the care of people living with HIV/AIDS;
- Support NGO implementation of effective HIV/AIDS interventions reaching most-at-risk populations; and
- Ensure coordination between NGOs in the COMCAVI program with other programs and institutions throughout Honduras.

Through this activity, COMCAVI awarded three 13-15 month grant cycles, with between 8 to 11 grantees participating in each cycle. An innovation implemented during this period was the implementation of VCT through NGOs under the technical supervision of the MOH beginning with the second grant cycle. COMCAVI provided the NGOs technical assistance in M&E including baseline and follow-up Knowledge, Attitudes, and Practices (KAP) studies. USAID extended the cooperative agreement for an extra year, through September 2009.

## **CURRENT USAID/HONDURAS HIV/AIDS PREVENTION PARTNERS<sup>14</sup>**

### **AIDSTAR-One (AIDS Support and Technical Assistance Resources)**

The focus of AIDSTAR-One activities in Honduras is to improve access to and the quality of HIV/AIDS services provided through the Secretariat of Health's Department of STI/HIV/AIDS, in partnership with the Secretariat of Health and the Honduran Association of People Living with HIV/AIDS (ASONAPVSI DAH).

### **AIDSTAR-Two**

AIDSTAR-Two, led by Management Sciences for Health (MSH), began in Honduras in 2008. The project provides grants and technical assistance to local NGOs to implement HIV/AIDS prevention and support programs for MARPs, which include MSM, CSWs, and the Garifuna (Afro-Caribbean population).

Program activities in Honduras include (1) ongoing capacity building; (2) support for implementation of VCT using rapid-tests; (3) social mobilization; (4) development and distribution of tools related to information, education and communications, behavior change communications and monitoring and evaluation; and (5) the creation of opportunities and mechanisms to share lessons-learned, materials and best practices.

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<sup>14</sup> Evaluation of the prevention component of USAID/Honduras's HIV/AIDS strategy, Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01.

## **ULAT (Unidad Local de Apoyo Técnico)**

ULAT, led by Management Sciences for Health (MSH), began in Honduras in 2002. ULAT is a USAID-funded program working with the MOH to improve equitable social sector investments and to increase the use of quality maternal, child, and family planning/reproductive health services. ULAT strives to deliver quality, results-based consulting services to the country's MOH focused on health sector reform and decentralization. In addition, ULAT's HIV/AIDS prevention communications program is aimed at increasing knowledge of HIV prevention methods among the general population. ULAT also assists the Global Fund's CCM in developing a resource mobilization proposal so that the CCM can access funding from a diversified donor base, including the MOH, to support its structure and daily activities.

## **PASMO (Pan American Social Marketing Organization)**

PSI/Honduras began its operations in 2000 through its Central American affiliate. Focusing mainly on sexual and reproductive health, the platform's goal has been to contribute to the overall reduction in the incidence of Sexually Transmitted Infections (STIs) and HIV/AIDS. PSI/Honduras has worked to achieve this goal through its social marketing program, which takes a holistic approach to promoting healthy behaviors. During 2010, their USAID/Honduras support was limited to condom distribution in high-risk outlets.

## **CDC (U.S. Centers for Disease Control and Prevention)**

CDC Global AIDS Program support for Honduras began through its Central American Regional Office. The Global AIDS Program provides direct support to building country capacity in the areas of surveillance and laboratory testing. A major focus of this effort is supporting the Sentinel Surveillance STI centers (VICITS) for MARPs (MSM and sex workers).



## II. METHODOLOGY

The Team performed an intensive desk review of the documents, including those provided by USAID, and data encountered through Internet searches, site visits and discussions with local counterparts (Appendix B). A Team Planning Meeting was held September 8 – 9, 2010 to draft the evaluation framework, followed by an orientation meeting with USAID on Monday, September 13. The framework was subsequently approved by USAID in an email dated September 27. Following that meeting, the Team met in Tegucigalpa with the implementing agencies and other stakeholders as identified by USAID (Appendix B). The Team finalized the evaluation framework in accordance with USAID feedback and guidance, and further tested and refined the discussion guides (Appendix D).

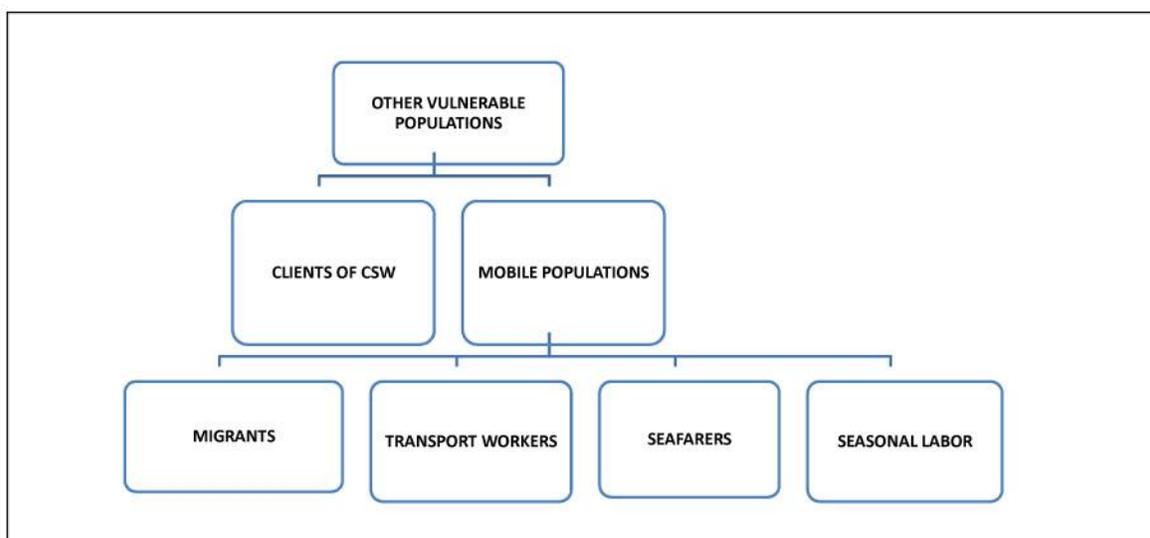
The Team disseminated the discussion guides in advance to the stakeholders and implementing agencies to inform them of the purpose of the visit and help them prepare for the meetings. Almost all of the partners and implementing agencies had received and printed the guide and had it with them at the meetings. Site visits to projects outside of Tegucigalpa began the week of September 20, with the Team returning to Tegucigalpa during the following week to visit projects in that city and to hold further discussions with stakeholders through October 6. Mission personnel accompanied the Team to introduce them to the MOH and to other stakeholders, and were present during discussions with UNAIDS and CHF.

On Thursday, October 7, the Team held an initial debriefing with USAID to receive further Mission feedback. After that meeting, the Team had separate discussion sessions with major stakeholders and implementing agencies to share initial impressions from the field and receive further feedback and suggestions. The Team made a formal presentation, including a PowerPoint presentation (Appendix F), to the Mission on Wednesday, October 13.

The primary information came largely from the application of the afore-mentioned structured qualitative in-depth discussion guides to key informants and from structured group discussions at various levels of the health system and from a variety of sectors (Appendix B). The draft discussion guides were submitted to USAID before testing, modification and delivery to the field. The discussion guides sought both spontaneous and prompted responses to the interviewees' knowledge of the projects and their activities. Where appropriate, questions were asked as to the management of the program to gather feedback on the technical, management and administrative aspects of the program. The Team also conducted structured discussions with selected groups of stakeholders, implementing agencies and clients to elicit further qualitative information. A special effort was made to gather input from especially vulnerable populations. Quantitative information came from a desk review of secondary sources, such as PENSIDA III, DHS, BSS+ and other special studies; USAID/Honduras results framework reports on the priority prevention indicators; the 2009 UNAIDS Country Progress Report; MOH statistics; and implementing partner reports and special studies.

For the purposes of this evaluation, the term priority client populations refers to those groups known to have a high HIV seroprevalence rate, beginning with PLWHA (100% seroprevalence), MARPs (male and female sex workers and MSM), and the Garifuna ethnic group, which is experiencing one of the most (if not the most) generalized epidemics in the Americas (Figure 1). Also to be considered for the purposes of this evaluation are other populations in some condition of vulnerability to HIV infection due to their situation and their likelihood of interaction with the high-prevalence groups in "hot zones," thereby providing a potential bridging mechanism to the general population. Included in these vulnerable populations are mobile populations (transport workers, migrant workers, other migrants, and seafarers) and clients of sex workers. It is also important to note that these groups are not necessarily mutually exclusive. For example, sex workers are highly mobile, domestically and internationally. Partially driven by stigma and the search for anonymity, MSM can also be highly mobile.

**Figure 8. Other Vulnerable Populations in Honduras**



Important groups intentionally omitted from this list include one high-prevalence population, prisoners, and one vulnerable group, the uniformed security services. Intravenous drug users (IDUs) are not included, but evidence of their presence is beginning to turn up. They were present, to some extent, in all four populations covered by the 2006 EVCV studies. These data need to be monitored in the next round of EVCV studies (due in 2011) with follow-up ethnographic research on this sub-culture, which could be growing and could pose a threat to current HIV control efforts and gains. These groups were omitted due to the difficulty USAID faces in working with them (prisoners) or due to the fact other U.S. Government agencies will engage them (such as the Department of Defense with the uniformed services).

The lists of contacts to be interviewed provided by USAID (Appendix A) and implementing partners was the starting point for identifying interviewees. The Team further enriched this list through discussions with local counterparts. Care was taken to include a cross section of stakeholders, counterparts and important program clients from the priority populations.

In addition to the meetings and discussions with stakeholders and implementing agencies, the Team directly observed a number of mostly nocturnal education activities and/or met with clients in Tela (CONASIDA), San Pedro Sula (Honduran Association for Women and Families [AHMF] and the Comunidad Gay Sanpedrana), and Tegucigalpa (Programs for the Development of Children and Mothers [PRODIM], Colectivo Violeta and PASMO). In Comayagua, the Team met with FSWs, clients of AHMF, AHMF educators and a member of the Core Group of MSM. Condom sales posts were visited and checked for availability and pricing as were materials in the Garifuna villages of Corazal, Triunfo de la Cruz and Tornabé, and in high-risk points of sale in La Ceiba, San Pedro Sula, and Tegucigalpa. Also visited were VICITS and UMIETS in Tegucigalpa (Las Crucitas, Alonzo Suazo, el Manchen), San Pedro Sula (Miguel Paz Barahona) and La Ceiba (Hospital Atlantida).

For each of the six evaluation component areas (Appendix D), the Team assessed (1) behavior change communication activities, (2) sexually transmitted infection control programs, (3) condom social programming and marketing, (4) voluntary HIV counseling and testing programs, (5) local capacity building of prevention programs, and (6) social mobilization relevance, effectiveness, efficiency, impact and sustainability.

## **TECHNICAL TEAM MEMBERS' ROLES AND RESPONSIBILITIES**

This assessment was a team effort, and although each Team member had areas of specialization as described below, they also contributed as needed to completing the assignment according to the Scope of Work.

### **Dr. Stanley S. Terrell – Team Leader**

As Team Leader, Dr. Terrell had overall responsibility for the direction and coordination of the Team's activities, including development of the work plan, the overall assessment methodology and data collection instruments, scheduling of staff visits, and preparation and final editing of the report to ensure that all relevant topics were included. Dr. Terrell represented the Team to USAID/Tegucigalpa and local partners, such as the MOH, civil society and other agencies, and was responsible for keeping GH Tech/Washington and USAID/Tegucigalpa informed of progress and of issues that may have arisen in the field. He was responsible for seeing that deliverables were delivered on time. Dr. Terrell had responsibility for drafting the Condom Social Programming and Marketing and General Questions sections of the report.

### **Dr. Carlos Balcáceres – Health Systems and Medical Interventions Specialist/Deputy Team Leader**

As the health sector systems and medical interventions specialist on the Team, Dr. Balcáceres had primary responsibility for developing the report sections on Sexually Transmitted Infection Control Programs and the Local Capacity-Building Component. Dr. Balcáceres also contributed to responding to the general questions in the Scope of Work. He assisted the other Team members in collecting information on their primary assignments and performed other tasks as necessary. As Deputy Team Leader, he represented the Team in Dr. Terrell's absence.

### **Lic. Meliné Caal – MARPs BCC Specialist**

As the MARPs prevention and behavior change specialist, Ms. Caal had primary responsibility for drafting the Behavior Change Communication Activities and HIV Counseling and Testing Programs sections of the report. She also contributed to responding to the general questions in the Scope of Work, assisted the other team members in collecting information on their primary assignments, and performed other tasks as necessary.



### III. EVALUATION FINDINGS AND CONCLUSIONS

#### A. OVERALL

In general, the USAID/Honduras Mission and its implementing partners, international and local, are to be lauded for implementing a country-appropriate and quality HIV/AIDS program, and for maintaining activities and services for high-risk and vulnerable populations through a difficult period, which included the recent political upheaval. USAID's contribution is widely recognized and appreciated by stakeholders, partners and service clients, and USAID is a major player in policy activities at the national level. Although attribution is always difficult, USAID's prevention program has probably made a significant contribution to containing the spread of the epidemic. The following sections of this report document some of those contributions, and, in some cases, provide suggestions for adjustments and improvements. However, the overall strategy and mix of project activities and services remain sound and should be continued. One recurrent cross-cutting theme across components is the need to apply more sophisticated social networking methods (interpersonal and electronic) to client recruitment to increase coverage.

#### B. COMPONENTS

##### I. Behavior Change Communication Activities

Since the 1999 evaluation<sup>15</sup>, USAID/Honduras has strongly emphasized the importance of the BCC component for populations with the greatest HIV prevalence (FSWs, MSM, the Garifuna and People Living with HIV/AIDS). Likewise, USAID/Honduras considered it important to strengthen NGO capacities to efficiently diffuse the messages and utilize appropriate materials for these target populations, in coordination with the National Multisectoral IEC Committee (while it was still functioning).

For the 2004-2008 period, USAID/Honduras authorized a cooperative agreement with the AED, with PSI as a sub-contractor, to implement the strategy through the *Comunicando Cambio para la Vida* project (COMCAVI). USAID/Honduras extended the cooperative agreement through September 2009. In October 2009, the USAID/Washington AIDSTAR-Two project began in Honduras as a follow on to COMCAVI. Methodologies (curricula) and materials for the BCC approach were constructed under the trans-theoretical model. According to this model, there are five stages of change: pre-contemplation, contemplation, preparation, action and maintenance. The stages mark the willingness or motivation of the client to change behavior as they become increasingly aware of the benefits of changing the behavior. Each stage becomes the basis for reaching the next stage<sup>16</sup>.

##### **What has the reach of the activities been within the intended target populations?**

BCC activities for this period were effectively targeted to the MARPs under consideration and the Garifuna community. The effectiveness of these behavior change interventions was measured by the annual NGO KAP studies and, in the case of PASMO, bi-annual TRaC studies (population-based surveys to measure levels, trends, and determinants of behavior). Some of the important changes included increased condom use by affective partners of FSWs and MSM and consistent condom use by the Garifuna. The interventions could be also considered efficient in the sense that they achieved a high percentage of the goals for the allocated budgets. Organizations that did not reach their targets did not

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<sup>15</sup> C. Cortez, et al. "Evaluation of the AIDS/STD Prevention and Control Project" (522-0216). USAID/Honduras.

<sup>16</sup> *Comunicando Cambio para la Vida (COMCAVI)* Honduras: Reporte Investigación Conocimientos, Actitudes y Prácticas (KAP) 2009.

receive subsequent funding. In the case of the Garifuna, there was high coverage of this population through a combination of mass media and interpersonal efforts. However, as discussed elsewhere in this report, certain hard-to-reach “pockets” of FSWs and MSM who need to be covered by prevention interventions still require further efforts and a modified approach.

COMCAVI prepared an implementation strategy based on the nature of the epidemic for each target population. For FSWs and MSM, who have a concentrated epidemic, COMCAVI proposed working not only with those two groups, but also with the clients and affective partners of the FSWs, and with female partners of the MSM. For the Garifuna, who have a generalized epidemic, the COMCAVI intervention strategy was designed to approach the entire population, but in a segmented manner: youths between 10 and 15 years old; youths between 16 to 24 years old; and men and women above 24 years of age. COMCAVI accessed the following: 3,929 FSWs; 1,995 MSMs; and 5,207 Garifunas (see Table I describing the populations reached by COMCAVI, PASMO, ULAT and AIDSTAR-Two).

As part of the 2004-2008 strategy and in order to increase the geographic coverage of the interventions, USAID/Honduras also provided financial support to PASMO and the Local Technical Support Unit (ULAT). PASMO covered the FSW and MSM populations at the national level. The PASMO agreement for BCC was extended through September 2009; however, BCC was not part of PASMO’s 2010 agreement. ULAT covered the Garifuna in four departments in the Northern Zone of the country (Atlántida, Colón, Cortés and Gracias A Dios). The ULAT contract was extended through September 2010.

The target population reached by PASMO between 2007 and 2009 was as follows: 4,762 FSWs; 4,883 FSW clients; 6,639 MSM; and 5,096 Garifuna (Table I).

**Table I. Population Reached with BCC Activities by Year; COMCAVI, PASMO, ULAT and AIDSTAR-Two**

PEPFAR indicators and core populations		2007			2008			2009			Dec. 2009 to June 2010
		COM-CAVI	PAS-MO	ULAT <sup>b</sup>	COM-CAVI	PAS-MO	ULAT <sup>b</sup>	COM-CAVI	PAS-MO	ULAT <sup>b</sup>	
Garifuna population directly or primary <sup>a</sup>		COM-CAVI	PAS-MO	ULAT <sup>b</sup>	COM-CAVI	PAS-MO	ULAT <sup>b</sup>	COM-CAVI	PAS-MO	ULAT <sup>b</sup>	AS-Two
4.1. Number of individual trained to promote HIV/AIDS, prevention through abstinence and/or being faithful.	Male	872			408			270			385
	Female	1,384			1,078			1,195			606
	Sub total	2,256	1,447		1,486	1,756		1,465	1,893		991
Population directly or primary of MSM and FSW											
4.2. Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.	MSM	576	2,126		541	2,349		878	2,464		310
	MSM women partners										50
	FSW	1,344	1,505		1,386	1,659		1,199	1,598		355
	FSW clients and partners		1,353 <sup>c</sup>			1,591 <sup>c</sup>			1,939 <sup>c</sup>		70
	PLWHA		337								
	Sub total	1,920	5,321		1,927	5,599		2,077	6,001		785
Total of population directly or		4,176	6,768		3,413	7,355		3,542	7,894		1,776

PEPFAR indicators and core populations		2007			2008			2009			Dec. 2009 to June 2010
primary											
Garifuna population reached indirectly or secondary <sup>a</sup>											
5.1. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.	Male	8,820		102	8,165		492,569	11,786			2,299
	Female	20,576		109	20,246		332,939	18,704			4,155
	Sub total	29,396	26,319	211	28,411	29,213	825,508	30,490	29,152		6,454
Population reached indirectly or secondary											
5.2. Number of individuals reached through community outreach HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	HSH	12,713	29,078		15,873	31,385		15,262	38,969		2,558
	FSW	29,663	19,784		16,482	20,267		20,080	22,761		9,429
	FSW clients and partners		20,876 <sup>c</sup>			21,843 <sup>c</sup>			30,321 <sup>c</sup>		11,851
	PLWHA		3,728								
	Garifuna People <sup>b</sup>			30,906			3,626			47,133	
	Sub total	42,376	73,466	30,906	32,355	73,495	3,626	35,342	92,051	47,133	23,838
Total of population reached indirectly or secondary		71,772	99,785	31,117	60,766	102,708	829,134	65,832	121,203	47,133	30,292

<sup>a</sup> Includes population groups: 10-14 years, 16-24 years and 25 and older. <sup>b</sup> Only Garifuna youth ages 12-24. <sup>c</sup> For PASMO only FSW clients.

Source: Reports indicators PEPFAR COMCAVI, PASMO and ULAT; activity reports of COMCAVI and AIDSTAR-Two. (2007-2010). Detailed information of PASMO was obtained in collaboration Julio Zuniga (October, 2010).

COMCAVI developed BCC activities through subcontracts with NGOs covering the geographical zones with the greatest HIV prevalence (Cortés, Yoro, Colón, Atlántida and Francisco Morazán). The impact of the work of the NGOs was evaluated each year through a KAP study, which was compared to the previous year's KAP. COMCAVI provided technical assistance to the NGOs in the development of BCC activities (from the creation of curricula through the evaluation of indicators that corresponded to each activity) and supported the exchange of experiences between the COMCAVI-supported NGOs. In addition, it accompanied and closely monitored the work of each NGO through an efficient monitoring system. By the end of USAID/Honduras financing, the COMCAVI NGOs had been strengthened in their capacity to provide BCC interventions for their populations.

BCC activities implemented by PASMO were carried out through a trained team of educators and consultants who provided national coverage of hot spots. PASMO developed a very efficient monitoring system that permitted advances in the achievement of goals under high-quality supervision. Every two years, PASMO activities were evaluated through TRaC studies, which provided information about changes in the project indicators.

Table I describes the populations reached by COMCAVI, PASMO, ULAT and AIDSTAR-Two. Both COMCAVI and PASMO were effective in reaching the FSW and MSM populations, but coverage was broader for PASMO than for COMCAVI and AIDSTAR-Two. However, the COMCAVI and AIDSTAR-

Two interventions were multi-stage processes while PASMO contacts tended to be more intermittent in places of commercial sex and where the target populations (including clients of FSWs) congregate.

ULAT utilized a different approach, under the “P Process” framework developed for the Communication Initiative Network by the USAID/Health Communication Partnership project. The five-stage process comprises (1) situation analysis/audience communication analysis, (2) strategic design, (3) development and testing, (4) implementation and monitoring and (5) evaluation and re-planning. The P Process also emphasizes strong participation by stakeholders at multiple levels and capacity strengthening to provide an environment conducive to individual, family and community adoption of healthy practices.

Utilizing this process from 2007 through 2010, ULAT worked with the Garifuna BCC sub-committee to develop a new communications strategy for HIV/AIDS prevention, oriented towards adolescents and youths from 12 to 24 years old in 36 Garifuna communities in the departments of Atlántida, Colón, Cortés, and Gracias a Dios. The new strategy consisted of the airing of two radio soap operas: *Ancestors Don't Die (Los ancestros no mueren)* and *Larubeya*. They were transmitted three times each on radio stations covering the Garifuna communities in the departments of Atlántida, Cortés, and Colón from 2005 to 2007. In 2008, the impact of this ULAT BCC strategy was evaluated through a quantitative and qualitative study.

Two important assessment items were the cultural relevance and usefulness of the soap operas as perceived by young Garifuna. The results of the evaluation indicated that the soap operas met two goals. The results in Table 2 show that 83% of young Garifuna surveyed believed that the soap opera *The Ancestors Don't Die* reflect the reality of Garifuna life. Another 78% of young people surveyed felt the same way for the soap opera *Larubeya*. In addition, 73% and another 68% of those surveyed, respectively, indicated that the soap operas have been useful to them.

In 2009, ULAT developed a third radio soap opera titled *Wanichigu* (Garifuna pride), with 120 twenty-minute chapters directed towards 12- to 24-year-old Garifuna from 36 communities in the departments of Atlántida, Colón, Cortés, and the Bay Islands. In addition, the project produced radio spots as well as theater shows and organized community mobilizations. The educational entertainment focus took into account the results from the evaluation of the two previous radio soap operas, the COMCAVI KAP studies and the 2006 ECVC. ULAT prepared work guidelines so that education center teachers would be able to discuss the radio soap opera themes in the classrooms.

In 2009, ULAT carried out a survey while the *Wanichigu* radio soap opera was being transmitted. The results indicated that the Garifuna population became accustomed to listening to the radio soap operas and that *Wanichigu* generated an important level of understanding of the HIV prevention messages. In 2010, the *Wanichigu* radio soap opera was aired again, and ULAT carried out another survey. The results showed that radio soap operas are an important tool for promoting continued behavior changes in the Garifuna communities (see Table 2).

**Table 2. Achievements of the First Two Garifuna Radio Soap Operas from 2005-2007 and 2009 and Results of the Surveys of the 2009 Transmissions and Retransmission in 2010 of the Third Garifuna Radio Soap Opera; Radio Transmissions in the Cities Near Atlántida, Colón and Cortés.**

	Evaluation		Survey 1	Survey 2
Radio soap operas	<b>Ancestors Don't Die (Los ancestros no mueren)</b> Mouwetiñu Wayunagu	<b>Larubeya</b> At the edge of the ocean	<b>Wanichigu</b>	<b>Garifuna Pride</b>

Transmission Period	Evaluation		Survey 1	Survey 2
	2005, 2006 and 2007	2006 (twice) and 2007 (only by Radio Católica in Trujillo)	2009	2010
Number of episodes and chapters	Ninety 15-minute episodes	Sixty 15-minute episodes	120 twenty-minute episodes	
Samples of youths surveyed, with exposure to radio soap operas	n=1153	n=851	N=422	N=605
Stated eight or more on a scale from 0-10 with respect to how real Garifuna life was demonstrated in the radio soap opera	83%	78%		
Tell me from 0-10 how much do you believe that the radio soap opera demonstrates real Garifuna life?			Average: 8.90 N=419	
Stated eight or more on a scale from 0-10 with respect to how useful the information presented in the radio soap opera was	73%	68%		
Tell me from 0-10 how much do you think the information presented in the radio soap opera has been useful for you?			Average 8.6 N= 221	
Spontaneously mentioned a health subject touched on by the radio soap opera			What subjects did the radio soap opera deal with?	
HIV/AIDS	79%	70%	65.2%	80.1%
Fidelity/sexual fidelity	22.0%	19%	10.7%	19.3%
Condoms	19.1%	18%	21.6%	32.5%
How to prevent HIV	20.8%	16%	22.7%	19.5%
Abstinence/postponement	10.7%	9.6%	16.8%	30.0%
Pregnancies/adolescent pregnancies	21.2%	19.6%	10.9%	16.5%
Sexually transmitted diseases	5.0%	3.7%	10.4%	19.1%
Maternal/child transmission			7.6%	11.4%
HIV test	7.0%	6.4%	7.1%.	13.4%

Source: "Report of the Evaluation of the Impact of the Garifuna Radio Soap Operas *Ancestors Don't Die* and *Larubeya* (2008) and Reports of the *Wanichigu* radio soap opera survey (2009 and 2010).

Table 2 shows that the Garifuna youth identified with the themes of *Ancestors Don't Die*, *Larubeya* and *Wanichigu* that emphasized fidelity, condoms, and how to prevent HIV. *Wanichigu* highlighted PMTCT and HIV testing.

In general, the results of the impact of the ULAT radio soap operas demonstrated that this resource has the power to achieve behavioral changes, motivating the adoption of specific healthy behaviors to prevent HIV. An important result of the evaluation of the impact of the *Ancestors Don't Die* (*Los Ancestros no Mueren*) and *Larubeya* radio soap operas was that it showed a higher percentage of condom use during their last sexual relationship among youth exposed to the radio soap opera (Table 3).

**Table 3. Percentage of Youths That Utilized Condoms During Their Last Sexual Relationship and Differences by Different Levels of Exposure to Radio Soap Operas Evaluation of the Impact of the Ancestors Don't Die (Los Ancestros No Mueren) and Larubeya Radio Soap Operas, 2008.**

<b>Behavior Indicator #2: % of youths that utilized condoms during their last sexual relationship</b>	<b>Exposed Group</b>	<b>Group Not Exposed</b>	<b>Net Change due to Exposure</b>
Low Exposure vs. No Exposure Compared	(54.6%)	(54.6%)	Not significant
High Exposure vs. No Exposure Compared	57.1%	50.1%	7.0

\*\*p<0.08, <sup>a</sup> n=801, <sup>b</sup> n=311, <sup>c</sup> n=506

Source: The evaluation report on the impact of radio soap operas (2008).

ULAT also organized 32 popular theater groups composed of young Garifuna, who participated in a training process in scenic arts and the preparation of theater scripts. The theater groups collectively created theatrical productions through which HIV/AIDS was approached from different perspectives.

The ULAT Communications Component (radio soap operas and theater groups and social mobilizations) reached 907,384 persons from 2007 and 2009, either indirectly or secondarily.

The work carried out by COMCAVI, PASMO-PSP-One, ULAT and AIDSTAR-Two documents that coverage of MARPs has been achieved in the geographic areas with the highest HIV incidence in Honduras. In addition, the target populations have included the affective partners of FSW and MSM female partners with culturally appropriate BCC messages specific to social contexts and the cultural characteristics of these sub-populations.

Nevertheless, the USAID-Honduras prevention interventions still have not adequately reached certain hidden populations of FSWs that practice different and newer modalities of sex workers, such as through classified ads, the Internet, and massage parlors. Likewise, hidden and non-declared MSM who do not frequent MSM meeting places or STI clinics and who often make contacts through the Internet are not adequately covered.

### **Are we effectively reaching the beneficiaries we want to reach?**

COMCAVI created participatory and specific methodologies for the MARPs, which it put into practice during the intervention period (2004-2008). The follow-up AIDSTAR-Two (PRODIM, COCSIDA, AHMF/Marie Stopes and CGSSI) followed a series of steps ranging from general information activities through a level where FSWs and MSM become facilitators of behavior change among their peers. In order to become facilitators, the MARP populations progressed from a pre-contemplation stage (of lack of a perception of the risk of HIV) towards awareness and the taking of preventative actions in their lives (changes in behavior).

The role of the FSWs and MSM facilitators is to carry out BCC activities with their partners and clients. Some FSW leaders graduated from the facilitator role to that of mentor, i.e., models for the other facilitators and FSWs in general. Interviews with eight FSW mentors (COCSIDA, PRODIM, AHMF/Marie Stopes-Comayagua) showed that the work of COMCAVI and, currently, AIDSTAR-Two has been effective. The FSWs interviewed assertively declared that in addition to using condoms with all clients and their affective partners, they have also changed their personal lives by incorporating healthier practices, such as controlling their emotions (anger) and ceasing the use of drugs.

Behavior changes, especially the increase in the correct and consistent use of condoms, are evident in the annual KAP results carried out initially by COMCAVI and currently through AIDSTAR-Two. The KAP 2006 and 2009 results demonstrate important gains of the President's Emergency Plan for AIDS

Relief (PEPFAR) indicators of increased use of condoms by the affective couple in their last sexual relationship and in the last three months (see Table 4, 2006 and 2009 KAP results).

**Table 4. Percent of Condom use in last Sexual Relationship by Type of Partner; COMCAVI 2006 and 2009 KAP**

Populations		KAPs COMCAVI									
		FSW		MSM		Garifunas Adolescents (16-24 years)		Garifunas Adults		PLWHA	
Years		2006	2009	2006	2009	2006	2009	2006	2009	2006	2009
Sample size		n=370	n=506	n=130	n=464	n= 333	n=238	n=247	n=278	n=269	n=311
Perceive themselves at risk for HIV infection	Client/ Occasional	85%	89%	77%	96%	57%	78%	52%	71%		
	Stable Partner	71%	92%		85%		66%				
Used a condom during last sexual encounter	Client/ Occasional	98%	95%	94%	93%	76%	79%	65%	59%		86%
	Stable Partner	46%	70%	90%	98%	56%	88%	36%	52%		91%

Source: Report activities de COMCAVI (2007) and KAP COMCAVI 2009.

Likewise, culturally appropriate activities with the Garifuna population have been incorporated into their daily lives. One example is the information boat activity, carried out by ECOLOGÍA Y SALUD (Ecology and Health) (ECOSALUD) on Garifuna fishing boats while at sea.

Also utilizing the trans-theoretical model during 2004 and 2009, PASMO carried out interpersonal communications activities utilizing a total of nine specific methodologies, each of which promotes seven healthy behaviors (abstinence, mutual fidelity, reduced number of partners, referral to treatment services for STIs and for HIV tests, correct and consistent condom use, and use of lubricants).

PASMO does not carry out its activities in stages. Each activity is not necessarily directly linked to the previous and next activity. The reason is that the PASMO educators and consultants who implement these activities do not have a fixed location but mobilize within the FSW and MSM work or meeting places in high-risk zones. In order to carry out activities with FSWs, PASMO obtains support from the owners or those in charge of places of commercial sex to carry out activities in the locations before providing scheduled services at the site. For activities with MSM, PASMO obtains support from the networks of gay men and other MSM in order to contact them and invite them to participate in the activities. Frequently, these activities are carried out in the homes of the MSM leaders contacted by PASMO. The “Vive la Vida” activity uses social networking for a series of successive meetings, usually in four parts. On other occasions, these educational activities are carried out in parks or gay community meeting places.

According to TRaC studies carried out by PASMO every two years with FSWs and MSM, PASMO prevention work appears to be yielding results in terms of condom use, especially with non-affective partners. The TRaC 2007 and 2009 studies for MSM reveal an increase in condom use with occasional partners (58.7% to 83.3% to 94.4%), with any partner (70.6% to 85.3% to 89.2%), and with commercial partner (86.8% to 95.3%) (Table 5).

**Table 5. Results of TRaC Studies of MSM**

PASMO	MSM		
	TRaC 2005 No information	TRaC 2007 N=561	TRaC 2009 N=596
Condom use at last sexual relationship... (Francisco Morazán y Cortés)			
- with an occasional partner	58.7%	83.3%	94.4%
- with a female partner	32.9%	74.2%	
- with any partner	70.6%	85.3%	89.2%
- with commercial partner		86.8%	95.3%

Source: TRaC 2007 and TRaC 2009

The TRaC 2005 through 2009 FSW studies show that condom use with new clients, occasional partners and any client increased from 2005 to 2007 and maintained the high levels in 2009. However, there was a significant decrease in condom use with affective partners (Table 6).

**Table 6. Results of TRaC Studies of FSW**

PASMO	FSW		
	TRaC 2005 No information	TRaC 2007 N=506	TRaC 2009 N=507
Condom use at last sexual relationship... (Francisco Morazán y Cortés)			
- with a new client	84.3%	98.1%	97.9%
- with occasional client	86%	99.0%	99.0%
- with regular client	94.9%	97.4%	98.3%
- with any client	82.6%	90.7%	93.9%
- with affective couples	42.7%	57.3%	42.3%

Source: TRaC 2007 and TRaC 2009

The data from the TRaC studies indicate that the PASMO BCC activities could have contributed to the measured increase in condom use with non-affective commercial partners, which are the highest risk sexual relationships, whereas COMCAVI/AIDSTAR-Two activities appear to have been more effective in promoting condom use with affective partners.

The only criticism of the PASMO BCC interventions encountered was in reference to the materials utilized in their methodologies. The CID/GALLUP study carried out in 2007 to evaluate four of the seven PASMO prevention modalities highlighted the fact that materials utilized for activity development should be more adapted to the sub-population's characteristics and needs. For example, Garifuna who participated in the evaluation requested materials that responded to their cultural context and were adequate for the information needs of their communities (adult male abstinence is not a practice in their communities). The CID/GALLUP study also pointed out that there were no materials available for people who cannot read.

PASMO has a web site, "Mi zona H" (<http://www.mizonah.com/>), which has information on the "No todos los hombres son iguales" (*Not All Men Are Equal*) mass media campaign. However, the information provided is outdated, and the medium is not being sufficiently utilized.

### **Are we reaching pockets of MARPs that we need to reach in order to have maximum impact?**

The coverage in terms of the geographic distribution of the HIV epidemic in Honduras (Atlántida, Colón, Cortés, Gracias a Dios, Islas de la Bahía and Francisco Morazán) as well as in terms of reaching populations and subpopulations (clients and affective FSW partners and MSM women partners) has been generally good. However, during the development of this evaluation, the Team found new forms of sexual work where the FSWs are not being approached, such as those who work in massage parlors and those who advertise and contact clients on the Internet or through classified ads in newspapers.

In relation to men having sex with men, a sub-group was identified that was not being covered, that is, the MSM group that does not visit meeting places or go to specialized health services (VICITS), but are Internet users. Also, the sub-culture of male sex workers (*Zopes*) that serve both men and women has not been sufficiently identified and covered.

The COMCAVI NGOs provided services for PLWHA until 2008. Since then, AIDSTAR-One assumed the responsibility for providing technical support for strengthening the national organization that coordinates support groups for PLWHAs (ASONAPVSIIDA). A preliminary version of the 2010-2014 III Strategic Plan is currently circulating. However, the Plan would benefit from a qualitative study on home visitation services and mutual support groups, including primary and secondary prevention services.

### **Do the current activities represent the most efficient and effective means to reach MARPs?**

The KAP studies carried out by COMCAVI and AIDSTAR-Two have provided data supporting the effectiveness and efficiency of the MARPs approach. One key example is the increase in MSM and FSWs condom use. Likewise, working with the female partners of MSM and the male partners of FSWs appears to have been effective. Results from the 2009 COMCAVI KAP show greater condom use with regular partners than with occasional partners (Table 7).

**Table 7. COMCAVI KAP 2009; Condom Use by Female Partners of MSM and Male Partners of FSWs**

Indicators PEPFAR	Female partners of MSM n=25		Male partners of FSW n=46	
	Stable Partner	Occasional Partner	Stable Partner	Occasional Partner
Used a condom in last sexual relationship	80%	64%	91%	69%
Used a condom in last 3 months	84%	68%	91%	69%

Source: COMCAVI KAP, 2009

Further and more reliable information on behaviors in MARPs will be available from the results of the 2011 ECVC.

In terms of the efficiency of the BCC activities, PASMO, as well as COMCAVI, AIDSTAR-Two and ULAT executed a very high number of activities with the available resources. COMCAVI adapted BCC methodologies proposed as best practices by CDC, such as *Friends Educating Friends*<sup>17</sup>, *Healthy Relationships*<sup>18</sup> and *Educational Video Forums*<sup>19</sup>. Likewise, the innovative ULAT methodologies, such as

<sup>17</sup> Popular Opinion Leader (POL): a community-level intervention that engages opinion leaders of social networks in risk reduction, advocacy, and role modeling.

<sup>18</sup> Healthy Relationships (HR): a small group-level intervention that encourages sexual risk reduction and positive coping skills among individuals living with HIV/AIDS. This intervention, as implemented under COMCAVI, is titled *Relaciones Saludables*.

radio soap operas with guides for using them in schools, were effective in promoting participation by the Garifuna communities in carrying out the activities.

COMCAVI produced important self-reflection print materials supportive of BCC activities with FSWs, such as life histories and a web page ([www.comcavi.org](http://www.comcavi.org)), to further disseminate their methodologies. COMCAVI also promoted exchanges of experiences among the NGOs it worked with.

### ***What are specific strategies to improve reach and quality?***

The stepwise BCC strategies developed by COMCAVI and AIDSTAR-Two implementing agencies, the utilization of appropriate materials for the characteristics and contexts of the FSWs and MSM populations, and the PASMO interventions have demonstrated results in achieving behavior change. The same holds true with the ULAT radio soap opera strategy for the Garifuna. The cumulative experience of PASMO, COMCAVI and AIDSTAR-Two should be shared with other institutions interested in or practicing prevention. These experiences would be of particular relevance to the GFATM sub-grantees being supported through CHF.

Likewise, the accumulated experience of COMCAVI and AIDSTAR-Two in providing NGOs systematic technical assistance in BCC—including direct observation with feedback and accompaniment in the design and planning of activities with specific instruments to determine the percent of achievement of goals—represents an important contribution.

### ***What is the optimal mix of multiple interventions to maximize effectiveness and efficiency?***

The interventions carried out through PASMO and COMCAVI between 2004 and 2008 and by AIDSTAR-Two between 2009 and 2010 had successes in their approach for HIV prevention with the FSW and MSM populations. USAID/Honduras should continue its support of FSW facilitator and mentor activities; at the same time, it should harness the efficiency of the PASMO approach in covering high-risk populations and zones and supervising the quality of the interventions. Using performance-based contracting could be one way to focus interventions on results. Having branded social marketing condoms available in high-risk outlets appears to have been an important complement to these other efforts as well as an insurance policy for condom availability, and has been the primary driver in making lubricants available to MARPs. The generic mass media social marketing campaigns also appear to be supporting the overall effort as evidenced by association of exposure to messages with condom use in the results of the TRaC studies. The approach should be to continue to strengthen condom use in MARPs' high-risk sexual relationships; reduce multiple simultaneous partners in MSM; and increase condom use with affective partners (complementary efforts).

The Garifuna strategy of combining mass media and youth drama groups is basically a sound one and could benefit from a closer integration with the Health Promotion Model for community development to strengthen local governance and the involvement of community leaders<sup>20</sup>.

As mentioned elsewhere in this document, the NGOs also need to implement more effective client recruitment methodologies such as PDIs to further penetrate into the target populations to increase coverage (see References in Appendix G on social networking).

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<sup>19</sup> Video-based Opportunities for Innovative Condom Education and Safer Sex (VOICES): a video-based, group-level intervention promoting condom education and negotiation for safer sex. This intervention, as implemented under COMCAVI, is titled *Video Foros Educativos*.

<sup>20</sup> Organización Panamericana de la Salud. División de Promoción y Protección de la Salud, Municipios y Comunidades Saludables. (n/d). *Guía de los Alcaldes para Promover la Calidad de Vida*.

## 2. Sexually Transmitted Infection Control Programs (VICITS)

In any HIV prevention program, targeted and intensive effort to decrease STI infections rates, especially among MARPs and bridging populations, should be a priority. There is evidence that early detection and treatment of other STIs can be an effective strategy for preventing sexually transmitted HIV infection<sup>21</sup>. Several studies have explored potential biological mechanisms by which other STIs can facilitate sexual transmission of HIV infection by increasing infectiousness or susceptibility<sup>22</sup>; for instance, it has been shown that the Herpes simplex virus type 2 (HSV-2) enhances HIV-1 susceptibility by affecting Langerhans cell function<sup>23</sup>.

In Honduras, despite dozens of staff trainings, development of STI norms, BCC interventions and other treatment efforts, the 2006 ECVC study revealed that 39.7% of MSM in Tegucigalpa were reported with HSV-2; in San Pedro Sula, 11.3% had syphilis and 9.9% were HIV+. The same study also reported that just 7 out of 10 MSM used a condom in the last sexual intercourse and had a deficient knowledge of HIV prevention.

According to the 2006 ECVC, FSWs also had high STI rates: 6 out of 10 suffered HSV-2 and 10% of those from San Pedro Sula and Tegucigalpa were reported to have syphilis. There was low condom use with stable partners across the four cities in the study.<sup>24</sup>

Honduras began its efforts to improve STI case management with the introduction of syndromic management in 1995. Within the political framework, a close relationship was developed between AIDSCAP and the MOH through its Department for the Prevention and Control of STI/AIDS, which allowed the project to respond to the needs of the National STIs Control Program. An inter-institutional committee was formed by the Resident Advisor of AIDSCAP/Honduras, the Chief of the STI/AIDS Department and a USAID representative, allowing for effective coordination among these institutions.

The strategy for syndromic management was implemented at the level of the four national regions that report the greatest number of AIDS cases in the country. This strategy was initiated with the identification of four Unidades de Manejo Integral de ETS (UMIETS-Units for Integrated Management of Sexually Transmitted Infections), one in each health region. These were key existing centers for the care and referral of STI cases. In order to initiate the project, AIDSCAP supported the remodeling and equipping of the facilities and staff training.

The current VICITS strategy (HIV/STI Sentinel Surveillance) to strengthen the response to STIs among MARPs was launched in 2006, starting in UMIETS at MOH facilities attending FSWs. In 2009, VICITS began attending MSM. VICITS is being implemented in six MOH facilities, with technical support from CDC financed by USAID/Honduras: Health Centers Alonso Suazo (MSM), Manchen (MSM) and Crucitas (FSWs) in Tegucigalpa; Atlantida Hospital in Ceiba (MSM and FSWs); Health Center Miguel Paz Barahona in San Pedro Sula (MSM and FSWs); Health Center Cornelio Moncada in Puerto Cortés (FSWs); and Hospital de Sur in Choluteca (FSWs).

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<sup>21</sup> A trial conducted in Mwanza, a rural area of Tanzania, demonstrated a decrease of about 40 percent in new, heterosexually transmitted HIV infections in communities with continuous access to improved treatment of symptomatic STDs, as compared to communities with minimal STD services, where incidence remained about the same (Grosskurth et al., 1995). [http://www.cdc.gov/std/Media/Facts\\_Treatment\\_Prevent\\_HIV\\_Infection.htm](http://www.cdc.gov/std/Media/Facts_Treatment_Prevent_HIV_Infection.htm)

<sup>22</sup> Centers for Disease Control and Prevention. 1998. HIV prevention through early detection and treatment of other sexually transmitted diseases - United States. MMWR 47(RR-12):1-24.

<sup>23</sup> de Jong M.A., de Witte L, Taylor M.E., Geijtenbeek T.B. "Herpes simplex virus type 2 enhances HIV-1 susceptibility by affecting Langerhans cell function." *J Immunol.* 2010 Aug 1;185(3):1633-41. Epub 2010 Jun 30.

<sup>24</sup> Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Trabajadoras Sexuales (ECVC) 2006.

The strategy's purpose is to conduct laboratory-based etiologic diagnosis, strengthen clinical management and training of staff in VCT and BCC, and generate STI/HIV strategic information. The STIs to be monitored are HIV, syphilis, gonorrhea, chlamydia, trichomoniasis, HSV and genital ulcer disease (by clinical examination).

## **Achievements**

The VICITS Strategy was developed through an intersectoral coordination: MOH, CDC/GAP, USAID, and several civil society organizations (OPROUCE, Kukulkan, Colectivo Violeta, Arco Iris, AHMF, PRODIM, COCSIDA, PASMO, CGSS). All 38 health workers in VICITS sites for MSM and FSWs are MOH employees, and each of those clinics occupies existing Government facilities. These facilities are located in accordance with the "T" shape of the country's high HIV- and possibly STI-prevalence distribution.

The information above highlights the active technical, financial and political involvement of the MOH, which are important elements for the sustainability of this initiative.

Another important finding is that NGOs working with prevention interventions among MARPs have a very positive opinion of VICITS, thereby facilitating an ongoing referral of clients from these organizations. According to the on-site, in-depth individual and group interviews conducted during this assessment, neither discrimination nor stigmatization from MOH personnel to sex workers and MSM was reported by NGO clients using these services. Since these entities are the main MOH channel to reach MARPs, a very close and fluent coordination with them is required.

Among FSWs, slight behavioral changes have been noticed through periodic check-ups at VICITS. For instance, according to the VICITS internal information system, condom use with new and regular clients has increased. Although such advances could not be exclusively attributed to VICITS, these interventions have contributed to the total impact of behavior change efforts in Honduras.

## **What distinguishes VICITS from other services?**

***As the MOH has different types of clinics delivering STI services, what services is VICITS offering as value added when compared to the other MOH STI services?***

***Do these sites provide a differentiated, friendly service, considering the different audiences they serve?***

Some comparative advantages of UMIET/VICITS as compared to a regular UMIET are the existence of:

- A standardized flow chart that is ethologic-based and responds to the MOH STI's norms.
- A standardized data collection form for doctors. Data recorded in the clinic are sent to data entry personnel for entry into database software. The information is received by both the MOH's regional level and by CDC/Tepinet. Currently, there are plans to have the doctors enter the information directly into the system to improve data accuracy.
- An intersectoral VICITS committee. UMIETs are conducted by MOH with irregular NGO cooperation.
- Specialized lab tests that allow health authorities to track STIs with accurate diagnosis. Such lab-based data are updating the national STI epidemiological profile.
- A sensitizing process about sexual diversity for the MOH personnel (not limited to VICITS personnel but also to the majority of the health center staff) to transfer the facilities into friendly venues for MSM subpopulations.

### ***Is the STI sentinel surveillance (VICITS) strategy an effective prevention strategy?***

VICITS is not yet an effective strategy, but has a strong potential to become one. VICITS makes it possible to address a critical facilitating factor in the spread of HIV (as mentioned above), data capture for second generation surveillance and VCT. Through enhancing certain factors—such as the VICITS committees, clinic hours, and promotion of services—these settings could be an important tool for prevention and decision making.

### ***In addition to the VICITS strategy, what else should the HIV prevention program include?***

VICITS needs to reach hidden sub-groups of MARPs, such as the “heterosexual” male sex workers that service both men and women and the new generation of transactional and electronic social networking sex workers. The modalities of sex work have expanded, and MSM have a wide variety of unattended subpopulations in terms of HIV and STI.

### ***Are VICITS activities alone enough?***

No VICITS activities alone are sufficient in terms of presenting a comprehensive national response to HIV. VICITS should be better linked to other prevention initiatives. One of the main gaps found during this assessment was the very rudimentary coordination among stakeholders and implementing organizations of the VICITS strategy. There is recognition of this situation and an incipient movement to address this problem.

## **Challenges**

### **Are VICITS services available to a significant number of MARPs who would otherwise have limited access?**

There is still a considerable proportion of vulnerable MSM and FSWs not covered by the VICITS. It is estimated that in Honduras there are 13,208 sex workers<sup>25</sup>. By September 2009, VICITS had enrolled 1,777<sup>26</sup> FSWs, which is a modest 13% of this population. Also, approximately 90,000 Hondurans are MSM,<sup>27</sup> and the VICITS are attending close to 250 of those<sup>28</sup>. However, there are very few other facilities that offer some of the services available in the VICITS.

### **What have been the constraints to scaling up VICITS services?**

Among the limitations to scaling up are the following: (1) VICITS hours are too early for most FSWs and MSM; (2) the promotion of its services is limited; (3) the stigma attached to the paradigm that people attending to VICITS are sex workers, thereby limiting a broader participation, e.g., by those persons engaging in transactional sex that do not perceive themselves as sex workers; and (4) the perception that since those using VICITS services suffer from an STI, they must also have HIV infection.

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<sup>25</sup> INE and Strengthening the National Response for Health Protection and Promotion in HIV/AIDS, Honduras Rolling Continuation Channel 2007.

<sup>26</sup> *Datos Epidemia del VIH y VICITS en Honduras*. Freddy Tinajeros, Consultant Senior Epidemiologist Country Leader, HIV/AIDS in Honduras TEPHINET-CDC/GAP Cooperative Agreement, September 2010.

<sup>27</sup> INE and Strengthening the National Response for Health Protection and Promotion in HIV/AIDS, Honduras Rolling Continuation Channel 2007.

<sup>28</sup> Data from field interviews by Dr. Carlos Balcaceres with health workers of Manchen, Alonso Suazo, Hospital Atlantida, Miguel Paz Barahona and Crucitas VICITs and from *Datos Epidemia del VIH y VICITS en Honduras*.

## What gaps need to be filled?

- Counter-referral from VICITS to NGOs is weak, which limits the domiciliary follow-up by NGO community leaders/facilitators.
- Limited BCC is done by MOH staff during the client visits at VICITS. BCC is done mainly by NGOs on a sporadic basis. Since each client visit at those clinics lasts around three hours, not taking advantage of this opportunity to do BCC is a missed opportunity.
- Unclear strategy to promote VICITS services among sex workers and MSM. Such promotion relies mainly on NGOs. MOH efforts to find new clients and provide domiciliary follow-up to those not attending their check-ups are weak. Having two VICITS attending only 73 MSM (which it is not cost-effective) in Tegucigalpa is a result of not having a defined promotion work plan. Efforts are under way to address this short-coming. However, this situation needs to be improved, along with the counter-referral system to the NGOs. Coordination between VICITS and NGOs must be clearly included in STI management norms.
- Limited strategic information for decision making is generated from VICITS data. For instance, HIV and STI incidence rates among clients being followed over time at the centers so far are unknown. An improved analysis and cross-validation of records is required to generate substantial input for decision making.

MOH staff, primarily nursing staff, rotates frequently. Trained personnel are moved from VICITS to other health facilities services as part of routine staff rotation, a practice that creates an increased need for training and sensitizing.

## 3. Condom Social Programming and Marketing

As mentioned in the Background Section, in 2000 USAID/Honduras invited PSI's Central American affiliate, PASMO, to initiate a condom social marketing program through the USAID/Washington AIDSMARK Project. PASMO is now registered in Honduras as both a commercial entity and a national NGO. The platform's goal has been to contribute to the overall reduction in the incidence of STIs and HIV/AIDS. From the outset and through 2009, USAID/Honduras supported PASMO in carrying out both condom social marketing and behavior change activities for MARPs through AIDSMARK (until 2005) and through the USAID/Washington PSP-One project (beginning in 2006). However, during 2010, the USAID/Honduras support for PASMO was limited to condom distribution in high-risk outlets. From 2007 to 2010, PASMO was relatively successful in achieving its targets for opening new high-risk sales outlets (e.g., bars, brothels, pool halls, small convenience stores and hotels/motels in "hot zones" for commercial sex), with a 91 to 102% achievement of annual targets for a current total of 1,573 high-risk sales outlets (Table 8). One very important feature of these outlets is that they are not only in the "hot zones" for commercial sex, but they also are open weekends and at night when the MOH clinics and traditional commercial channels, such as pharmacies, are closed. Due to the rotation of sales points as well as the changing nature of the sex trade (by location and modality), some of these sales points go out of business or new "hot zones" emerge and need to be serviced. Of the 1,573 sales points established by the project, PASMO estimates that about 1,200 are currently active. Opening new high-risk sales points to respond to this evolving situation while servicing existing ones will be a continuing need.

**Table 8. PASMO Achievements against Targets in Opening New High-Risk Sales Outlets**

FY07		%	FY 08		%	FY09		%	FY10 (To date)		%
Target	Actual		Target	Actual		Target	Actual		Target	Actual	
382	376	98%	412	389	94%	240	244	102%	310	283	91%

**Is the social marketing intervention reaching the intended beneficiaries?**

**Has this intervention made condoms more accessible to the target populations?**

As can be seen from the data in Table 9, from 2004 to 2009, sales of the lower-priced social marketing condoms, VIVE Amor and VIVE Original, have steadily increased in spite of the large injection of free condoms through the public sector. Results to date indicate that this growth in sales of social marketing condoms is continuing. Interestingly, private sector condom sales have also increased steadily over this period. The trend is probably due to a combination of increased promotion and distribution and the prevention efforts of the MOH and civil society organizations, including correct condom use demonstrations that help demystify condom use and facilitate condom negotiation skills by the target populations. NGOs, MOH clinics and sex workers all stated that due to logistics problems, the no-logo donated condoms are not always available. However, due to PASMO's vigilance of the supply channel as a social marketer, the availability of VIVE has been fairly constant over time.

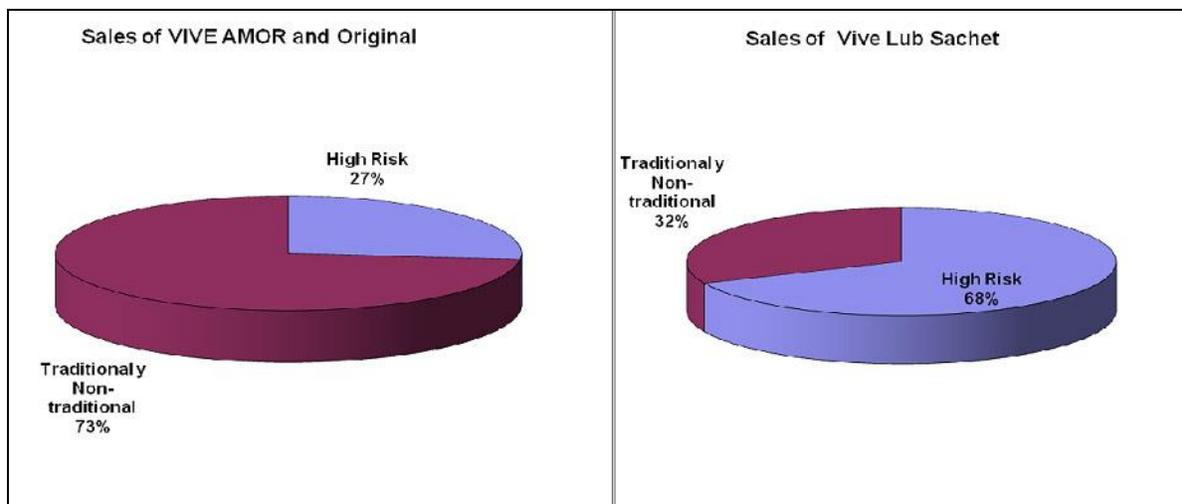
According to the 2009 PASMO TRaC study, VIVE is by far the preferred condom for MSM (80.5%) and FSWs (85.5%). In the same study, 90.1% of FSWs and 76.4% of MSM reported that they could find a condom within 10 minutes, and 84.7% of FSWs found condoms inexpensive.

**Table 9. Trend in Condom Distribution in Honduras by Channel**

	2004	2005	2006	2007	2008	2009
Public Sector	3,622,000	2,671,864	5,902,064	6,344,520	17,269,392	6,589,464
<b>Social Marketing</b>	<b>1,092,144</b>	<b>1,438,869</b>	<b>1,745,130</b>	<b>2,300,354</b>	<b>2,245,766</b>	<b>2,784,816</b>
Private Sector	2,728,301	2,953,084	3,348,258	3,630,399	3,911,250	3,255,030
Total Market	7,442,445	7,063,817	10,995,452	12,275,273	23,426,408	12,629,310
Total Private Sector	3,820,445	4,391,953	5,093,388	5,930,753	6,157,016	6,039,846

Of even greater importance, through efforts at servicing the high-risk outlets, 27% of VIVE social marketing condom sales from 2006 to 2009 (2,350,185 condoms) came from those high-risk outlets as did two-thirds of the lubricant sachets sales (150,536 units). In the latter case, PASMO has been practically the only provider of lubricants outside of the traditional commercial pharmacy sector. Furthermore, in 2009, PASMO sold 66,240 of its colored/flavored condoms and 13,392 of its textured condoms through the high-risk outlet channel. Young adult MSM in particular expressed a strong preference for these items. By adding a positive allure to the condom and counter-acting the perception that condoms reduce pleasure, these other condoms contribute to safer sex in high-risk groups.

**Figure 9. Percent of VIVE Social Marketing Condom and Lubricant Sachet Sales in High Risk Outlets 2006 – 2009**



**Is the activity responding adequately (falling short, meeting, or exceeding demands) to the demand for subsidized condoms?**

PASMO has done a good job of meeting demand in that they keep the supply chain full and in that most sales points visited in urban high-risk zones reported a turnover of several master cartons (16 boxes of three condoms each) a month.

**What have been the constraints to improving condom distribution in high-risk outlets?**

Constraints include the fact that identification and maintenance of these outlets is labor intensive (requiring servicing after hours) and the fact that the outlets are often located in dangerous locations. Few commercial distributors routinely visit all of these outlets and are not highly motivated to distribute social marketing condoms due to their low profit compared to their bread and butter items (snack food, etc.). Some of these outlets, particularly discos and night clubs, are concerned about the effect that condoms and promotional materials have on their establishments’ image and prefer not to make such items available. There is also significant duplication of coverage in high-risk outlets by NGOs donating condoms. In some cases, such as brothels, this is probably healthy because it gives the client a choice. In other cases, such as hotels/motels that are required to make condoms available, it is both unnecessary and undesirable since it provides a subsidy where one is not needed, creates dependency, and diminishes the sustainability of the condom social marketing program. Since the condom is not a top priority for the owners of these establishments, the sales points require constant servicing. These issues need to be further covered in the development of the national condom strategy.

PASMO seems to have developed an effective distribution system through its own sales team, as well as through intermediate distributors. According to PASMO, sales outlets generally do not order more than what they expect to sell in the coming month. This practice reduces shelf life, which helps to conserve condom quality. However, this kind of “just in time” inventory system also requires constant maintenance.

**How many condoms are being distributed?**

See Table 9 above: “Trend in Condom Distribution in Honduras by Channel.”

## Who is using condoms?

### With which partners are people using condoms?

### With what consistency are people using condoms?

Whereas condom use for fertility regulation in the general population (sexually active women of reproductive age) remains around 3%, according to the 2005–2006 Demographic Health Survey (ENDESA), usage rates are much higher in the HIV/AIDS context. The following tables are compiled from data from the PASMO TRaC and the ECVC studies. The TRaC and ECVC data are not directly comparable due to differences in year, methodologies (the ECVC used respondent-driven sampling for the FSWs and MSM whereas the TRaC used location time sampling for FSWs), and location (the ECVC was in Tegucigalpa, San Pedro Sula, La Ceiba and Comayagua whereas the TRaC was in areas around those municipalities and also Choluteca). In addition, the ECVC was an audio computer-assisted interview, and there were some differences in the questionnaires.

Table 10 below shows a general gradient of increased condom use in last sexual relationship by perceived risk (least with regular partner and most with occasional or commercial partner) with the levels in the Garifuna being lower by a disturbing degree.

**Table 10. Percent of Condom Use in Last Sexual Relationship by Type of Partner**

Type of Partner	MSM (TRaC 2009)	PLWHA Male (ECVC 2006)	PLWHA Female (ECVC 2006)	Garifuna Urban (ECVC 2006)	Garifuna Rural (ECVC 2006)
Commercial	95	83	83	74	56
Occasional	94	75	61	50	61
Regular-Stable	78	71	58	23	17
Female (of MSM)	78				

Although the results in Table 11 below on consistent condom use are lower across the board than those for last sexual relationship, they display the same tendency toward increased condom use by perceived risk, with the Garifuna and female PLWHA data on condom use being alarmingly low.

**Table 11. Percent of Consistent Condom Use in the Last 30 Days by Type of Sexual Partner**

Partner	MSM (TRaC 2009)	PLWHA Male (ECVC 2006)	PLWHA Female (ECVC 2006)	Garifuna Male (ECVC 2006)	Garifuna Female (ECVC 2006)
Commercial	92	60	58	-	-
Occasional	91	60	42	42	37
Regular-Stable	75	59	37	12	10
Female	75				

Data for condom use by FSWs in last sexual relationship (Table 12) show high condom use rates for new clients and generally decreasing values as the levels of familiarity and trust increase. Differences between the levels of the TRaC and ECVC studies are probably due to the differences in the methodologies mentioned above.

**Table 12. Results from 2006 EVCV and TRaC 2007, 2009 for Condom Use by FSWs in Last Sexual Relationship, in Percent**

Type of Partner	TRaC 2007	TRaC 2009	EVCV 2006			
			Tegucigalpa	San Pedro Sula	La Ceiba	Comayagua
New Client	98	98	94	89	89	83
Occasional client	99	99				
Regular client	97	98	95	87	79	82
Occasional partner			69	72	62	71
Affective/stable partner	57	42	38	43	48	54

**Table 13. Results from 2006 EVCV and TRaC 2007, 2009 for Consistent Condom Use by FSWs in Last 30 Days, in Percent**

Type of Partner	TRaC 2007	TRaC 2009	EVCV 2006			
			Tegucigalpa	San Pedro Sula	La Ceiba	Comayagua
New Client	94	97	88	83	98	74
Occasional client	97	93				
Regular client	94	95	89	89	99	76
Occasional partner			88	86	92.2	56
Affective partner	57	38	41	53	100	50

There is less information available for lubricant use. However, as seen in Table 14 below, there was a significant increase in lubricant use in last month by FSWs (2007 – 2009), although the levels of use for that group are still low. More work needs to be done to increase access to lubricants for this group, a number of whom have stated that they feel irritation from frequent condom use.

**Table 14. Lubricant Use along with Condom Use, in Percent (from 2009 TRaC)**

Last sexual relationship	FSW		MSM	
	2007	2009	2007	2009
	31	28 (ns)	61	59 (ns)
In last month	35	41 (p< .05)	69	71 (ns)

### What are the barriers to condom use?

Important reasons mentioned in the EVCV for PLWHA not using a condom are sex with regular/stable partner (particularly for females), alcohol use (more so by men), masturbation and oral sex by partner, perception that partner does not like condoms, and partner being also infected (particularly for females). For MSM, substance use (alcohol and drugs) is the main reason given.

**Table 15. Reasons for Not Using a Condom, in Percent (from EVCV 2006)**

Reason	PLWHA		MSM		
	Males	Females	Tegucigalpa	San Pedro Sula	La Ceiba
Consumption of alcohol	23	10	54	51	60
Consumption of drugs	6	5	20	20	21
Sex with regular/stable partner	25	44	6	9	6
Oral Sex by self	14	10	2	0	2
Oral sex by partner	10	8	0	1	0
Masturbation	30	14			
Partner is infected with HIV	9	19			

Reason	PLWHA		MSM		
	Males	Females	Tegucigalpa	San Pedro Sula	La Ceiba
Partner doesn't like	19	22			
When the other does not ejaculate inside			8	6	8
When self does not ejaculate inside			6	4	2

According to information provided by the FSWs in the 2009 TRaC study, factors significantly associated with consistent condom use include exposure to media, belief in efficacy of condoms, higher education, and confidence in the ability to acquire and use condoms. Factors significantly associated with inconsistent use were erroneous beliefs about whom could be trusted, fatalism about contracting AIDS, and a belief that condoms reduce pleasure. Being married or in a consensual union was significantly associated with inconsistent condom use in affective relationships as was the belief that they are unimportant to other people. Also associated with inconsistent use in an affective relationship were not feeling guilty about sex work and the belief that condoms are easy to obtain (this latter reason being somewhat counterintuitive).

**Table 16. Factors That Determine Consistent Condom Use versus Inconsistent Use by FSWs TRaC 2009**

Population	Consistent Use	Inconsistent Use
With clients	<ul style="list-style-type: none"> <li>Quantity of mass media messages exposed to</li> <li>Believe that lubricants used together with condoms reduces the risk of AIDS</li> <li>Believe that condoms are effective in preventing AIDS and other diseases</li> </ul>	<ul style="list-style-type: none"> <li>Have erroneous beliefs about whom they can trust to not use a condom with</li> <li>Believe that sooner or later they will contract AIDS</li> <li>Believe that using condoms reduces pleasure</li> </ul>
With affective partners	<ul style="list-style-type: none"> <li>Complete primary education or higher</li> <li>Believe it is easy for them to use condoms all the time</li> <li>Believe that condoms are not expensive</li> <li>Are not worried about protecting themselves from AIDS</li> </ul>	<ul style="list-style-type: none"> <li>Married or in consensual union</li> <li>Do not feel guilty about the work they are in</li> <li>Believe that they are unimportant to most people</li> <li>Believe that it is easy to get condoms near where they work</li> </ul>

For MSM, exposure to media (in this case, the campaign *Hombre de Verdad*) was associated with increased condom use during the last sexual act. Also positively associated with condom use in the last act were having used a lubricant with a condom in the previous month and having charged or paid for sex with another male in the past year. Associated with non-use were drug use, erroneous beliefs about whom they could trust not to use a condom and, counterintuitively, affirmative response to statements of positive self-esteem. MSM consistent condom use with a male partner was related to ease of use and ease of procuring a condom. Belief in effectiveness of partner reduction was associated with inconsistent use.

**Table 17. Factors That Determine Condom Use versus Non-Use by MSM in Last Sex Act TRaC 2009**

Population	Use	Non-Use
Last sexual relation	<ul style="list-style-type: none"> <li>Remember having seen <i>Hombres de Verdad</i> on TV</li> <li>Having charged or paid for sex with a male in the last year</li> <li>Have used lubricant (together with a condom) in the last month</li> </ul>	<ul style="list-style-type: none"> <li>Have used some kind of drug at least once before having sex with a male partner</li> <li>Have erroneous beliefs about whom they can trust to not use a condom with</li> <li>Believe that they are at risk for</li> </ul>

Population	Use	Non-Use
		contracting AIDS because occasionally they do not use a condom <ul style="list-style-type: none"> <li>• Respond affirmatively to statements of positive self-esteem</li> <li>• Feel secure in the way they should use a condom</li> <li>• Have problems refusing anal sex with an occasional partner if neither has a condom</li> </ul>
Consistent use with a male partner	<ul style="list-style-type: none"> <li>• Believe that it is easy for them to use a condom all the time</li> <li>• Believe it is easy to get a condom or find a place to buy one</li> </ul>	<ul style="list-style-type: none"> <li>• Believe that reducing the number of occasional partners reduces the risk of AIDS</li> </ul>

The three tables above present a very different dynamic in terms of PLWHA, FSWs and MSM condom use. PLWHA appear to be insufficiently informed of the need for protection for themselves as well as for their partners. Drug and alcohol use was key for MSM. Both MSM and FSWs had a positive association between condom use and media exposure, and both also had an association between erroneous beliefs about who they could trust not to use a condom and non-condom use.

### How effectively are condoms being used?

In general, condom use increases with the level of risk (perceived or real) of the relationship, with use being higher in commercial and occasional relationships. This could be part of the reason for the trends in reduction of seroprevalence (Figures 4 and 6 in the Background Section).

### How cost effective are different condom distribution programs?

According to PASMO, the commercial condom marketing through pharmacies and non-traditional channels is self-sufficient in terms of cost recovery (all costs, direct and indirect, of commodity purchase, distribution and promotion). However, due to higher maintenance costs of the high-risk sites and lower income (fewer unit sales and an average lower price due to the product mix), the high-risk sites still require a subsidy. Thirty percent of PASMO marketing costs go to opening and maintaining high-risk sites, but these sites generate only 15% of PASMO's condom sales income. Total costs (direct and indirect) per condom for distribution through the high-risk outlet channel are \$.22/condom, which drops to \$.11/condom net cost after deducting revenues. The wholesale price of VIVE Amor is about \$.13 each and about \$.20 for each VIVE Original, so money is lost on each sale through this channel.

Not included in this cost analysis is income from the higher-priced VIVE brand condoms (colored and textured), which has accounted for 12.5% of the unit sales in the high-risk outlets so far in 2010. As sales through these outlets increase, the net unit cost for maintaining these sales points will decrease. These higher-priced condoms also make condom use appealing and are making a marginal contribution to condom use in high-risk sex acts.

## 4. Voluntary HIV Counseling and Testing (VCT) Programs

USAID supports PEPFAR efforts to expand VCT services to increase HIV care and treatment for persons who are unaware of their serostatus. The HIV rapid test has permitted VCT services to expand beyond the health installations and reach into the communities<sup>29</sup>.

<sup>29</sup> USAID Technical ISSUE Brief - HIV Counseling and Testing, 2010, p. 1.

In 2006, as a pioneering effort, COMCAVI began offering NGO-based VCT with HIV rapid tests with the objective of making the HIV test more accessible and friendlier for the Garifuna population and MARPs by reducing stigma and discrimination. This is important for MSM, who reported discomfort in visiting reproductive health and other clinics offering HIV tests<sup>30</sup>. COMCAVI also used VCT interventions as primary and secondary interventions for behavior changes and for referrals to STI and comprehensive HIV/AIDS treatment services.

The MOH, through the STI/HIV/AIDS Department and the National Laboratory, trained and certified the NGO VCT counselors. The training comprised three components: counseling (two days), HIV rapid test (five days, including supervised practice), and epidemiological surveillance (two days)<sup>31</sup>.

The MOH trained the first 17 VCT counselors in 2006<sup>32</sup> and 16 more in 2007<sup>33</sup>. By 2008, COMCAVI had a team of 20 trained VCT counselors<sup>34</sup> offering rapid HIV test services through 10 NGOs. In June 2010, AIDSTAR-Two succeeded in having the MOH train 12 new VCT counselors; and for October, 2010 AIDSTAR-Two expects to have a second group of 6 trained counselors. In addition to MOH training, COMCAVI, as well as AIDSTAR-Two, trained the VCT staff in complementary counseling areas and strengthened aspects of administering the HIV rapid test.

### **Is VCT efficient and cost effective?**

The VCT strategy with HIV rapid tests is efficient per se, since the HIV rapid tests are very accurate: they are carried out in less than 30 minutes, require little or no additional equipment or reagents, and create less medical waste<sup>35</sup>. Likewise, because they do not require a blood sample or other complex procedures, these tests can be carried out by any well-trained staff from the work teams. As such, the HIV rapid tests help ensure accurate and timely results while dramatically reducing failure to follow up. These tests are ideal for environments with limited resources and facilities<sup>36</sup>.

COMCAVI equipped each NGO with a mini-refrigerator, furniture, and posters with information on the testing procedures. In accordance with MOH guidelines, Oraquick was offered as a confirmatory test to the initial Determine screening test. Both tests have high sensitivity and specificity. When AIDSTAR-Two took over from COMCAVI, it continued utilizing Determine for screening, but changed to Bioline, which is equally sensitive and specific, as a confirmatory test.

In relation to the cost of the tests, for the period from October 2004 through September 2008, COMCAVI budgeted US\$18,903.00 for the purchase of 176 Determine kits (17,600 tests), 472 Oraquick tests (47,200 tests) and 5,055 ELISA tests. The number of rapid tests with VCT from January through May 2006 was 973, of which 17 were positive (1.7%) (Table 21).

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<sup>30</sup> *Comunicando Cambio para la Vida (COMCAVI) Honduras HIV/AIDS Program Continuing Application (October 2006 – September 2007)*, 2006, p. 24.

<sup>31</sup> *USAID Technical ISSUE Brief - HIV Counseling and Testing*, 2010, p. 4.

<sup>32</sup> *Comunicando Cambio para la Vida (COMCAVI) Honduras HIV/AIDS Program Continuing Application (October 2006 – September 2007)*, 2006, p. 25.

<sup>33</sup> *Comunicando Cambio para la Vida (COMCAVI) Honduras HIV/AIDS Program Continuing Application (October 2007 – September 2008)*, 2007, p. 26.

<sup>34</sup> *Comunicando Cambio para la Vida (COMCAVI) Honduras HIV/AIDS Application for Extension (October 2008 – September 2009)*, 2008, p. 11.

<sup>35</sup> *USAID Technical ISSUE Brief HIV Counseling and Testing*, 2010, p. 2.

<sup>36</sup> *Comunicando Cambio para la Vida (COMCAVI) Honduras HIV/AIDS Program Continuing Application (October 2006 – September 2007)*, 2006, p. 25.

**Table 18. VCT with Rapid Tests Applied by COMCAVI in 2006, 2007 and 2008**

NGO	Population	Men	Men (HIV+)	Women	Women (HIV+)	Pregnant Women	Pregnant Women (HIV+)	Total test	Total (HIV+)
Cruz Roja Hondureña	FSW	307	4	698	5	5	0	1005	9
PRODIM		390	6	1272	15	12	0	1662	21
AHMF		0	0	0	0	0	0	0	0
COCSIDA		205	0	292	11	15	0	497	11
Iglesia Episcopal		141	0	0	0	0	0	141	0
<b>Subtotal FSW</b>		<b>1,043</b>	<b>10</b>	<b>2262</b>	<b>31</b>	<b>32</b>	<b>0</b>	<b>3,305</b>	<b>41</b>
Comunidad GAY SPS	MSM	1,040	41	94	4	0	0	1,134	45
<b>Subtotal MSM</b>		<b>1,040</b>	<b>41</b>	<b>94</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>1,134</b>	<b>45</b>
ODECO	Garifuna	11	0	14	0	0	0	25	0
ANEDH		357	12	448	8	2	0	805	20
ECOSALUD		486	7	981	11	92	0	1467	18
Bolsa Samaritana		209	3	390	14	9	0	599	17
CAUSE		20	0	48	0	1	1	69	1
<b>Subtotal Garifona</b>		<b>1,083</b>	<b>22</b>	<b>1,881</b>	<b>33</b>	<b>104</b>	<b>1</b>	<b>2,965</b>	<b>56</b>
Catholic Relief Services (CRS)	General population	199	2	848	7	372	1	1,419	10
CEPROSAF		189	2	223	2	69	0	481	4
<b>Subtotal Other</b>		<b>388</b>	<b>4</b>	<b>1,071</b>	<b>9</b>	<b>441</b>	<b>1</b>	<b>1,900</b>	<b>14</b>
<b>TOTAL</b>		<b>3,554</b>	<b>77</b>	<b>5308</b>	<b>77</b>	<b>576</b>	<b>2</b>	<b>9,304</b>	<b>156</b>

Source: Data reported by COMCAVI in 2006, 2007 and 2008

For the period from January to August 2010, AIDSTAR-Two in turn reported a total of 7,116 tests with 38 positive results (0.5%) (Table 22). The number of HIV rapid tests carried out by AIDSTAR-Two through August 2010 represents 13.5% of registered tests for the same period (52,86437) by the National Laboratory.

**Table 19. VCT Rapid Tests Applied by AIDSTAR-Two from January to August 2010**

NGO	Men	(+) Men	Women	(+) Women	Pregnant Women	(+) Pregnant Women	Total tests carried out	VIH + Tests
AHMF	596	5	568	4	16	0	1164	9
CGSSI	663	5	151	1	15	0	814	6
COCSIDA	699	5	1048	1	175	0	1747	6
ECOSALUD Atlántida	361	3	669	1	71	0	1030	4
ECOSALUD Colon	178	1	638	0	27	0	816	1
PRODIM	315	5	1230	7	13	0	1545	12
<b>Total</b>	<b>2,812</b>	<b>24</b>	<b>4,304</b>	<b>14</b>	<b>317</b>	<b>0</b>	<b>7,116</b>	<b>38</b>

Source: Chart provided by Italia Valladares of AIDSTAR-Two. Honduras, October 5, 2010

<sup>37</sup> 2010 preliminary data provided by Rita Meza, National Laboratory Director. Honduras, October 11, 2010.

In evaluating the cost benefits, considering the costs of tests reported by COMCAVI and the direct and indirect costs to carry out the activity, the cost for this intervention is high. However, the benefit of having VCT willingly accepted by the Garifuna and MARPs and of having an HIV rapid test available is an important accomplishment in HIV prevention at the national level.

Similarly, the quality of NGO VCT services, the ethics of managing patient confidentiality regarding the results, and the schedules during which rapid tests are offered have made the AIDSTAR-Two NGO partners the preferred service provider among the MARPs. The provision of quality and responsive VCT services has strengthened the relationship of the NGOs with their target populations, thereby facilitating the prevention work that they have integrated with the VCT services. While the FSWs wait inside the NGO installations (or in public areas such as at AHMF in San Pedro Sula, which provides VCT in a mobile unit), they participate in BCC activities organized by the NGO educators and assisted by the FSW facilitators and mentors.

### ***Is it effective for an NGO to provide this service?***

The NGOs have succeeded in making the HIV test accessible and friendly and have a clear idea of the percentage of positive results in their populations. The lack of trained counselors is currently limiting the NGOs' capacity to extend this service. One VCT counselor interviewed commented that the FSWs who perform the HIV tests are the FSWs covered by the NGO. There are very few FSWs who arrive at the service for the first time. This situation limits the ability to reach additional members of the populations, one of the objectives of the community-based VCT services; hence, more effective client recruitment methods are needed.

### ***What impact does VCT have on a person's behavior?***

The number of rapid tests offered by the AIDSTAR-Two NGOs to the FSW clients and affective partners and the MSM female partners is presented in Table 23. The FSW clients and affective partners and some MSM female partners are included in the general population category. When offering the HIV rapid test to FSW clients and partners and MSM female partners, the AIDSTAR-Two-supported NGOs perform BCC work, the goal of which is correct and consistent condom use and the adoption of healthy practices (e.g., participation in VICITS/ UMIETS).

**Table 20. VCT with Rapid Tests Applied by AIDSTAR-Two by Population Group - January to August 2010**

Population	Men	(+) Men	Women	Mujeres (+) Women	Pregnant Women	(+) Pregnant Women	Total tests performed	HIV + Tests
Garífuna	539	4	1307	1	98	0	1846	5
MSM	663	5	0	0		0	663	5
FSW	0	0	2,846	12	204	0	2846	14
General Population	1,610	15	151	1	15	0	1761	16
<b>Total</b>	<b>2812</b>	<b>24</b>	<b>4,304</b>	<b>14</b>	<b>317</b>	<b>0</b>	<b>7,116</b>	<b>38</b>

*Source: Chart provided by Italia Valladares of AIDSTAR-Two. Honduras, October 5, 2010.*

### ***What is the quality of the counseling component and protocol?***

AIDSTAR-Two-financed NGOs offering the HIV rapid test follow the MOH guidelines and procedures for counseling and the algorithm-protocol for processing tests. Likewise, AIDSTAR-Two works in close coordination with the National Laboratory, whose director periodically performs quality control on the

test results of each NGO. This quality control consists of the NGOs processing blood sera samples sent by the National Laboratory and returning the results to the National Laboratory. The National Laboratory director compares the results sent by the NGO VCT counselors with those previously obtained at the National Laboratory for the same serum samples and calculates the percentage of coincidence between the results. According to the National Laboratory director, the percentage of coincidence has been between 95 and 100%.

### **How is the health provider performing?**

NGOs have succeeded in positioning themselves at the forefront of the target populations as the best sites for taking the HIV test; that is, they are the preferred places for the FSWs and MSM to obtain their serologic status. In terms of the FSWs, they are required to be tested by the MOH (see below). The NGOs providing VCT, first COMCAVI and then AIDSTAR-Two, report the number of HIV tests and the results to the regional health offices. And, as mentioned above, they have performed well on quality control assessments.

### **What is the level of service availability and barriers?**

Services offered by the AIDSTAR-Two NGOs are of excellent quality (including the management of confidentiality) and are available during hours convenient for the FSW and MSM populations, who attend regularly. For example, the FSWs are required to take the test every two or three months in order to obtain the ID card that allows them to work.

The number of new HIV infections detected (38 positives out of 7,116 tests) does not appear to be high given that these are high-risk populations. This phenomenon could have various explanations. On the one hand, it could indicate that the work in prevention is demonstrating results and, as a consequence, the FSW population approached by AIDSTAR-Two is controlled. On the other hand, it could indicate that not all FSWs who should be reached with VCT are being reached. At this time, it is difficult to increase coverage because there is a limited number of VCT counselors, some of whom perform multiple functions, as in the case of PRODIM where the VCT counselors are educators and carry out BCC interventions as well as HIV rapid tests. Moreover, many sero-negative persons may have multiple tests whereas the NGOs do not re-test confirmed positives. However, as mentioned above, the NGOs do not appear to have been highly successful at expanding their client base for VCT in hidden populations. Alternate client recruitment methods, possibly using incentives, should be tried.

### **Are the services being used?**

According to NGO staff interviewed, the rapid test service is demanded by the population. At one NGO in Tegucigalpa, the five FSWs interviewed stated they would like to have two counselors available for the HIV rapid tests in order to reduce waiting time because they prefer to have the tests done at the NGO.

### **Is VCT creating additional access for MARPs that would not otherwise exist? Are people more willing to seek VCT services from the NGO than from the MOH?**

VCT is reinforcing HIV control and prevention in the groups attended by the NGOs. An important point to stress is that the NGOs are offering the VCT services to FSW clients and affective partners and MSM women partners. This is an important milestone for HIV prevention for MARPs, many of whom would not have been reached otherwise due to their resistance to attending public health services. The VCT service offered by the NGOs is clearly preferred by the clients who attend. Although some FSWs interviewed indicated that they also go to MOH centers, they prefer the NGOs because of the higher level of confidentiality and better counseling. They commented that counseling at the health centers is

limited to questions by health staff from a check list, with no in-depth discussion on risky behaviors or prevention measures. They also considered the counseling at the MOH more impersonal.

Likewise, the FSWs attended by the NGOs are given condoms and are referred for STI testing/treatment or to the Comprehensive Care Units when positive results are obtained. In some cases, NGO staff or volunteers accompany them or direct them to these services. Nevertheless, as mentioned above, the NGOs need to improve their recruitment methods to attract more clients from hidden sub-populations.

## **5. Local Capacity Building**

AIDSTAR-One and AIDSTAR-Two have continued COMCAVI's capacity-building initiative to help local NGOs achieve the greatest possible HIV/AIDS program impact through improved organizational practices. The assistance provided to develop the specific skills and competencies of those organizations was based on previous assessments.

AIDSTAR-Two assisted two groups of NGOs: eight organizations under the Global Fund's umbrella mechanism and six U.S. Government grantees. For the latter group, they conducted the Management and Organizational Sustainability Tool (MOST) as well as the Business Planning for Health Program (BPHP). MOST, developed by Management Sciences for Health in 1996-97, is a structured, participatory process that allows organizations to assess their own management performance, develop a concrete action plan for improvement, and carry out their plan. The cornerstone of the MOST process is a three-day workshop, during which the organizational leadership and selected staff meet to build consensus about the stages of development of their organization's management practices, the improvements needed, and an action plan for making those improvements. This process is aided by detailed instructions on using MOST, including the MOST assessment instrument, a facilitators' guide, and four modules that comprise the workshop agenda.

GFATM NGOs attended the Leadership Development Program (LDP), whose objectives were to:

- Conduct a leadership and management self-assessment to identify strengths and weaknesses in leading and managing skills and opportunities to improve these skills.
- Work as a team (governance and technical bodies) to create a shared vision, mission, and measurable result achievable within six months and conduct an analysis of the barriers to achieving this result.
- Identify an organizational challenge present in the current situation and create an action plan to address the challenge, with support and feedback from technical experts.
- Communicate more effectively with their colleagues.

All of the programs above (MOST, BPHP and LDP) had an initial informational workshop followed by work plan development, in which participants committed to specific assignments (e.g., NGOs that went through LDP had to have their organization's Vision and Mission statements defined/redefined and placed in visible sites; those receiving BPHP had to have a concrete business plan for a feasible service).

AIDSTAR-One's objectives with the national HIV/AIDS support groups network, Honduran Association of People Living with HIV/AIDS (ASONAPVSIDAH), were to strengthen the technical capacity of this association and its ability to provide prevention, care and support services to PLWHA in coordination with the HIV/AIDS Comprehensive Care Unit (CAI). AIDSTAR-One also worked to strengthen the referral system between the CAI and ASONAPVSIDAH to ensure a continuum of care for PLWHA. As technical support for enhancing ASONAPVSIDAH's capacities, AIDSTAR-One is developing three key products: (1) norms to standardize the quality of domiciliary visits (in process); (2) norms to

standardize the quality of self-support groups (in process); and (3) a five-year Strategic Plan (currently under revision).

Across all in-depth interviews, the opinions of NGO representatives about capacity-building efforts were positive and optimistic. For example:

- A CENADEC/JOCAVIS' representative stated that the governance board and technical team of his organization are working more closely and making joint decisions.
- The Comunidad Gay San Pedrana de Salud Integral's team identified a variety of social services they could offer besides prevention of HIV-AIDS to become a self-sustained entity.
- After LDP, Jovenes sin Fronteras decided to reinitiate the process to obtain its legal registration as an NGO.

**Does the local capacity-building proposal respond to country priorities and strategy? How? Is the local capacity building addressing all counterparts as needed? Which counterpart should be the priority for capacity-building activities? Which are the key and cost-effective capacity-building elements the plan should focus on for investment purposes?**

**Table 21. Capacity-Building Priorities Identified in the NGOs' Action Plans**

<b>COCSIDA:</b> <ul style="list-style-type: none"> <li>• Decision making</li> <li>• Planning</li> <li>• Financial resources mobilization</li> </ul>	<b>ECOSALUD</b> <ul style="list-style-type: none"> <li>• Planning</li> <li>• Human resource management</li> <li>• Financial resources mobilization</li> </ul>
<b>CASM</b> <ul style="list-style-type: none"> <li>• Information management (data collection)</li> <li>• Information management (usage of data for planning, evaluating, and decision making)</li> <li>• Financial resources mobilization</li> </ul>	<b>CGSSI</b> <ul style="list-style-type: none"> <li>• Communications (internal and external)</li> <li>• Decision making</li> <li>• Financial resources mobilization</li> </ul>
<b>CASM</b> <ul style="list-style-type: none"> <li>• Information management (data collection)</li> <li>• Information management (usage of data for planning, evaluating, and decision making)</li> <li>• Financial resources mobilization</li> </ul>	<b>CGSSI</b> <ul style="list-style-type: none"> <li>• Communications (internal and external)</li> <li>• Decision making</li> <li>• Financial resources mobilization</li> </ul>
<b>AHMF</b> <ul style="list-style-type: none"> <li>• Decision making</li> <li>• Links to potential clients</li> <li>• Financial resources mobilization</li> </ul>	<b>PRODIM</b> <ul style="list-style-type: none"> <li>• Communications</li> <li>• Supply quality</li> <li>• Financial resources mobilization</li> </ul>

According to local organizational capacity assessments carried out by AIDSTAR-One and Two as a baseline among institutions to be strengthened, the main institutional needs they identified are being addressed by current capacity-building efforts. Despite this, there are still unaddressed organizational areas needing strengthening, such as financial management capacity, project design, monitoring and evaluation, and individual empowerment in areas such as human relations, mediation and conflict resolution.

The Honduran public sector agencies cannot assume the full burden of STI/HIV/AIDS preventive work, nor will they likely be able to do so any time in the foreseeable future. As their counterparts, the NGOs have a critical advocacy and service delivery role to play in the phase-out of the Global Fund in Honduras in terms of prevention programs, particularly those for MARPs. Only technically, organizationally and financially solid organizations could perform that important role. USAID should prioritize these types of NGOs for further strengthening initiatives.

## **Is supporting NGOs to develop prevention and care strategies the best option to reach MARPs?**

USAID should continue with capacity building for certain national NGOs, practically the only effective option to reach MARPs so far. Furthermore, in addition to their role of delivering prevention services, NGOs can be important advocates for the recognition of the importance of HIV/AIDS prevention, particularly those for MARPs.

Community opinion leaders, who are not part of any NGO—e. g., rural MSM leaders (not belonging to NGOs), educators, faith counselors/leaders, community-based organization leaders—are an alternative way to reach MARPs. Such individuals have the capacity to influence the attitudes and behaviors of others through informal communication channels.

### ***What has been achieved in the last five years? What more can be done?***

The decline in HIV prevalence rates in certain populations over the past 10 years could be due in part to the fundamental work of the NGOs, supported by external cooperation agencies. Through capacity building provided in these past five years, some organizations have become solid and technically capable. PRODIM, ECOSALUD, COCS, AHMF (Marie Stopes) and Gay Community San Pedrana were strengthened in capacity building by the COMCAVI project. These organizations comprised five out of the six organizations that obtained AIDSTAR-Two FY10 grants, largely due to their relatively strong institutional capacity.

One NGO credited COMVAVI/AIDSTAR-Two with having revived and re-invigorated the organization after it had gone through a stretch of hard times. One Garifuna village receiving support from the Global Fund credited AIDSTAR-Two with having helped its inhabitants understand more about the political-legal environment, particularly in regards to the rights of the Garifuna people, and were interested in strengthening its policy dialogue with the Government and leveraging its resources, such as with the Honduran Tourism Institute. Through the LDP, the same village had developed community-level plans down to the barrio level. Another Global Fund-supported Garifuna community expressed the opinion that LDP had strengthened the community and the board of directors in problem solving and working as a team and had brought the leaders together. Conflict resolution through identifying and solving problems was also mentioned as an important product of project technical assistance.

### ***Can NGOs become cost-efficient, long-term sustainable actors in prevention?***

NGOs should be transition actors in prevention during donors' (mainly Global Fund and USAID) phase-out until the Government assumes its role in sponsoring HIV/AIDS prevention programs, including those for MARPs. Institutional strengthening should be directed toward increasing NGO sustainability to meet this coming commitment. NGOs cannot be sustainable when their funding relies solely on foreign aid. Therefore, to achieve sustainability, it will be necessary for them to diversify funding (corporate donations and self-generated income, e.g., contract grants with the national government).

### ***What is the potential long-term sustainability of the current strategy aimed at MARPs?***

Two out of 20 NGOs interviewed during this evaluation had some unstructured ideas to alleviate the financial gap that would be created by the cessation of external grants. These two NGOs have not developed an implementation plan. Local NGOs have poor internal capacity for financial sustainability (with the exception of PASMO).

In Honduras, the future of the modality of NGOs working on prevention with MARPs through external donor financing seems to be in doubt. To face the coming funding scarcity for HIV/AIDS worldwide,

donors are forced to prioritize among the most vulnerable countries. As a lower-middle-income country, Honduras would not be a high priority for external cooperation under this likely scenario.<sup>38</sup>

### **What is the most effective strategy for delivering prevention activities to MARPs and creating long-term capacity?**

One suggested strategic effort would be the design of a five-year national plan (with the participation of all HIV national response stakeholders) to confront the Global Fund's phase-out. The plan's purpose should be to prevent any gaps in HIV prevention during this transitional period and include clear and feasible activities for each stage. The most cost-effective and long-term sustainable HIV prevention program would be one in which governmental agencies and self-sustaining NGOs addressing MARPs work jointly and complement each other's efforts.

### ***What mechanisms have been put in place to allow USAID implementing partners to coordinate efforts with the Global Fund? Is there duplication of activities? How have they produced synergy of efforts?***

#### ***Where redundancy of effort exists, what steps can be taken to eliminate overlap?***

AIDSTAR-One and Two are the main local capacity-building mechanisms for NGOs working in HIV/AIDS. No duplication was found in terms of capacity building. Capacity building has facilitated a fluent coordination between USAID/Honduras and CHF/GFATM.

### **Has improved capacity been institutionalized? Is this improved capacity sustainable? If so, how?**

The Global Fund grantees working with MARPs and vulnerable populations have improved governance bodies through LDP training given by AIDSTAR-Two. Furthermore, the coordination and communication between technical and governance bodies have become fluent and bi-directional. Two of these organizations (CENADEC and *Jovenes sin Fronteras*) have begun a formal process to obtain their legal registration as NGOs. The AIDSTAR-Two grantees finished the MOST and Business Plan process, the latter of which was critical to preparing for AIDSTAR-Two FY 2011 grants.

In spite of the successes to date, the NGOs improved capacity is not fully sustainable under current conditions since, among other things, their operational infrastructure is dependent upon international financing. Furthermore, needs for continued capacity building in other areas—such as M&E, planning, and proposal development—still exist. To sustain institutional capacities, organizations also must develop and adopt certain instruments, such as articles of confederation and bylaws, personnel policies and procedures and a financial accounting system.

### **What have been the constraints to capacity-building interventions?**

#### **What gaps need to be filled?**

Among the constraints to capacity-building interventions are:

- Low budgets for NGOs to replicate workshops and carry out necessary steps to improve current institutional status;
- Unclear coordination among AIDSTAR-Two's capacity-building, finance and programmatic areas to monitor NGOs' improvements; and

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<sup>38</sup> PlusNews Global HIV/AIDS news and analysis website: [www.plusnews.org/report.aspx?ReportID=90708](http://www.plusnews.org/report.aspx?ReportID=90708).

- A low level of involvement from the Global Fund’s umbrella organizations as supporting entities in the NGO capacity-building process.

Furthermore, capacity building is not considered by USAID and Global Fund grantees as a contractual commitment; hence, this strengthening process is set aside or delayed due to programmatic tasks.

Capacity building should include clear goals in terms of having a clear picture of the goals the process should or could reach with the selected NGOs. Capacity building has been conducted to meet a project work plan, not to facilitate the advance of NGOs to an enhanced organizational level.

## 6. Social Mobilization

Understanding the dynamics of HIV transmission cannot be separated from understanding the broader context of poverty, inequality and social exclusion which create conditions conducive to unsafe behaviors. The occurrence of HIV/AIDS is influenced by a number of socio-economic, cultural and ecological determinants. Social change communication—with a particular focus on gender inequality, stigma and discrimination, and human rights violations—is an inclusive way of tackling structural and contextual drivers of the HIV epidemic.

The AIDSTAR-Two social mobilization component intends to facilitate the development and implementation of a plan to achieve a more enabling environment to improve MARPs access to prevention and care services. This activity contains four phases:

1. A participatory analysis of the negative social norms that hinder prevention and other services.
2. Commitment and planning with key sectors.
3. Mobilization of activities in alignment with these sectors.
4. Implementation of the plan using targeted communications to support mobilization efforts.

In its first year (2009-2010), the project developed activities with the MSM communities (gay, bisexual, transgender) located in Tegucigalpa, La Ceiba, Comayagua and San Pedro Sula. MSM were chosen since they are the MARP with the highest HIV/AIDS prevalence rate in Honduras (9.9% according to the 2006 ECVC).

To conduct the mobilization process, AIDSTAR-Two selected a core group consisting of MSM community leaders from Tegucigalpa, La Ceiba, San Pedro Sula, and Comayagua, as well as representatives from the MOH, CHF, UNAIDS and CDC. As a result of the first phase, five key social norms were identified as the main obstacles for MSM to access prevention and care programs.

**Table 22. Key Social Norms Identified and Prioritized by the Communities that Participated in the Analysis Phase of the Social Mobilization Program in Honduras**

Social Factors	Level
Machismo	Society, MSM community
Low self-esteem	Individual
Discrimination (homophobia)	Society
Lack of or limited sex-related education	Public policies and programs
Violence (family, with partners and community)	Society

Based on this analysis, the core group, in coordination with AIDSTAR-Two, developed five key priority sectors for an MSM Strategic Plan for Social Change Communication targeting opinion leaders in the health, justice, local government and journalism sectors. The efforts to approach these groups were successful in that these leaders were receptive to the core group’s sensitizing and advocacy efforts, and all of them expressed a willingness to support the vindication of the human rights of sexual diversity

communities by participating in sensitizing sessions. All of these social mobilization and communication activities were carried out by MSM volunteers. As a direct result of this social change communication/social mobilization effort, the Commissioner on Human Rights of the National Autonomous University of Honduras (UNAH) and the Inter-institutional Commission on Penal Justice initiated a plan to vindicate the rights of minorities at the university.

This initiative produced three concrete products: MSM Strategic Plan for Social Change Communication (pending final review and approval); MSM Operational Plan for Social Change Communication; and an Analysis of Social Patterns Adversely Affecting the Adoption of Healthy Sexual Behaviors among MSM. However, competing interpersonal and inter-institutional interests among MSM organizations, with traditional MSM leaders blocking the emergence of new leaders, along with disagreements as to the way AIDSTAR-Two was conducting the process, led to a halt in activities. Therefore, AIDSTAR-Two incorporated social mobilization into the current MSM prevention solicitation. However, given the current environment, conducting MSM social mobilization through the AIDSTAR-Two contractual mechanism does not appear to be a viable option at this time. Nevertheless, to continue this process, USAID should consider adapting the Proyecto Acción SIDA de Centroamérica (PASCA) (including possibly inviting PASCA to conduct the remaining process) due to the achievements reached to date, the potential importance of this initiative, and the great acceptance of this component among the MSM core group and MSM community leaders, the Strategic Alliance model, which does not channel funds for these activities through a single local entity.

The response to the HIV/AIDS epidemic in Honduras necessitates working directly with the core transmitter groups (the high-risk behavior groups) in those geographical areas where the epidemic is still concentrated. If current social prejudices and practices continue stigmatizing and discriminating against MARPs, this will drive these groups further underground, thereby creating conditions favorable to bridging the epidemic to the general population.

## **C. GENERAL QUESTIONS AND OBSERVATIONS**

### **What have been the constraints to achieving an optimal prevention strategy?**

The primary constraints to achieving optimal prevention strategy coverage is that the priority populations are highly stigmatized groups, often hidden and hard to penetrate with conventional prevention efforts which use informal social networking strategies for new client recruitment. Furthermore, the high-prevalence populations and other vulnerable populations are further divided into sub-groups that require interventions tailored to their particular situations and needs (Figures 8 and 9).

On the policy side, there is a current leadership vacuum, partly due to the recent political situation and partly to the perception in certain policy circles that the resources from the Global Fund have gotten the problem under control such that attention can be turned elsewhere. CONASIDA has been inactive as has the IEC committee that brought about coordination in BCC efforts. The MOH National STI/AIDS Program has had a much lower role and profile than in previous years, and their intramural BCC actions appear to be weak. HIV/AIDS also appears to have dropped off the radar screen of interagency coordination in that it has not been a recent agenda item of the *Mesa de Donantes*, nor has the UNAIDS Expanded Theme Group been active recently.

On the civil society side, leadership on the part of affected populations has not matured sufficiently to provide a unified and effective advocacy voice. Leadership has been fragmented, often due to competing personal and institutional interests. A number of important programs, such as VICITS, have not instituted a social auditing feedback mechanism.

Data is being collected (VICITS, VCT, sub-grantee project KAPs), but there is limited evidence of in-depth analysis or the use of strategic information for decision making. Best practices in prevention developed through USAID technical assistance and grants have not been sufficiently disseminated and adapted by other projects. Capacity building among the multiplicity of NGOs receiving HIV/AIDS grants has not been sufficiently strengthened through umbrella organizations.

Provisions in the “Law on Police and Social Affairs” have provided a basis for discrimination against physical violence and abuses against the transgender population, further driving them underground and limiting their occupational opportunities for clandestine commercial sex<sup>39</sup>. The current legal structure requiring parental consent for “invasive” procedures such as VCT hinders the program’s effectiveness in attending to the needs of the younger members of the priority populations.

### **Are the different prevention activities coordinated to form an effective, comprehensive prevention strategy? Why or why not?**

There have been some very good examples of coordination, but more can be done in this area. AIDSTAR-Two has worked closely with the CHF to avoid duplication of grant activities, and the AIDSTAR-Two technical assistance in capacity building to GFATM sub-grantees working with MARPs has further helped promote communication and coordination. It would be useful also to expand this coordination in technical assistance to include prevention for Global Fund grantees to promote best practices and harmonize methods and messages. As mentioned above, the national HIV/AIDS IEC Committee, which performed an important coordination and policy support function, has been dormant and needs to be reactivated. Other areas that need systematic strengthening in their coordination functions include those between the VICITS and the NGOs’ (counter-referrals, patient follow-up) promotion and social auditing of services, and between the CAI and the ASONAPVSI DAH to strengthen comprehensive care, including the follow-up and extension of community-based palliative care and primary and secondary prevention services.

### **What are the gaps that need to be filled?**

Major gaps in the response that require attention include the policy vacuum and need for leadership development at all levels; strategic information, including ethnographic studies of certain key groups such as the Garifuna, IDUs, and transactional sex workers; and the new electronic social networking modalities in commercial sex that recently have come into play.

### **What could be done to strengthen the integration of the prevention pieces?**

The USAID prevention pieces have been well designed to be complementary, and most of the players have been working together for a long time and know each other well. Whereas some of the AIDSTAR-Two Prevention NGOs, such as Mary Stopes/AHMF, coordinate well with PASMO, others have less interest and appreciation of social marketing, which is unfortunate. NGOs need to begin to think about diversifying their suppliers and sources of revenue in case hard times come in terms of condom donations and funds for prevention activities.

In terms of integrating USAID prevention pieces in the future, it is important to emphasize this funding need in the solicitation documents and require that annual partner work plans address the issue. The need for strengthening coordination with the Global Fund and how to do so and the need to revive other donor and public sector coordination are dealt with in Section IV.C.I above.

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<sup>39</sup> “Not Worth a Penny, Human Rights Abuses against Transgender People in Honduras,” Human Rights Watch, May 2009.

**Are there pieces that need to be modified or discontinued? Are there pieces that need to be added?**

**Are there populations and geographic areas that are not being effectively reached by current programs (USAID or Global Fund) that should be prioritized for future programming?**

One prevention piece that could be added is a male circumcision pilot, particularly for the Garifuna population, which has a decidedly generalized epidemic. According to the 2006 ECVC, there was a 9.3% prevalence rate of circumcision in adult male Garifuna, which means that the procedure is at least known, if not common. In discussions with the Garifuna communities, there was general interest in the idea, both among stakeholders and the target population, although no one volunteered to be first in line. It is worth conducting a small investigation to develop a culturally available package for adult males and possibly as a standardized opt-out delivery room procedure offered to all in certain hospitals on the North Coast, where many Garifuna are born (Atlántida, Puerto Cortés, Tela and Trujillo).

The transgender populations, possibly the most affected group in terms of both HIV prevalence and social vulnerability, require further attention. The high-risk population about which the least is known includes drug users, IDUs and others. Data from the ECVC below show, in some cases, alarming rates of the use of injectable drugs, with many of those users admitting to having shared syringes. Also alarming is the use of other dangerous drugs, such as “crack” (Tables 26 and 27). A FSW high on crack, or emotionally down and needing another hit, is not likely to effectively negotiate condom use with a client.

**Table 23. Percent of Populations that have Injected Drugs at Some Point in Their Life - ECVC Studies 2006**

PLWHA		Garifuna		MSM		
Male	Female	Urban	Rural	Tegucigalpa	San Pedro Sula	La Ceiba
3.9	2.0	9.9	10.7	6.9	13.4	.01

**Table 24. Percent of FSWs That Have Used Drugs in the Past Year, ECVC 2006**

Drug	Tegucigalpa	San Pedro Sula	La Ceiba	Comayagua
Injected cocaine or heroin	2.0	4.6	3.3	6.6
Inhaled cocaine or crack	22.1	23.0	11.5	9.5

Other populations that could benefit from further ethnographic studies are the male sex workers (*Zopes*) who service men and women, transactional sex workers (waitresses, food vendors, etc., who do not consider themselves FSWs), and the new generation of electronic networking sex workers.

In terms of additional geographic areas, there is largely anecdotal evidence from the Southern corridor, including the cities of San Lorenzo and Choluteca and the area along the Pan American Highway connecting El Salvador to Nicaragua through Honduras, which needs to be supported with further primary information.

**Does the population believe that the HIV prevention and diagnostic activities meet the community needs? What strengths are observed? What weaknesses are observed?**

There was a generally high level of satisfaction among the Garifuna, especially with the communications program, which they thought was effective in involving youth and changing their attitudes and behaviors, particularly in terms of respect for one another. They also had very positive comments on capacity-building activities in terms of leadership development and the development of a business plan. The FSW leaders and mentors also expressed satisfaction and gratitude, and several mentioned personal changes

in their lives, such as giving up alcohol and drugs (except when with clients). While in one sense the leaders-mentors activity can be considered a best practice, it is also labor-intensive, costly, and difficult to scale up. The NGOs need to implement more effective client recruitment methodologies, such as PDIs (see bibliography section on social networking) to further penetrate the target populations and increase coverage as described in the BCC Section (IV.B.1).

However, the transgender community in general and MSM outside of the San Pedro Sula area both expressed a strong feeling that they were not sufficiently attended to and/or involved in USAID-sponsored project activities. A variety of factors, including leadership problems and rivalries among the MSM community, halted the social mobilization process (Section IV.B.6) for policy advocacy for this group. There were also a number of questions raised about the transparency and fairness of the sub-granting process by non-recipients, so considerable care needs to be taken in this area.

### **What else could be done to ensure that interventions are effective?**

Intervention efforts can have their effectiveness enhanced through improved strategic information, including further analysis and dissemination of program and study data such as the VICITS database, the VCT data, the TraC studies, and the ECVC. Quantitative data needs to be enriched by ethnographic data on key sub-populations, such as drug users, Trans sex workers, the “Zopes” sex workers, and the new emerging modalities of commercial sex. As described above, newer social networking modalities for client recruitment should be introduced to penetrate hidden populations further.

Mass media and drama presentations, especially for Garifuna youth, should be followed with structured discussions to involve the audience and to ensure that key messages are properly understood and interpreted.

### **What else could be done to ensure that interventions are sustainable?**

Honduras has been a leader in the development of trained professional HIV/AIDS human resources personnel who have left their positions to work for international development agencies, either at home or abroad. This migration will continue until it becomes more attractive to remain in position. Therefore, a constant upgrading of human resources will be necessary, along with the creation of policy instruments (e.g., norms, standards, and official policies) that transcend changes in personnel and governments.

Client ownership and organizational capacity are also important for sustainability. For the Garifuna, this means further community organization and strengthening of community governance, leadership and conflict resolution under the health promotion model<sup>40</sup>. For sexually diverse populations, it means further strengthening in leadership, advocacy and policy dialogue, proposal development and linkages with international sexual diversity advocacy groups, and conflict resolution. Another option to mitigate financial vulnerability may be to explore linkages with existing programs for credit and income-generation projects for key NGO MARPs partners as part of the capacity-building program. The commercial marketing activities of the PASMO condom social marketing program are currently self-sufficient, although the current level of support for the high-risk sales locations is not.

Sustainability for FSWs is more problematic. The most effective approach may be to focus on mature organizations, programs and structures (e.g., VICITS, AHMF and PRODIM) that best serve and represent the interests of this group. Organizations such as AHMF and PASMO, which have affiliations

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<sup>40</sup> Organización Panamericana de la Salud. División de Promoción y Protección de la Salud, Municipios y Comunidades Saludables.(n/d). *Guía de los Alcaldes para Promover la Calidad de Vida*.

with international PVOs, have an advantage in terms of accessing funds, and the Mission might want to consider promoting further partnering. The religious sector has a tradition of these linkages, but has an irregular track record when it comes to working with MARPs, although there have been some exceptional examples, such as the Maryknoll nuns and the Sisters of the Oblate Order in Guatemala.

HIV/AIDS programs for MARPs are particularly vulnerable in the policy arena as well as in the financial area. The country has made strong commitments to universal access to ART and PMTCT. Without the injection of finances from the Global Fund and agencies such as USAID, there will be real difficulty in maintaining basic prevention services, such as the provision of condoms and VCT, much less IEC and interpersonal prevention campaigns. Without international financial agency advocates at their side, MARPs will have little leverage in the competition for scarce public health resources and in combating stigma and discrimination. There is a modest potential for leveraging private-sector programs for some vulnerable populations, such as with employers of transport workers (marine and terrestrial) and possibly agricultural workers on large plantations, but these programs will be operating at the fringe of the problem.

#### **D. MANAGEMENT FINDINGS**

Since the outset of *Comunicando VIDA* (the COMCAVI predecessor project) in 2002 through today, USAID/Honduras has employed multiple simultaneous implementation mechanisms. Current mechanisms/implementing partners include PASMO, Local Technical Assistance Unit (ULATS) (about to end), AIDSTAR-One and CDC through an interagency agreement. This apparent multiplicity of implementing agencies (not including sub-grantees) has functioned well due to the clarity of responsibilities and scopes of work, disposition of the partners to collaborate, and proactive coordination of the Mission project officers, including the periodic convening of coordination meetings. There have been occasional examples of redundancy, such as in the case of PASMO and NGO educators working with the same populations, but generally work appears to have progressed quite smoothly.

One recent structural problem is that there have been a series of one-year extensions of COMCAVI (including AIDSTAR-Two), which means the partners have been operating off of one-year work plans instead of through a more strategic framework and vision. Furthermore, the one-year NGO sub-grant cycles present an onerous management burden on both project and NGO staff, including the solicitation process and the subsequent close-outs, which leave little time in between for programmatic efforts to achieve and measure meaningful results.

## **APPENDIX A. SCOPE OF WORK**

### **Global Health Technical Assistance Project GH Tech Contract No. GHS-I-00-05-00005-00**

#### **SCOPE OF WORK (Revised: 07-22-10)**

#### **I. TITLE**

Activity: **Evaluation of the prevention component of USAID/Honduras's HIV/AIDS strategy**  
Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

#### **II. PERFORMANCE PERIOD**

The performance period begins in early September and continues through o/a end November 2010. Team will work in country from o/a September 7 – o/a October 13<sup>th</sup>.

#### **III. FUNDING SOURCE**

#### **IV. USAID/HONDURAS THROUGH FIELD SUPPORT**

#### **V. PURPOSE**

This is a Statement of Work (SOW) for the evaluation of the prevention component of USAID/Honduras's HIV/AIDS strategy. The purpose is to determine the effectiveness of programs for targeted beneficiaries; to document that program objectives have been met; to provide information about service delivery that will be useful to program staff and other audiences; and to enable program staff to make changes that improve program effectiveness.

This evaluation will focus on evaluating the impact of prevention activities, inclusive of, but not limited to: mass media campaigns targeting most-at-risk populations (MARPS); theater groups; behavioral change communication (BCC) activities; social mobilization; condom social marketing; clinic-based sexually transmitted infections services for testing and counseling (VICITS) for MARPS; and local capacity building. The evaluation report will include a description and analysis of progress made in meeting program objectives, coordination of USAID-funded activities with the Ministry of Health (MOH) and other donor programs, especially the Global Fund, and recommendations for further refining the program. The results of this evaluation will be used by USAID/Honduras to make informed decisions about future HIV programming in Honduras.

#### **VI. BACKGROUND**

In June 2004, USAID/Honduras and the Government of Honduras (GOH) signed a Strategic Objective Grant Agreement (SOAG) for the Health Activity, under the Mission's Strategic Objective, "Investing in People." The original Completion Date of the SOAG was September 30, 2009, which was subsequently extended through September 30, 2011. In collaboration with the Ministry of Health (MOH) and private sector partners, the HIV-related component of the SOAG contributes to the achievement of the intermediate result "HIV and Other Infectious Diseases Contained".

To that end, the USAID HIV program provides assistance to: (i) prevent the transmission of HIV; (ii) provide basic care and support services to people with HIV/AIDS; (iii) measure changes in the prevalence of HIV infection and risk-taking behavior; and (iv) increase the capacity of the National AIDS Program to monitor and evaluate HIV/AIDS activities. These activities have been carried out in those geographical areas with the highest prevalence of HIV/AIDS infection and focusing on MARPs, namely commercial sex workers (CSW), transgender people, men who have sex with men (MSM), the Garifuna<sup>41</sup>, and people living with HIV/AIDS (PLWHA).

As follow-on to the abovementioned SOAG, the Mission is in the process of developing a new Assistance Agreement with the GOH for implementation of its new Country Assistance Strategy (CAS) for the period 2009-2013. Under the CAS, the HIV component focuses on the improvement of health status of CSW, transgender people, MSM, the Garifuna, and PLWHA.

Under the CAS, the Mission aims to: (i) increase access to quality prevention services, especially for MARPs; (ii) increase access to quality clinical and community care and support services, for HIV-infected adults and their families; (iii) strengthen the organizational and technical capacity of local NGOs to implement prevention activities and expand community-based HIV counseling and testing among MARPs; (v) support mass media communication and community mobilization; (vi) strengthen the MOH's national HIV surveillance and monitoring and evaluation systems; and (vii) provide technical assistance to improve supply chain management for antiretroviral drugs.

Under its new Results Framework (currently pending approval in Washington), the Mission will seek to achieve Intermediate Result (IR) 4.3, "Use of Quality HIV/AIDS Services Expanded," under Assistance Objective 4, "Health status for underserved and vulnerable populations improved." This IR is supported by two Sub-IRs:

Sub-IR 4.3.1: Access to quality prevention services for most-at-risk populations.

Sub-IR 4.3.2: Quality of HIV/AIDS treatment and care and support services improved

The associated HIV prevention indicators are as follows: (i) percentage of MARPs reporting use of condom with most recent partner (disaggregated by population); (ii) percentage of MARPs reporting reduction of partners during last 12 months (disaggregated by population); (iii) number of target population reached with individual and/or small group level preventative interventions based on evidence and/or meet minimum standards required; (iv) number of local organizations provided with technical assistance for HIV related institutional capacity building; (v) number of individuals who received counseling and testing for HIV and received their results; (vi) number of eligible adults and children provided with one minimal care service according to national and international standards.

In March 2010, a Central American Regional HIV/AIDS Partnership Framework was signed. The framework, signed with COMISCA, the Central American council of Ministers of Health, outlines the general framework for USG assistance in the region. Although the Honduras program is bilateral, it must also fit within the general outlines of the Framework. The Framework offers the U.S. Government (USG) the opportunity to partner with Central American governments, regional and national agencies, civil society, and other donors to influence and mitigate the impact of the HIV epidemic through focused technical assistance and capacity building of persons and health systems. In the case of bilateral missions, such as Honduras "activities under this regional Framework are intended to support, complement and coordinate with existing USG bilateral HIV programs to ensure that activities not managed through the USG regional HIV program contribute to supporting the major goals of the Framework."

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<sup>41</sup> Hondurans of Afro-Caribbean ethnicity.

## ***The HIV Epidemic in Honduras***

Honduras has an estimated adult HIV prevalence rate of 0.7%. With only 18% of the population of Central America, Honduras reports 38% of the AIDS cases in the region. The male:female ratio of AIDS cases is 1.1:1, indicating what is believed to be a predominantly heterosexual mode of transmission. Within the general population, the age group most affected is between 15 and 49 years old, representing approximately 70% of the cases. The epidemic is concentrated along the central corridor of the country, between Choluteca and the North Coast. While all departments have reported HIV/AIDS cases, accumulated incidence rates show the most affected departments to be Cortés, Francisco Morazán, Atlántida, Yoro, Choluteca, and Colón. In addition, the MOH reports an antenatal HIV prevalence rate of 0.3%.

Although the prevalence rate of the general population is below 1%, Honduras is considered to have a concentrated epidemic, with specific populations showing significantly higher prevalence rates than the general population. In 2006, a Behavioral Surveillance Survey (BSS, 2006) was implemented to measure knowledge, attitudes, practices, and HIV/Sexually Transmitted Infection (STI) prevalence rates in four populations, including MSM, CSWs, PLWHAs and the Garífuna. Data were gathered from Tegucigalpa, San Pedro Sula, Comayagua and several Garífuna communities on the North Coast. The data below compares the results from a 2001 multicentric study<sup>42</sup> (EMC, 2001) with those from the recent 2006 BSS:

HIV prevalence among MSM (approximate population of MSM population of 90,000):

- EMC (2001): 8.2% in Tegucigalpa, 16% in San Pedro Sula
- BSS (2006): 5.7% in Tegucigalpa, 9.7% in San Pedro Sula

HIV prevalence among CSW (approximate population of CSW population of 13,208):

- EMC (2001): 8.0% in Tegucigalpa, 13% in San Pedro Sula
- BSS (2006): 5.5% in Tegucigalpa, 4.6% in San Pedro Sula

In 1998 the estimated HIV prevalence rate in the Garífuna community was 8.4% (1998 MOH Syphilis, Hepatitis B and HIV Investigation).<sup>43</sup> However, the 2006 BSS showed a prevalence rate of 4.5% in the Garífuna population.

## ***The Government of Honduras' Response to HIV/AIDS***

Over the past decade, the GOH has taken various steps to respond to the AIDS epidemic. The first HIV/AIDS National Strategic Plan (PENSIDA I) was put into effect from 1998 to 2001. In 1999, the GOH passed legislation to protect the rights of persons living with HIV/AIDS and formed a National Commission on AIDS (CONASIDA) to coordinate national HIV/AIDS policies and programs.

A second HIV/AIDS National Strategic Plan (PENSIDA II) was implemented from 2003 to 2007. PENSIDA II was developed through a consultative process around two main strategic components: preventive interventions targeted at high-risk populations to reduce vulnerability, and provide STI treatment and HIV/AIDS care.

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<sup>42</sup> Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 2002; Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en mujeres trabajadoras comerciales del sexo en Honduras. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 2002.

<sup>43</sup> Estudio seroepidemiológico de Sífilis, Hepatitis B y VIH en población Garífuna de El Triunfo de la Cruz, Bajamar, Sambo Creek y Corozal. Departamento de ITS/VIH/SIDA, Secretaría de Salud, Honduras, 1999.

A third PENSIDA III for 2008-2012 is now in effect. Under PENSIDA III, prevention efforts for MSM, Garifuna, CSWs and pregnant women are being scaled-up; the Sula Valley, North Coast, and southern Honduras are being prioritized due to their higher prevalence rates; and more resources are being provided for HIV diagnosis and treatment in the priority regions and for the monitoring and evaluation of PENSIDA.

### **USAID's HIV/AIDS Activities in Honduras**

USAID has worked in close collaboration with the GOH in the prevention of HIV since 1993. Beginning in 1995, USAID/Honduras has supported four umbrella-grant activities to prevent HIV and strengthen local organizations. A September 1999 evaluation of these activities concluded that USAID's focus on building an effective NGO AIDS-prevention network was sound but that USAID should focus more on NGOs working with high-risk groups.<sup>44</sup> A number of changes were made in the Mission's AIDS program as a result. In 2000, USAID asked the Pan American Social Marketing Organization (PASMO) to initiate a condom social-marketing program for high-risk groups and invited the Population Communications Services (PCS) Project to assist the Mission and the MOH to develop a national mass-media campaign. Also in 2000, the Mission re-competed the cooperative agreement for its umbrella grants program. In August 2002, AED was selected and began to implement "Comunicando Vida." In 2004, COMCAVI was awarded, again to AED, through another competitive process; this umbrella grants program ran through November 2009. The aforementioned activities continued to run for the duration of the Mission's four-year HIV/AIDS strategic plan (2004 – 2008). Under that strategy, which was subsequently been extended to September 30, 2011, the major objectives have been to: (i) prevent the transmission of HIV; (ii) provide basic care and support services to people with HIV/AIDS; (iii) measure changes in the prevalence of HIV infection and of risk-taking behavior; (iv) increase the capacity of the National AIDS Program to monitor and evaluate HIV/AIDS activities. These activities have been supported in those geographical areas with the highest prevalence of HIV/AIDS infection and specifically among MARPs.

Under the extension of the current strategy, the current HIV activities (with implementing partners shown below in brackets) are as follows:

- Condom social marketing, especially for MARPs in high risk outlets [PASMO/ABT].
- NGO behavior-change communication programs, including activities to promote partner reduction, abstinence, and condom use and to reduce stigma associated with HIV infection, especially among high-risk populations [AIDSTAR II – Until recently this was managed by AED/COMCAVI (2004-2008). This activity is now managed by MSH/AIDSTAR II].
- Voluntary testing and counseling by NGOs, especially for high-risk populations, including post-test prevention counseling [AIDSTAR II – Until recently this was managed by AED/Comunicando Cambio para la Vida (2003-2004) and AED/COMCAVI (2004-2008). This activity is now managed by MSH/AIDSTAR II].
- Procurement of rapid HIV tests for use in program-supported NGO activities.
- Development and implementation of a small-scale social mobilization program to address detrimental social norms that increase vulnerability among MARPs. [AS II]
- Build the capacity of NGOs working to prevent HIV/AIDS among key high-risk groups that receive USG funding for their activities, as well as those that are funded by the Global Fund. [AS II]

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<sup>44</sup> Cortez, C. and Fitzgerald, A. et al. EVALUATION OF THE AIDS/STD PREVENTION AND CONTROL PROJECT (522-0216). USAID/Honduras. Under Contract No. HRN-C-00-99-00005-00. November 1999.

- NGO care and support programs for HIV positive people, including but not limited to prevention counseling, referral for anti-retroviral therapy and STI, tuberculosis and other medical and social services [AS I]
- Technical support to strengthen the national response to HIV/AIDS through improved provision of prevention, PMTCT, counseling and testing, treatment, care and support services [AIDSTAR I].
- Data-collection and reporting systems related to the above.
- Design and implementation of systems to measure national HIV sero-prevalence high-risk behaviors among high-prevalence groups [CDC].
- Design and implementation of program monitoring and evaluation mechanisms [CDC].
- Strengthen the sentinel surveillance (VICITS) of sexually transmitted diseases (STDs) in SWs and MSM [CDC]

The current USAID HIV/AIDS program, in coordination with other donors, the MOH, and private sector partners, provides technical assistance and budget support to (i) prevent the transmission of HIV; (ii) provide basic care and support services to people with HIV/AIDS; (iii) measure changes in the prevalence of HIV infection and of risk-taking behavior; and (iv) increase the capacity of the National AIDS Program to monitor and evaluate HIV/AIDS activities.

Priority prevention indicators under the current USAID program are as follows: (i) percent of MARPs reporting use of condom at last sex act (disaggregated by population); (ii) median number of no regular male sex partners reported by MSM; (iii) percent of target population who know two ways to prevent sexual transmission of HIV; (iv) percent of target population who reject the most common misconceptions about HIV infection; and (v) percent of MSM, CSWs, and Garifuna who know their HIV status.

### ***The Global Fund in Honduras***

USAID and the Global Fund are the largest HIV/AIDS donors in Honduras. In addition, USAID is an active member of the Fund's local governing board.

Honduras was awarded a Round I Global Fund HIV/AIDS grant and UNDP served as the Principal Recipient. Global Fund approved continuing support on a rolling basis for an additional six years. Since May of 2008, Honduras Country Coordinating Mechanism has chosen CHF as the country's Principal Recipient.

The three main objectives of the Global Fund's program are to:

- I. Promote and defend the human rights of PLWHA;
- II. Protect at-risk populations through adoption of risk-reducing behaviors; and
- III. Strengthen comprehensive, integrated services for PLWHA.<sup>45</sup>

The Global Fund program received an initial HIV/AIDS grant of \$27.3 million from 2003-2008. At the Global Fund's invitation, Honduras submitted a proposal to extend this grant, and a \$47 million extension of the program to 2014 was approved. Under Objective 2, the Global Fund has awarded over 45 grants to local NGOs, to work with most at risk populations. In addition, activities are being scaled up from 39 to 69 municipalities which will allow the extension of antiretroviral (ARV) therapy coverage and increased prevention activities.

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<sup>7</sup> Honduras, CCM. GFATM Proposal Form Rolling Continuation Channel, Phase III. July 2007.

Recently, the Global Fund approved a ninth-round for an HIV/AIDS grant for a maximum of \$21.9 million over a five year period to provide support to orphans and vulnerable children in 25 priority municipalities.

## **VII. METHODOLOGY**

The evaluation team should consider a range of possible methods and approaches to collecting and analyzing the information which will be required to assess the evaluation objectives and questions outlined in section VIII below – including but not limited to: review of background documents (preliminary list provided in Annex 1), key informant interviews (preliminary list provided in Annex 2), focus groups and site visits, and a team planning meeting. Data collection methodologies will be discussed with and approved by USAID prior to the start of the evaluation. The approach taken to the evaluation will be participatory, and the outcome will be a summary of progress to date and a set of recommendations to improve performance and ultimate impact.

The team will conduct a two-day team planning meeting upon arrival in Honduras and before starting the in-country portion of the evaluation. During this meeting, evaluation team members will review and clarify any questions on the SOW, draft an initial work plan, develop a data collection plan, finalize the evaluation questions, develop the evaluation report table of contents, clarify team members' roles and responsibilities, and assign drafting responsibilities for the evaluation report. The meeting's outcomes will be shared with USAID/Honduras, and the health team of the Mission will participate in sections of the meetings, as appropriate.

## **VIII. SCOPE OF WORK**

The purpose of the current SOW is to determine the effectiveness of the USAID HIV prevention program for targeted participants; document that program objectives have been met; provide information about service delivery that will be useful to program staff and other audiences; and enable program staff to make changes that improve program effectiveness. The consultant team will be familiar with international and regional best practices for concentrated epidemics, and will use these to inform their recommendations.

The current SOW will be executed at the end of USAID's current strategy in order to determine what, if any, effect (short and long-term) the program has had on the targeted primary and secondary beneficiary populations and communities. Since some components of the prevention program are still ongoing, it is expected that this study will also find out what actually occurs in practice and if the program is operating as planned, document interactions with participants, and discover which components work best and if the program meets the needs of the participants.

Based on the review of relevant materials, field visits, and in-country consultations with key contacts, the evaluation team will assess: i) relevance; ii) effectiveness; iii) efficiency; iv) impact; and, v) sustainability for each of the following areas:

### **I. Evaluating Behavior Change Communication (BCC) Activities**

Questions should address evaluation of the change in the following stages of the BCC model: change in knowledge, beliefs, perceived risk, skills, and advocacy. The BCC interventions of the USAID prevention program include mass media campaigns, theater groups, social mobilization, self support groups, and others.

- a. What has the reach of the activities been within the intended target populations?
  - Are we effectively reaching the beneficiaries we want to reach?

- Are we reaching pockets of MARPs that we need to reach in order to have maximum impact?
- b. Do the current activities represent the most efficient and effective means to reach MARPs?
  - What are specific strategies to improve the reach and quality?
  - What is the optimal mix of multiple interventions to maximize effectiveness and efficiency?

## **2. Evaluating Sexually Transmitted Infection Control Programs**

- a. Is the STI sentinel surveillance (VICITS) strategy an effective prevention strategy?
  - In addition to the VICITS strategy, what else should the HIV prevention program include? Are VICITS activities alone enough?
- b. What distinguishes VICITS from other services?
  - As the MOH has different type of clinics delivering STI services, what services is VICITS offering as value added when compared to the other MOH STI services?
  - Do these sites provide a differentiated, friendly service considering the different audiences they serve?
- c. VICITS services available to a significant number of MARPs who would otherwise have limited access?
- d. What have been the constraints to scaling-up VICITS services?
- e. What gaps need to be filled?

## **3. Evaluating Condom Social Programming and Marketing**

The evaluation will address condom availability and condom quality, including quality of customer service. Questions on logistics to determine availability will also be used by the evaluators, as well as outlets check and mapping, as appropriate.

- a. Is the social marketing intervention reaching the intended beneficiaries?
- b. Has this intervention made condoms more accessible to the target populations?
- c. Is the activity responding adequately (falling short, meeting, or exceeding demands) to the demand for subsidized condoms?
- d. What have been the constraints to improve condom distribution in high-risk outlets?
- e. How many condoms are being distributed?
- f. Who is using condoms?
- g. With which partners are people using condoms?
- h. With what consistency are people using condoms?
- i. What are the barriers to condom use?
- j. How effectively are condoms being used?
- k. How cost-effective are different condom distribution programs?

## **4. Evaluating Voluntary HIV Counseling and Testing (VCT) Programs (clinic-based) for MARPs**

The evaluation will address how counseling and testing services are delivered and how effective the program is in term of promoting prevention behavior.

- a. Is VCT efficient and cost effective?

- Is it effective for an NGO to provide this service?
  - What impact does VCT have on a person's behavior?
  - What is the quality of the counseling component and protocol?
- c. How is the health provider performing?
  - d. What is the level of service availability and barriers?
  - e. Are the services being used?
  - f. Is VCT creating additional access for MARPs that wouldn't otherwise exist? Are people more willing to seek VCT services from the NGO than from the MOH?

## **5. Evaluating the Local Capacity Building Component**

- a. Does the local capacity building proposal respond to country priorities and strategy? How? Is the local capacity building addressing all counterparts as needed? Which counterpart should be the priority for capacity building activities? Which are the key and cost-effective capacity building elements the plan should focus on for investment purposes?
  - b. Is supporting NGOs to develop prevention and care strategies the best option to reach MARPs?
    - What has been achieved in the last five years? What more can be done?
    - Can NGOs become cost efficient, long-term sustainable actors in prevention?
  - c. What is the potential long-term sustainability of the current strategy aiming at MARPs?
  - d. What is the most effective strategy to get prevention activities to MARPs and create long-term capacity?
    - What mechanisms have been put in place to allow USAID implementing partners to coordinate efforts with the Global Fund? Is there duplication of activities, How have they produced synergy of efforts?
    - Where redundancy of effort exists, what steps could be taken to eliminate overlap?
- a. Has improved capacity been institutionalized? Is this improved capacity sustainable? If so, how?
  - b. What have been the constraints to capacity building interventions?
  - c. What gaps need to be filled?

### **The following general questions should be addressed in the evaluation in addition to the specific programmatic components aforementioned:**

- a. What have been the constraints to achieving an optimal prevention strategy?
- b. Are the different prevention activities coordinated to form an effective comprehensive prevention strategy? Why or why not?
- c. What are the gaps that need to be filled?
- d. What could be done to strengthen the integration of the prevention pieces?
- e. Are there pieces that need to be modified or discontinued?
- f. Are there missing pieces that need to be added?
- g. Are there populations and geographic areas that are not being effectively reached by current programs (USAID or Global Fund) that should be prioritized for future programming?
- h. Does the population believe that the HIV prevention and diagnostic activities meet the community needs? What strengths are observed? What weaknesses are observed?
- i. What else could be done to ensure that interventions are effective?
- j. What else could be done to ensure that interventions are sustainable?

Additionally, as gender dynamics have a direct impact on health status; existing inequities between men and women affect both access to quality health services and participation in community processes. The evaluation should address power imbalances between men and women that affect relative abilities to seek (and to provide) needed HIV/AIDS services and to make informed decisions related to healthy behaviors.

## IX. TEAM COMPOSITION

The evaluation team will consist of three people: one Team Leader - a local or regional professional - and two local team members who are familiar with the HIV/AIDS situation in Honduras. The Team Leader must have strong analytical and writing skills and be fluent in English and Spanish. The team leader should have experience in and familiarity with Central America and the HIV epidemic in the region. He/she should have experience developing, assessing, and managing HIV prevention programs. The team leader should have previous experience leading assessment/evaluation teams.

For the local team members fluent spoken and written Spanish is required. The team members must have documented experience in HIV prevention behavior and social change, communication, and social marketing. A public health background and solid experience in working with government counterparts, local NGOs, and HIV/AIDS prevention with MARPs in Honduras is preferred.

## X. TIMELINE AND LEVEL OF EFFORT

USAID/Honduras anticipates that preparation days, in-country work in Tegucigalpa, and site visits, as well as drafting and finalizing the evaluation report, will be completed according to the following Level of Effort (illustrative).

A 6-day work week is authorized while working in-country.

The Level of Effort for this assessment will roughly be as follows (illustrative):

Task	LOE (Days)
Document review/preparation (out of country)	2
Team planning meeting	2
Finalize evaluation framework/protocol	2
Interviews and discussion with key stakeholders	7
Field studies at project implementation sights – possibly 1-2 flights involved (e.g., LaCeiba and the NGOs situated along the corridor)	15
Group discussions/Analysis of findings	4
USAID debriefing	1
Draft report writing	5
Report revisions, based on Mission comments (out of country) (Team Leader: 5/Team Members: 2)	5
Travel (to and from Honduras) for Team Leader	2
<b>TOTAL CONSULTANT LOE</b>	<b>45 (Team Leader) 40(Team Members)</b>

The above tasks are to include adequate time for consultations, exchanges of findings, team planning, and report preparation and discussion with Mission staff.

The evaluation should be completed in nine weeks (estimated), including preparation days, all in-country work, and report writing and finalization. GH Tech may take additional 2-3 weeks after Mission sign-off on the document to send the final report.

## **XI. LOGISTICS**

GH Tech will provide all logistical arrangements such as flight reservations, country cable clearance, in-country travel, airport pick-up, lodging, and interpreters, as necessary.

USAID/Honduras will provide key documents and background materials for reading and help arrange the in-briefing and debriefing. The Mission may choose to participate in the evaluation as much as possible. Although exact participation will be determined during the team planning meeting; someone from USAID will participate in key meetings with the Ministry of Health and other stakeholders and as well some field visits.

The evaluation team will schedule meetings as appropriate. USAID/Honduras staff will be available for consultations regarding contacts, sources, and technical issues before and during the evaluation.

## **XII. RELATIONSHIPS AND RESPONSIBILITIES**

The evaluation team members will report to the Team Leader, and the Team Leader will be supervised by the USAID/Honduras Project Management Specialist.

**GH Tech** will conduct and manage the assessment and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the three-person evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.
- Respond to all points included in the SOW, including the submission of the final report.

**USAID/ Honduras** will provide overall technical leadership and direction for the evaluation team throughout the assignment and will undertake the following specific roles and responsibilities:

### **Prior to in-country work:**

USAID/Honduras will undertake the following prior to in-country work:

- Consultant Conflict of Interest (COI). To avoid COI or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding any potential COI.
- Background Documents: Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.
- Key Informant and Site Visit Preparations: Provide a list of key informants, site visit locations, and suggested length of field visits for use in planning for in-country travel and accurate estimation of country travel line items costs (i.e. number of in-country travel days required to reach each destination, and number of days allocated for interviews at each site).
- Lodging and Travel: Provide information as early as possible on allowable lodging and per diem rates for stakeholders that will travel/participate in activities with the evaluation team. Also, provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics.

## During in-country work:

USAID/Honduras will undertake the following while the team is in-country:

- Mission Point of Contact: Ensure constant availability of the Mission Point of Contact person(s) to provide technical leadership and direction for the consultant team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. While consultants typically will arrange meetings for contacts outside the Mission, support the consultants in coordinating meetings with stakeholders,
- Formal and Official Meetings. Arrange key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings).
- Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.
- Facilitate Contacts with Partners. Introduce the team to project partners, local government officials, and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

## Following in-country work:

USAID/Honduras will undertake the following once the in-country work is completed:

- Timely reviews: Provide timely review of draft and final reports and approval of the deliverables.

## XIII. DELIVERABLES

**I. Protocol or Framework:** Present USAID with the protocol or framework for the evaluation after the team planning meeting (TPM), including all the materials produced during the meeting. The framework paper will describe the methodology, data collection instruments, processing and analyzing data and a description on how the study will document and analyze the impact of the program and ongoing activities. USAID/Honduras will assist the evaluation team in developing a detailed budget, which will be attached to the protocol. The protocol should also include a section on ethical issues to be dealt with during the study, if applicable. Evaluation framework and protocol must be finalized and approved by USAID prior to the initiation of interviews and site visits.

The first two days of the assessment will be dedicated to the TPM. On the second day of the TPM, the team will meet with Mission staff to discuss the work plan preparations and evaluation framework. Among other matters, the Statement of Work, the intent or purpose of the evaluation will be explained, discussed and amended as appropriate for clarification of expectations. After the first days of activities, it is expected that the team will have learned which persons are in a position to actually use the findings, understanding how the evaluation results are to be used; proposing final explicit evaluation questions to be answered; describing practical methods for sampling, data collection, data analysis, interpretation, and judgment; polishing the written protocol that summarizes the evaluation procedures, with clear roles and responsibilities for all stakeholders; and planned if critical circumstances change.<sup>46</sup>

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<sup>46</sup> Adapted from a) Joint Committee on Standards for Educational Evaluation. Program evaluation standards: how to assess evaluations of educational programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994; and b) U.S. General Accounting Office. Designing evaluations. Washington, DC: U.S. General Accounting Office, 1991; publication no. GAO/PEMD-10.1.4.

**2. Preliminary finding presentations:** The team will schedule 2-3 meetings with the USAID team while in-country to discuss preliminary findings and recommendations. These will be scheduled at the convenience of the team and USAID once in country.

**3. Mission final debriefing:** The team will conduct the final debriefing of USAID/Honduras staff. The final debriefing will include the presentation of main findings and recommendations, and will be presented both orally and in writing. The debriefing should present key findings and recommendations in a power point format. The power point presentation will be shared with GH Tech prior to the debriefing.

**4. Draft Report:** The evaluation team will submit the first draft report [in English –hard copy and electronic file- of the final assessment report to the Mission and GH Tech at the end of the team’s visit. This draft will include findings, conclusions/lessons learned, and recommendations for Mission review and comment. The Mission will provide written comments to the evaluation team and GH Tech within 10 working days of receiving the draft report.

**5. Final Report:** The evaluation Team Leader will submit the final unedited report to USAID/Honduras and GH Tech within 10 working days after the team receives comments from USAID/Honduras. GH Tech will provide the edited and formatted final document approximately 30 days after USAID provides final approval of the content. USAID/Honduras requests both an electronic version of the final report (Microsoft Word 2003 format) and 5 hard copies of the report. Procurement sensitive information will be removed from the final report and incorporated into an internal USAID Memo. The remaining report will then be released as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and the GH Tech project web site ([www.ghtechproject.com](http://www.ghtechproject.com)).

Draft Table of Contents (to be discussed and finalized during the team planning meeting)

Acronym List

Executive Summary

Evaluation Findings and Conclusions

    Overall

        Components

        Other observations

        Management Findings

        Observations

Recommendations

    For USAID

    For partners

    For the future

Annexes

    1. SOW

    2. List of people met

    3. Schedule

    4. Data collection instruments

#### **XIV. ESTIMATED BUDGET**

TBD

#### **XV. MISSION CONTACT PERSON**

Ritza Yamileth Avilez de Briceño  
HIV/AIDS Project Management Specialist  
USAID/Honduras Mission  
Tel: (504) 2369320 ext 4360  
Fax: 2367776  
Cell: 88650546

## **ANNEX I.**

### **Preparatory Materials**

USAID/Honduras will provide GH Tech electronic copies of background and other relevant materials to be distributed to team members. The team members will be expected to review the materials prior to arrival in Honduras and will be given five person days of preparation time prior to departure from the United States.

The materials will include, but not be limited to:

- USAID/Honduras HIV/AIDS Country Strategy 2004-2008
- HPN Results Frameworks (2005-2009 and 2010-2015)
- BSS 2006 and DHS Reports
- PENSIDA III
- GFATM Rolling Continuation Channel Proposal
- USAID Stakeholder Continuing Applications, M&E Plans, program descriptions for the local NGO grants, and reports on OP indicators
- COMCAVI “end of grant cycle” data
- Cortez, C.; Fitzgerald, A. et al. EVALUATION OF THE AIDS/STD PREVENTION AND CONTROL PROJECT (522–0216). USAID/Honduras. Under Contract No. HRN-C-00-99-00005-00. November 1999.
- Epidemiologic profile 2007: “El perfil epidemiológico de ITS/VIH/SIDA en Honduras, 2007: ¿A dónde debemos dirigir recursos, y qué otros datos necesitamos?”
- Central American Partnership Framework

## ANNEX 2.

### List of Key Stakeholders and Partners

Name	Organization	Position
Dr. Lícida Bautista	AS II	Director
Dr. Mayte Paredes	CHF	HIVOS
Dr. Amanda Sevilla	CAI, Miguel Paz Barahona	
Ing. Milton Funes	CHF	Director
Dr. Jeremías Soto	World Vision	
Dr. Hector Galindo	Department of STI/HIV/AIDS	Director
Dr. Marco Urquía	Department of STI	Director
Dr. Rolando Pinel	AS I	Director
Dr. Fanny Mejía	Global Fund CCM	Executive Secretary
Justa Suazo	Global Fund CCM	President
Julio Zuniga	PASMO	Country Manager
Henry Sabillon	PASMO	Behavior Change Communications Coordinator
Dr. Alvaro Gonzalez	MSH/ULAT	Executive Director
Perla Alvarado	MSH/ULAT	Director of Communications Activities
Dr. Alberto Stella	UNAIDS	Representative
Lic. Juan Ramón Gradelhy	UNAIDS	Senior Technical Advisor
Dr. Elsa Palou	CAI Tórax	Director
Dr. Rita Meza	Central Laboratory	Director
Dr. Gina Morales	HIV/AIDS Program: Central Region	Director
Dr. Melisa Lazo	CAI Hospital Escuela	Director
Donny Reyes	Arco Iris (NGO)	Director
Dr. Lesby Castro	Metropolitan Region	Chief of HIV/AIDS Metropolitan Program
Humberto Castillo	Garífuna IEC Committee	Coordinator
Leticia Hernández	ASONAPVSIIDA	President
Dr. Juana Aldana	Region No. 3	HIV/AIDS regional coordinator
Dr. Karen Erazo	CAI Hospital Mario Catarino Rivas	Medical Assistance
Dr. Karla Zepeda	PAHO/WHO	
Dr. Flor María Matute	UNFPA	HIV/AIDS POC
Dr. Freddy Tinajeros	Tephinet/CDC	Director
Lic. Norma Galindo	Tephinet/CDC	

Select local NGOs participating in AS II and Global Fund programs such as:

### Organizations working under the umbrella of ASII Honduras

Organization	Director	Project Coordinator
CASM	Lic. Nelson Garcia	Evlin Chacon
ECOSALUD	Lic. Melida Quevedo	Dra. Sonia Guiti
Comunidad Gay Sampedrana	Ramón Valladares	Oscar Carrión
Asociación Hondureña Mujer y Familia	Lic. Concepcion Caceres	Marlen Ordoñez
PRODIM	Dr. Sadith Cáceres	Dr. Javier Calix
COCSIDA	Prof. Maria Luisa de González Triminio	Kenia Cárcamo

## Participants of MSM Core Group

#	Name	Organization
1	Javier Medina (Coordinador del grupo núcleo)	Líder gay Tegucigalpa
2	Patricio Vindel	Líder de la comunidad LGTB/HSH, La Ceiba
3	Dany Rodríguez	Líder de la comunidad LGTB/HSH Tegucigalpa
4	Claudia Spellman	Líder de la Comunidad TTT San Pedro Sula
5	Donny Reyes	Líder de la comunidad LGTB/HSH Tegucigalpa
6	José Santos Maldonado	Líder de la comunidad LGTB/HSH Comayagua

## Organizations that have received support in Capacity Building from AIDSTAR II Honduras

#	Organization	Participants
1	Asociación Cultural RIMAS Sede: Tegucigalpa, M.D.C.	a) Director: Martha Hernández b) Coordinador del Equipo PDL: Abigail López
2	Colectivo Violeta Sede: Tegucigalpa, M.D.C.	a) Director: José Bonilla b) Coordinador del Equipo PDL: Oscar Amador
3	Organización Pro Unión Ceibeña OPROUCE Sede: La Ceiba; Atlántida	a) Director: Patricio Vindel b) Coordinador del Equipo PDL: David Sequeiros
4	Patronato Triunfo de la Cruz Sede: Tela, Atlántida	a) Presidente de Junta Directiva: Braulio Martínez b) Coordinadora del Equipo PDL: Edda Elvir
5	Patronato Tornabe Sede: Tela, Atlántida	a) Presidente de Junta Directiva: Luis Zuniga b) Coordinadora del Equipo PDL: Andrea Valerio
6	Jóvenes Sin fronteras Sede: Siguatepeque, Siguatepeque	a) Directora: Elffy Reyes b) Coordinadora del Equipo PDL: Carolina Reyes
7	CENADEC Centro Nacional de Capacitación Sede: El Progreso, Yoro	a) Directora: Rommel Meza b) Coordinadora del Equipo PDL: Dilma Lizeth Sevilla

## **ANNEX 3.**

### **USAID HIV/AIDS Prevention Partners**

#### **AIDSTAR-One (AIDS Support and Technical Assistance Resources)**

AIDSTAR-One is a global United States Agency for International Development (USAID) project, awarded in 2008 to John Snow, Inc. The Project's focus is to provide high quality technical assistance services to the Office of HIV/AIDS and USAID Missions in PEPFAR non-focus countries.

The focus of AIDSTAR-One activities in Honduras is to improve access and quality of HIV/AIDS services provided through the Secretariat of Health's Department of STI/HIV/AIDS, in partnership with the Secretariat of Health, the Honduran Association of People Living with HIV/AIDS (ASHONAPVSIIDA), other USAID implementing partners and USAID/Honduras.

#### **AIDSTAR-Two (AIDS Support and Technical Assistance Resources)**

AIDSTAR-Two, led by Management Sciences for Health (MSH), began in Honduras in 2008. The project provides grants and technical assistance to local non-governmental organizations (NGOs) to implement HIV/AIDS prevention and support programs for most-at-risk populations (MARPs), which include men who have sex with men (MSM), commercial sex workers (CSW), Garifuna (Afro-Caribbean population), and people living with HIV/AIDS (PLWHA).

Program activities in Honduras include: ongoing capacity building; support for implementation of VCT using rapid-tests; development and distribution of tools related to information, education and communications, behavior change communications and monitoring and evaluation; and the creation of opportunities and mechanisms to share lessons-learned, materials and best-practices.

#### **ULAT (Unidad Local de Apoyo Técnico)**

ULAT, led by Management Sciences for Health (MSH), began in Honduras in 2002. ULAT is a USAID-funded program working with the Ministry of Health (MOH) to improve equitable social sector investments and to increase the use of quality maternal, child, and family planning/reproductive health (FP/RH) services. ULAT strives to deliver quality, results-based consulting services to the country's Ministry of Health with regard to health sector reform and decentralization. In addition, ULAT's HIV/AIDS prevention communications program is aimed at increasing knowledge of HIV prevention methods among the general population and reducing the stigma and discrimination against people living with HIV/AIDS. ULAT also assists Global Fund's Country Coordinating Mechanism (CCM) in developing a resource mobilization proposal so that the CCM can access funding from a diversified donor base, including the Ministry of Health, to support its structure and daily activities.

#### **PASMO (Pan American Social Marketing Organization)**

PSI/Honduras began its operations in 2000 focusing mainly on sexual and reproductive health. The platform's goal has been to contribute to the overall reduction in the incidence of Sexually Transmitted Infections (STIs) and HIV/AIDS. PSI/Honduras has worked to achieve this goal through its social marketing program, which takes a holistic approach to promote healthy behaviors. PSI/Honduras works to empower individuals by providing information through various formats, so that it is not only easy for individuals to understand, but also so that it may be associated with products which are accessible, available and contribute to saving lives. Therefore, as the populations served continue to learn about good health – and demand it – they will have with them the necessary tools to lead healthy lives.

## CDC (U.S. Centers for Disease Control and Prevention)

CDC Global AIDS Program support for Honduras began through its Central American Regional Office. The Global AIDS Program provides direct support to build country capacity in the areas of surveillance and laboratory. These and all CDC's global HIV/AIDS activities are a part of the unified US Government effort to turn the tide against the epidemic, the President's Emergency Plan for AIDS Relief, which was announced in 2003.

## **APPENDIX B. PERSONS CONTACTED**

### **USAID-Washington**

Lindsay Stewart, LAC/HPN  
Clancy Broxton, GH/Prevention Specialist

### **USAID-Guatemala**

Heidi MIHM, PEPFAR Regional Coordinator

### **USAID-Honduras**

Kellie Stewart, HPN  
Ritza Avilez de Briceño, Project Management Specialist  
Christine Janes, SPS  
Courtney Dunham, Passant

### **Global AIDS Program/Regional Office for Central America & Panama/ Centers for Disease Control and Prevention (CDC)**

Lily De León, Senior Program Manager

## **HONDURAS**

### **UNAIDS**

Alberto Stella, Country Coordinator  
Juan Ramón Gradelhy, Senior Technical Advisor

### **OPS**

Gina Watson, Country Representative  
Karla Zepeda, HIV Consultant

### **UNFPA**

H. Clavijo, Country Representative

### **Global Fund – CCM**

Fanny Mejía, Executive Secretary

### **Community Housing Foundation- (CHF)**

Milton Funes, Director  
Dr. Mayte Paredes, Directora Tecnica CHF/GFATM

### **USAID Projects**

#### **AIDSTAR One**

Rolando Pinel, Director  
Nora Maresh, Program Officer  
Liziem Valladares, Senior Technical Adviser

#### **AIDSTAR Two**

Lícida Bautista, Previous Director  
Jorge Fernández, Actual Director  
Italia Valladares, Technical Assistant  
Arturo Kafati, Capacity Building Manager  
Italia Valladares, Technical Assistant  
Perla Alvarado, Coordinator of Communication

Monica Palencia, Educator and Monitoring  
Glenda Duron, Finance Assistant  
Marisela Bustillo Manager of Communication  
María Elena Ramírez, Finance Director  
Norma Moncada, Finance Assistant

### **ULATS**

Álvaro Gonzales Marmol, Project Director

### **PASMO**

Julio Zuniga, Country Director  
Sussy Longo, Regional Communications Director  
Susy Barrios, Regional Administrator  
Onan Saul Duran, Supervisor  
Jose Fausto Castillo, Promoter  
Juana Pastora Estrada, Promoter  
Adolfo Velásquez, Seller  
Juan Carlos Martínez, Seller  
Elvin Nuñez, Seller

### **CDC/TEPHINET**

Dr. Freddy Tinajeros, Director  
Dra. Norma Leticia Artiles, VICITS Coordinator

### **Ministry of Health**

#### **National Program ITS/VIH/SIDA**

Marco Antonio Urquía, Head of Program ITS, National Program ITS/VIH/SIDA  
Hector Galindo, Head of Department ITS/VIH/SIDA, National Program ITS/VIH/SIDA  
Raul Henríquez, Medical-Technical Integral Attention, National Program ITS/VIH/SIDA  
Abel Antonia Rosales, Psychologist, National Program ITS/VIH/SIDA  
Xiomara Oyuela, Pharmaceutical unit, National Program ITS/VIH/SIDA  
Diana Núñez, Coordinator UU Epidemiological, National Program ITS/VIH/SIDA  
Odalys García, Coordinator Program PTMI, National Program ITS/VIH/SIDA  
Olga Castañeda, Nurse of National Program ITS/VIH/SIDA  
Mirna Isabel Toledo, Coordinator Unit, National Program ITS/VIH/SIDA  
Lesby Castro, Coordinator Metro Region, National Program ITS/VIH/SIDA  
Gina Morales, Technical Assistant, National Program ITS/VIH/SIDA  
Rita Meza, Director, Central Laboratory

### **UMIETS/VISITS**

Amanda Sevilla, Coordinator VICIT San Pedro Sula  
Iveth Barahona, Supervisor  
Lourdes M. Godoy, Medical Assistant  
Berlin Tosta, Nurse  
Marbin Leiva, Educator  
Dra. Dixiana Flores, Coordinator VICIT Ceiba  
Dra. Suyapa Regina Elvir, Medical Doctor VICIT Las Crucitas  
Erlinda L. Ramirez, Typing Personnel  
Dr. Virgilio Maradiaga, Medical Doctor VICIT Alonso Suazo  
Dra. Magdalena García, Medical Doctor VICIT Manchen  
Dra. Marlen Henríquez, Director of CESAMO Manchen

## **NGOs**

### **Asociación Hondureña Mujer y Familia (AHMF)**

Sara Mercedes Cortes, Project Educator  
Sandra Iveth Amador, Educator  
Malene Jeanett, Project Coordinator  
Karla Mendieta, Technical Monitoring  
María Concepción Cáceres, Executive Director  
Juan Bautista Carbajal, Educator Comayagua

### **Grupo LGTB – Comayagua**

José Santos Maldonado, President

### **OPROUCE - La Ceiba**

Patricio R. Vindel, Coordinator

### **PRODIM - Tegucigalpa**

Martha Luz Berrios, Educator  
Leonel M. Cruz, Educator  
Javier Cáliz Borjas, Project Manager

### **Jóvenes sin Fronteras**

Alonso Ernesto Cruz, Facilitator  
Elffy Florentina Cruz, National Coordinator  
Lorenzo Rodriguez Castellanos, Facilitator

### **COCSIDA - La Ceiba/Tela**

Kenya Cárcamo, Coordinator  
Teresa de Andrade, Director  
Nimfa Germer, General Medical  
Dunia Lemus Diaz, Educator  
Leslie de Alfonso, Project Coordinator

### **CASM – San Pedro Sula**

Cesar Augusto Cárcamo, General Coordinator  
Elvin Chacon, Project Coordinator

### **Colectivo Violeta - Tegucigalpa**

Juan Luis Enamorado, Educator

### **ECOSALUD**

Melida Quemado, Director  
Sonia Guity, Project Coordinator

### **ASONAPVSI DAH**

Justa Suazo, President  
Denis Martinez, Executive Director  
Karla Patricia Sanchez, Facilitator

**Colectivo Unidad Color Rosa**

Fernanda Vallejo, Educator  
Roxana Almendrades, Project Coordinator  
Lisa Camacho, Educator  
Gabriela Redondo, Educator  
Claudia Spellmam, Executive Director

**CGSSI**

Oscar Carrier, Project Coordinator  
Ramon Valladares, Executive Director  
Daisy Maldonado, Administrator  
William Acosta Paz, Technical Educator  
Hector Alfredo Castillo, Educator

**Patronato Triunfo de la Cruz**

Marla Aurora Martinez, Promoter  
Jaime Aranda, Administrator  
Zenaida Solíz, Artisan  
Edda Elvir, Coordinator  
Leonardo Morales, Secretary  
Braulio Martinez, President

**Patronato Tornabé**

José Luis Ortez, Vocal I  
Jorge Castillo, President  
Arnol Bernárdez, Vice President  
Edwin Barrios, Pro-Secretary  
Iris Arzú, Secretary  
Maribeth Vásquez, Vocal II  
Walter Suazo, President  
Cristian Reyes, 5th Vocal

**CENADEC/JOCAVIS**

Rommel Meza, Coordinator  
Darwin Perez, Technical Educator

**KUKULKAN**

Javier Medina, Director  
Dany Rodríguez, Kukulkan Educator and Leader of LGTB/MSM Core Group

**Asociación Cultura Rimas**

Martha Hernández, Director  
Abigail López, Team Coordinator

**CEPRES**

Josué Hernández, Director  
Darwin Perez, Technical Educator

**Fundación LLAVES**

Rosa González, Director and Editor of the magazine LLAVES

## APPENDIX C. SCHEDULES

September 2010						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2 Document review/preparation	3 Document review/preparation	4
5	6 Labor Day	7 <b>Travel to Honduras (Stan, Carlos, Meline)</b>	8 <b>Team Planning Meeting (TPM)</b>	9 <b>TPM</b>	10 Finalize evaluation framework/protocol	11 Finalize evaluation framework/protocol
12	13 Meet w/USAID to discuss work plan & finalize evaluation framework Conduct interviews	14 Interviews & discussions w/key stakeholders. Visit VICITS Tegucigalpa	15 National Holiday (Independence Day)	16 Interviews & discussions w/key stakeholders	17 Interviews & discussions w/key stakeholders	18 Group discussion/prepare for field work
19 Rest day	20 Fly to <b>La Ceiba</b> Visit 3 institutions Overnight in La Ceiba	21 Drive to <b>La Tela</b> Visit 3 institutions Overnight in La Tela Visit VICITS SPS Overnight San Pedro	22 Inicia taller VICIT en Comayagua Drive to <b>El Progreso</b> Overnight in San Pedro Sula (SPS)	23 Drive to project sites in <b>SPS</b> (4 institutions) Overnight in SPS	24 Drive to project sites in <b>SPS</b> (4 institutions) Overnight in SPS	25 Group discussions/analysis of findings Overnight in SPS
26 Rest day Overnight in SPS	27 Drive to project sites in Siguatepeque (1) and Comayagua (2) Return to Tegucigalpa	28 Tegucigalpa PRODIM 11 a.m. AIDSTAIR 1 (Meline) and AIDSTAR 2 CB (Carlos) 2:00 p.m.	29 Tegucigalpa 10:30 a.m. USAID Ritza Aviles. 2:30 p.m. Asociación Cultural RIMAS	30 8:30 a.m. Colectivo Violeta. 11:00 a.m. Javier Medina (grupo núcleo) 1:00 p.m. Dany Rodríguez Líder de comunidad HSH		

October 2010						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 Group discussions/ analysis of findings	2 Group discussions/ analysis of findings
3 <b>National Holiday</b>	4 10:00 a.m. Dr. Lesby Castro. Chief of HIV/AIDS Metropolitan Program and Dra. Norma Artiles CDC/ Tephinet	5 Group discussions/ analysis of findings	6 Group discussions/ analysis of findings	7 USAID Debrief/PPT AS I, AS II, CDC, PASMO y Secretaria de Salud Meeting ONUSIDA, CHF, CCM, OPS Y UNFPA Meeting	8  Draft report writing	9  Draft report writing
10 <b>Carlos needs to depart</b>	11 <b>Columbus Day</b>  Draft report writing	12 <b>National Holiday</b>  Draft report writing	13 <b>Submit draft report to USAID Stan &amp; Meline depart</b>	14	15	16
17	18	19	20	21 <b>National Holiday</b>	22	23
24	25	26	27 USAID provides comments on draft report	28 TL/TMs work on revised report	29 TL/TMs work on revised report	30

## APPENDIX D. DATA COLLECTION INSTRUMENTS

### GUIA PARA CLIENTES

Buenos días. Mi nombre es \_\_\_\_\_ y formo parte del equipo del Proyecto GH Tech de USAID/Washington quienes nos encontramos desarrollando una Evaluación de los programas de prevención de VIH para las poblaciones de mayor riesgo (PEMAR) apoyados por USAID y nos interesa conocer su opinión sobre la marcha del Proyecto. Como PEMAR están incluidos las y los trabajadores de sexo (TS) y sus clientes y Hombres que tienen sexo con hombres. También la población Garífuna tiene una alta prevalencia de VIH y las personas que viven con VIH tienen necesidad de programas de prevención. Todos sus aportes serán estrictamente confidenciales.

Desde ya agradecemos *el tiempo* que nos brinda y le invitamos a contestar unas preguntas sobre las intervenciones de comunicación para *el cambio* de comportamiento (CCC), servicios de Prueba voluntaria con consejería o VCT, Vigilancia centinela de ITS (VICITS) y mercadeo social, para la prevención del VIH.

Nombre de entrevistador: \_\_\_\_\_

Fecha: \_\_\_\_\_

Lugar: \_\_\_\_\_

Nombre del entrevistado: \_\_\_\_\_

Instancia: \_\_\_\_\_

### **COMPONENTE DE CAMBIO DE CONDUCTAS (CCC)**

1. Para empezar dígame ¿qué actividades de prevención de VIH realiza esta organización para su grupo? ¿dónde, cuándo y con qué frecuencia se realizan las actividades? (*indagar intervenciones online*)
2. ¿Ha participado en alguna de las actividades? ¿En cuál/es? ¿De qué manera le ha ayudado a usted participar en estas actividades?
3. ¿Considera que los temas que se tratan en las actividades son temas que necesita su grupo? ¿Por qué? Por favor cuénteme ¿qué temas que se tratan? Estos temas ¿se entienden, pueden ponerse en práctica?
4. Participando en las actividades de prevención de VIH para su grupo ¿qué cambios personales ha podido hacer en su vida? ¿qué dificultades/obstáculos/barreras ha encontrado para hacer esos cambios personales?
5. ¿Qué opina de la variedad de actividades de prevención de VIH que esta organización realizan para su grupo? ¿Qué otras actividades considera que hace falta hacer? ¿Cómo se podrían mejorar las actividades de prevención que se realizan para su grupo?

### **COMPONENTE DE ITS PARA LAS PEAR AFUERA DE LOS VICITS**

1. ¿Ha sufrido ITS en el último año?
2. Si es afirmativa la respuesta ¿Ha recibido atención médica? ¿Dónde? ¿Por qué?
3. Si es negativa la respuesta ¿Conoce alguien que si haya sufrido de ITS en el último año? Si o no ¿Recibió atención médica? ¿Dónde? ¿Por qué?
4. ¿Conoce los VICITS? ¿Sabe donde están? ¿Qué opina de ellos? ¿Qué ha escuchado sobre ellos?
5. Si ha ido a un VICITS ¿Recibió CCC para ITS/VIH/SIDA?
6. ¿Le dieron condones? ¿Cuántos?

### **COMPONENTE DE MERCADEO SOCIAL DEL CONDÓN VIVE**

1. ¿Cuáles son las barreras del uso de condones en su grupo?
2. ¿Cómo se puede superar estas barreras?
3. ¿Cuáles son sus lugares preferidos para conseguir condones? ¿Donde los conseguiste la última vez?
4. ¿Piensa(n) usted(es) que el acceso a los condones es adecuado? Si, no es adecuado, ¿cómo se puede mejorarlo?
5. ¿Ha(n) estado en una situación en que quiso usar un condón, pero no fue disponible? ¿Por qué no?
6. ¿Ha(n) escuchado y/o visto algún propaganda, cuna radial, spot de TV o material sobre el condón y el VIH/SIDA? ¿Qué era y como le pareció?
7. ¿Confía(n) usted(es) en la calidad del condón que sea de marca o no logo (regalado)? ¿Piensa(n) que es una medida efectiva para prevenir la transmisión del VIH/SIDA? ¿Ha(n) tenido algún problema en usarlo?
8. ¿Encuentra(n) ustedes el precio del condón disponible en el mercado barato, regular o caro?
9. ¿Cuál es su condón preferido? ¿Cuál usa más?

### **COMPONENTE DE VCT**

1. En general, las personas de su grupo ¿a dónde van a realizar la prueba de VIH? ¿Por qué considera usted que prefieren a esos lugares a hacer la prueba de VIH?
2. ¿Qué piensa usted de las Pruebas de VIH que brinda esta organización para su grupo? ¿Considera que las ONG que brindan pruebas de VIH ayudan a que las personas de su grupo para que se hagan su prueba de VIH? ¿Por qué?

3. Cuando Ud. ha realizado la prueba de VIH en esta organización ¿se sintió cómodo con la atención que le brindó el personal que lo atendió? ¿Por qué? o ¿Por qué no?
4. Cuando Ud. realizó la prueba de VIH en esta organización ¿en cuánto tiempo recibió su resultado? ¿Cómo le pareció este tiempo de espera?
5. Cuando Ud. realizó la prueba de VIH en esta organización le dieron consejos sobre cómo prevenir las ITS y el VIH? Mencione algunos consejos. ¿Ha logrado seguir esos consejos? ¿Qué dificultades ha tenido para poner en práctica esos consejos?
6. Cuando Ud. realizó la prueba de VIH en esta organización ¿le dieron preservativos? ¿Le orientaron como usarlos? Por favor explíqueme qué indicaciones le dieron.
7. ¿Para qué la ha servido hacer la prueba de VIH? ¿Ha realizado algún cambio personal después de realizar su prueba de VIH?
8. ¿Cada cuánto realiza Ud. su prueba de VIH? ¿Por qué razón?
9. En general, ¿qué dificultades tiene su grupo para hacer la prueba de VIH? ¿Qué sugerencias daría para mejorar los servicios de la prueba de VIH en las ONG que ofrecen este servicio?

**MUCHAS GRACIAS POR SU PARTICIPACION**

## GUÍA DE ENTREVISTA PARA STAKEHOLDERS

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Nombre de entrevistador: \_\_\_\_\_

Fecha: \_\_\_\_\_

Lugar: \_\_\_\_\_

Nombre del entrevistado: \_\_\_\_\_

Instancia: \_\_\_\_\_

### **COMPONENTE DE CAMBIO DE CONDUCTA (CCC)**

1. ¿Qué trabajo en prevención de VIH ha apoyado USAID para la población garífuna y PEMAR en Honduras? ¿Cuáles son las prioridades para trabajar en la prevención de VIH con la población garífuna y PEMAR?
2. ¿Cuáles han sido los logros en cambios de comportamiento para la población garífuna y PEMAR? ¿Hay evidencia de cambio de comportamientos en estas poblaciones?
3. ¿Cuáles considera que han sido los obstáculos para lograr cambios de comportamientos en estas poblaciones? ¿De qué manera se han superado estas dificultades? ¿Cuáles aún no se superan?
4. ¿Considera que USAID/Honduras ha fortalecido las capacidades para intervenciones de CCC en las ONG que desarrollan proyectos de prevención en estas poblaciones? ¿Cómo?
5. ¿Piensa que los proyectos de prevención en estas poblaciones apoyados por USAID han contribuido a controlar la epidemia? ¿Como?
6. ¿Le gustaría agregar algo más sobre cómo puede contribuir USAID en la respuesta nacional del VIH en la prevención de la transmisión de VIH en la población garífuna y las PEMAR?

### **COMPONENTE DE ITS**

1. ¿Cuáles son las iniciativas más exitosas de prevención y atención de la ITS en Honduras con poblaciones PEMAR y las garífunas? ¿Por qué?
2. ¿Cuáles son las debilidades y brechas de las iniciativas para prevenir y atender las ITS en Honduras? ¿Cómo se puede aumentar la cobertura de estas poblaciones?
3. ¿Los VICITS dan un valor agregado a la atención regular de ITS en PEMARs y las garífuna? ¿Hay otras alternativas mejores?
4. ¿Cuáles son las amenazas y limitantes de los VICITS (apoyo político, coordinación interinstitucional)?
5. ¿En qué sugeriría a USAID que apoye para mejorar las iniciativas preventivas de ITS en estas poblaciones? ¿Qué tipo de apoyo (financiero, técnico, abogacía)?

### **COMPONENTE DE MERCADEO SOCIAL DE CONDÓN**

1. ¿Piensa usted que la distribución y acceso a los condones para la población garífuna, las personas que viven con VIH y las poblaciones PEMAR son adecuados? Si, no son adecuados, ¿cuáles son los grupos que no tienen acceso? ¿Por qué piensan que no son adecuados?
2. ¿Han aumentado los puntos no tradicionales de distribución y venta de condones para las poblaciones prioritarias en los últimos años? ¿Qué falta? ¿Qué se puede hacer para mejorar la distribución y acceso a estas poblaciones a través de cuáles mecanismos y/o instancias?
3. ¿Existe algún Plan Nacional para la distribución de condones que abarque: 1) el sector comercial; 2) el MSC (el condón subsidiado); y 3) el condón no-logo-gratis? Si responde “si”, favor describir la política y sus fortalezas y debilidades. Si responde “no” ¿Qué hace falta para tener una política? ¿Qué opina usted que es el rol de cada uno de los 3 sectores? ¿Cuál canal es lo más efectivo para alcanzar estas poblaciones?
4. ¿Qué otras barreras además del acceso hay para el uso de condón en relaciones sexuales de riesgo en estas poblaciones? ¿Qué más se puede hacer para superar estas barreras y aumentar el uso en estas situaciones?
5. ¿Cuál es el rol de las campañas masivas para aumentar el uso del condón en las relaciones sexuales de riesgo? ¿Cuáles son las mensajes y medios claves y a quienes deben estar dirigidos?
6. ¿Qué piensa usted que sería necesario para garantizar el acceso al condón para estas poblaciones prioritarias; 1) financieramente; 2) técnicamente; y 3) políticamente?
7. ¿Le gustaría usted agregar algo más sobre el condón y la prevención de VIH-SIDA en estas poblaciones prioritarias en Honduras?

## COMPONENTE DE VCT

Me gustaría que se explorara sobre la consejería pre y post prueba, por ejemplo su calidad, que tan frecuente se dan ambas consejerías, que piensan los entrevistados que se debería hacer para mejorar la consejería existente.

1. ¿Hay disponibilidad de pruebas de VIH para estas poblaciones prioritarias en el país? ¿Quiénes las están ofertando? ¿Qué papel juegan la Secretaría de Salud, las ONG y los laboratorios privados en el programa de VCT?
2. ¿Contar con VCT a través de las ONG es una manera eficaz y eficiente para aumentar la cobertura para PEMAR y la población garífuna?
3. ¿Qué retos considera que tiene el programa de VCT en las ONG para mejorar la calidad y extensión de estos servicios?
4. ¿Le gustaría agregar algo más sobre cómo puede contribuir USAID en la respuesta nacional del VIH en PEMAR a través del programa de VCT?

### **COMPONENTE DE CAPACITY BUILDING**

1. ¿Los esfuerzos de los proyectos de USAID en fortalecimiento y creación de capacidades para ONG locales responden a las prioridades del país en el tema de VIH/SIDA? ¿Cómo?
2. Estos proyectos ¿están fortaleciendo las organizaciones locales que trabajen con los PEMAR y garifunas en la respuesta nacional al VIH/SIDA?
3. En su opinión ¿las ONG locales implementan las capacitaciones y herramientas brindadas en el proceso de fortalecimiento y creación de capacidades? Si o no ¿Por qué piensa eso?
4. ¿Los proyectos de USAID han fortalecido la capacidad de las ONG técnicamente para realizar CCC? ¿En la movilización de recursos? ¿Movilización social y abogacía? Mencione ejemplos
5. ¿Cree usted que USAID podría hacer otros esfuerzos además de apoyar las ONG para llegar a las PEMAR?
6. ¿Qué cree que ocurriría si las ONG locales actualmente en proceso de fortalecimiento y creación de capacidades dejaran de recibir financiamiento de donantes externos? ¿Habría capacidad sostener sus acciones de prevención?
7. En el fortalecimiento y creación de capacidades ¿percibe que hay duplicidad de esfuerzos por parte de las agencias de cooperación? Favor mencionar donde hay duplicidad
8. ¿Qué brechas hay aún en el proceso de fortalecimiento y creación de capacidades para las ONG locales?
9. ¿Qué sugerencias le daría a USAID para mejorar el proceso de fortalecimiento y creación de capacidades instituciones locales?

**MUCHAS GRACIAS POR SU PARTICIPACION**

## GUIA PARA AGENCIAS IMPLEMENTADORAS

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Nombre de entrevistador: \_\_\_\_\_

Fecha: \_\_\_\_\_

Lugar: \_\_\_\_\_

Nombre del entrevistado: \_\_\_\_\_

Instancia: \_\_\_\_\_

### **COMPONENTE DE CAMBIO DE CONDUCTAS (CCC)**

1. ¿Qué actividades de CCC realiza su organización para cada población? (Solicitar informes anuales de actividades para tener datos cuantitativos de cada población)
2. Para la población de hombres que tienen sexo con hombres ¿utilizan las redes sociales de internet para realizar intervenciones de CCC? ¿Si sí, cómo ha funcionado la experiencia? Si no, ¿por qué razones?
3. ¿Cuáles han sido sus intervenciones de CCC más exitosas? ¿A qué atribuyen el éxito? ¿Hay evidencia de cambio de comportamiento en las poblaciones? ¿Cuál es la evidencia?
4. ¿Cuál es el modelo de Cambio de Comportamiento que utilizan y cuáles son los comportamientos en los que trabajan para cada población?
5. Para población garífuna ¿promocionan la circuncisión como conducta deseada? Si sí, ¿cuáles han sido las intervenciones? Si no, ¿por qué razones? ¿Le parece factible?
6. ¿Cómo su organización asegura que las actividades de CCC son apropiadas para cada población? ¿De qué manera consideran los aspectos culturales y las particularidades de las poblaciones?
7. ¿Cómo abordan ustedes el tema de género con sus poblaciones?
8. De las poblaciones que su organización cubre, ¿hay subgrupos que no están siendo alcanzados con actividades de CCC? ¿Qué considera que se puede hacer para lograr llegar a ellos?
9. ¿Qué obstáculos han encontrado para realizar las actividades de CCC en las poblaciones que su organización atiende? ¿De qué manera han superando los obstáculos? ¿Qué obstáculos no han sido superados?
10. ¿Qué fortalecimiento ha recibido su organización por parte del proyecto de USAID para realizar las actividades de CCC? ¿Cómo estaba su organización en el tema de CCC antes de trabajar con USAID? ¿Qué áreas o temas falta fortalecer?
11. ¿Tiene alguna sugerencia para mejorar las actividades de CCC con las poblaciones que atiende su organización?

### **COMPONENTE DE ITS**

1. ¿Cuáles son las iniciativas más exitosas de prevención y atención de la ITS en Honduras con poblaciones PEMAR y las garifunas? ¿Por qué?
2. ¿Cuáles son las debilidades y brechas de las iniciativas para prevenir y atender las ITS en Honduras? ¿Cómo se puede aumentar la cobertura de estas poblaciones?
3. ¿Los VICITS dan un valor agregado a la atención regular de ITS en PEMARs y las garífuna? ¿Hay otras alternativas mejores?
4. ¿Cuáles son las amenazas y limitantes de los VICITS (apoyo político, coordinación interinstitucional)?
5. ¿En qué sugeriría a USAID que apoye para mejorar las iniciativas preventivas de ITS en estas poblaciones? ¿Qué tipo de apoyo (financiero, técnico, abogacía)?

### **COMPONENTE DE MERCADEO SOCIAL DEL CONDÓN**

1. ¿Piensa usted que la distribución y acceso a los condones para la población garífuna, las personas que viven con VIH y las PEMAR son adecuados? Si, no son adecuados, ¿cuáles son los grupos que no tienen acceso? ¿Por qué piensan que no son adecuados?
2. ¿Han aumentado los puntos no tradicionales de distribución y venta de condones para las poblaciones prioritarias en los últimos años? ¿Qué falta? ¿Qué se puede hacer para mejorar la distribución y acceso a estas poblaciones a través de cuáles mecanismos y/o instancias?
3. ¿Existe algún Plan Nacional para la distribución de condones que abarque: 1) el sector comercial; 2) el MSC (el condón subsidiado); y 3) el condón no-logo-gratis? Si responde “sí”, favor describir la política y sus fortalezas y debilidades. Si responde “no” ¿Qué hace falta para tener una política? ¿Qué opina usted que es el rol de cada uno de los 3 sectores? ¿Cuál canal es lo más efectivo para alcanzar estas poblaciones.
4. ¿Qué otras barreras además del acceso hay para el uso de condón en relaciones sexuales de riesgo en las poblaciones mencionadas arriba? ¿Qué se puede hacer para superar estas barreras y aumentar el uso en estas situaciones?
5. ¿Cuál es el rol de campañas masivas para aumentar el uso del condón en estas relaciones sexuales de riesgo? ¿Cuáles son las mensajes y medios claves y a quienes deben estar dirigidos?
6. ¿Qué piensa usted que sería necesario para garantizar el acceso a condón para estas poblaciones prioritarias; 1) financieramente; 2) técnicamente; y 3) políticamente?
7. ¿Le gustaría usted agregar algo más sobre el condón y la prevención de VIH-SIDA en estas poblaciones prioritarias en Honduras?

### COMPONENTE DE VCT

1. ¿Considera que hay disponibilidad y acceso suficiente de pruebas de VIH para población garífuna y PEMAR en Honduras? La Secretaría de Salud y los laboratorios privados ¿ofrecen este servicio a la población garífuna y PEMAR?
2. (Para los que ofrecen) ¿Qué logros ha obtenido su organización al ofrecer VCT a PEMAR? ¿Se han logrado cambios de comportamiento en PEMAR? ¿Hay evidencia del cambio de comportamiento?
3. (Para los que ofrecen) ¿De qué manera el servicio de VCT que brinda su organización responde a las necesidades de prevención de VIH de PEMAR? Las normas de atención en salud para las mujeres trabajadoras del sexo ¿obstaculizan o favorecen que su organización ofrezca el servicio de VCT a esta población?
4. (Para los que ofrecen) ¿Qué obstáculos ha encontrado su organización para ofrecer el servicio de VCT a PEMAR? ¿De qué manera han superando los obstáculos? ¿Cuáles aún no se logran superar?
5. (Para los que ofrecen) ¿Qué retos considera que tiene el programa de VCT para lograr cambios de comportamientos en las poblaciones?
6. (Para los que ofrecen) ¿Qué fortalecimiento en VCT ha recibido su organización por parte del proyecto de USAID? ¿En qué áreas o temas considera que se necesita más fortalecimiento institucional?
7. ¿Cómo el servicio de VCT que ofrece su organización responde a los protocolos de laboratorio para el procesamiento de las pruebas? ¿A quienes reportan los datos de VCT?
8. ¿Le gustaría agregar algo más sobre el trabajo de VCT que realiza su organización?

### **COMPONENTE DE LOCAL CAPACITY BUILDING**

1. Los esfuerzos de fortalecimiento y creación de capacidades para ONG locales apoyados por USAID ¿responden a las prioridades del país en el tema de VIH/SIDA? ¿Como?
2. ¿Cuáles han sido los esfuerzos más valiosos en el proceso de creación de capacidades para su institución? ¿Cuáles han servido más para el quehacer institucional según su opinión?
3. Los proyectos de USAID ¿han fortalecido la capacidad técnica de su institución para realizar la movilización de recursos? ¿Han fortalecido la movilización social y abogacía? ¿De que manera?
4. ¿Cree usted que USAID podrían hacer otros esfuerzos además de apoyar las ONG para llegar a los PEMAR?
5. (Para los que reciban financiamiento de USAID) Además de USAID ¿recibe financiamiento de organismos bilaterales o multilaterales su institución para trabajar en prevención? ¿Qué organismos son?
6. Si dejara de recibir dicho financiamiento ¿que haría para darle continuidad a las acciones de prevención?
7. En el fortalecimiento y creación de capacidades ¿percibe que hay duplicidad de esfuerzos por parte de las agencias de cooperación? Favor menciónelos donde hay duplicidad.
8. ¿Qué sugerencias le daría a USAID para mejorar el proceso de fortalecimiento y creación de capacidades de organismos locales que trabajan con PEMAR?

**MUCHAS GRACIAS POR SU PARTICIPACION**

## GUÍA DE ENTREVISTA VICITS

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### **PROVEEDORES DE SERVICIO EN VICITS**

1. ¿Ha notado una mayor afluencia de PEMAR en búsqueda de ayuda desde que abrieron este establecimiento? ¿Si no? ¿Por qué?
2. ¿Cuáles son los logros que ha notado en las PEMAR o en general desde que se abrió este establecimiento?
3. ¿Qué dificultades o limitantes (sean insumos materiales o capacitación) ha tenido para atender y educar PEMAR en ITS y VIH/SIDA?
4. ¿Qué tanto tiempo puede dedicar a dar mensajes preventivos (CCC) sobre VIH/SIDA e ITS a las personas que atiende?
5. ¿Ha percibido cambios de conducta de los PEMAR debido a los mensajes educativos para prevenir VIH/SIDA e ITS? ¿Puede mencionar cuales cambios?
6. ¿Qué sugerencia daría para mejorar el servicio que brinda este establecimiento? ¿Cómo podría mejorarse la comunicación para el cambio de comportamiento?
7. ¿Por qué cree que las personas que sufren de ITS y no han venido a consultar no se han acercado a este establecimiento? ¿Percibe alguna barrera para estos PEMAR?

### **CLIENTES DE VICITS**

1. ¿Qué piensa usted y sus conocidos sobre el servicio para atender ITS brindado por este establecimiento?
2. ¿Se sintió cómodo y respetado con la atención que le ha brindado el personal del servicio? ¿Sí o no? ¿Por qué?
3. ¿Le brindaron orientación como prevenir las ITS y VIH/Sida durante la consulta durante la consulta? Mencione algunos consejos
4. ¿Le facilitaron preservativos durante la consulta? ¿Le orientaron como usarlos de forma correcta? explíquenos
5. ¿Conoce gente que padece o ha padecido de ITS y no ha venido a consultar a este establecimiento? ¿Conoce las razones por las que no haya venido?
6. ¿Qué sugeriría para mejorar el servicio en este establecimiento? ¿Qué cambiaría para hacerlo más adecuado para atender este tipo de problemas de salud?
7. ¿Conoce otro tipo de establecimiento que brinde servicio para atender problemas de ITS? Menciónelos

**MUCHAS GRACIAS POR SU PARTICIPACION**

## APPENDIX E. EVALUATION COMPONENT SUMMARY TABLES

Evaluación de la estrategia de prevención de VIH de USAID/Honduras Componente de Comunicación para el Cambio de Comportamiento				
Relevancia	Efectividad	Eficacia	Impacto	Sostenibilidad
Prevencción primaria				
<p>Responden a la necesidad de acompañamiento para mantener el cambio de comportamiento.</p> <p>Abordan clientes y parejas afectivas.</p> <p>El subcomité de IEC garífuna es el único que funciona a nivel nacional.</p> <p>La comunidad garífuna valida las intervenciones de CCC.</p> <p>Falta sistematizar el trabajo de las redes sociales.</p> <p>Falta sistematizar la estrategia de CCC en prevención primaria y secundaria para PVVS.</p>	<p>Son efectivas porque consideran las características culturales de las poblaciones garífunas; y las peculiaridades de cada sub-grupo y las particularidades del trabajo sexual en TS.</p> <p>Ha iniciado el trabajo de redes sociales, puesto que cuando las PEMAR cambian comportamientos en sus vidas, son involucradas, como facilitadoras/es y mentoras, en la conducción de actividades para sus grupos. En el caso de población garífuna se realiza a través de jóvenes actores.</p>	<p>Hay evidencia en los CAP anuales que se han alcanzado y mantenido los comportamientos deseados, como el uso de condón en la población garífuna y uso de condón con la pareja afectiva en las poblaciones de mujeres trabajadoras del sexo y hombres que tienen sexo con hombres.</p> <p>Las organizaciones que abordan a las poblaciones cuentan con conocimiento y mucha experiencia en su abordaje; y en la aplicación del modelo transteórico de cambio de comportamiento.</p> <p>Desarrollar intervenciones de proceso (escalonadas) y no puntuales, ha sido clave en la eficacia para el cambio de comportamiento.</p> <p>Mayor cantidad de jóvenes garífunas y no garífunas están solicitando y buscando condones, al igual que hombres garífunas.</p>	<p>El trabajo ha impactado en las poblaciones y no solamente en la incorporación del condón en sus vidas, sino más allá de eso han cambiado sus vidas totalmente<sup>47</sup>.</p> <p>Este impacto ha sido posible gracias al trabajo permanente de las ONG que llevan realizando las intervenciones a lo largo de 5 y hasta 9 años, de acuerdo a MTS y HSH entrevistados.</p>	<p>Es necesario el mantenimiento del cambio de comportamiento, y no podrá ser sostenible sin el acompañamiento de las ONG. Sin embargo, se puede valorar la utilización de incentivos en las los grupos de facilitadoras/res y mentores.</p> <p>Los grupos de teatro podrían ser auto-sostenibles porque una vez conformados, requieren poco acompañamiento. Puesto que en su conformación se potencian la autonomía de funcionamiento (saben hacer guiones y cuentan con un director capacitado.</p>

<sup>47</sup> Algunas mujeres trabajadoras del sexo entrevistadas, indicaron que gracias a las actividades en las que han participado en las ONG, han dejaron por completo el consumo de drogas. El consumo de alcohol solamente se da en el contexto de trabajo cuando beben con los clientes.

VICITs Summary Table				
Relevance	Effectiveness	Efficiency	Impact	Sustainability
<p>9 VICITs/UMIET in Honduras, are located in high HIV prevalence cities: San Pedro Sula (2), Tegucigalpa (3), Ceiba (2), Puerto Cortez and Choluteca. Locations are in accordance with the “T” shape of the country’s high HIV prevalence distribution.</p> <p>The VICITs strategy was developed through an intersectoral coordination: MOH, CDC/GAP, USAID, Civil Society organizations (OPROUCE, Kukulkan, Colectivo Violeta, Arco Iris, AHMF, PRODIM, PASMO, CGSSI, etc.)</p> <p>The VICITs hours are inconvenient for FSW and HSH and limits coverage.</p>	<p>From 2006-2009, 1,777 FSWs were enrolled in the VICITs program.<sup>48</sup> Most are establishment-based FSWs.</p> <p>Since December 2009 about 250 MSM were enrolled in the VICITs<sup>49</sup></p> <p>There is a referral of clients from NGOs to VICITs. However, counter-referral from VICITs to NGOs is weak.</p> <p>Poor BCC is done by MOH workers during clients’ stay at VICITs</p> <p>Unclear strategy to promote VICITs among sex workers and MSM</p> <p>VICITs has provided training in updated STI management to MOH staff</p> <p>Developed new guidelines for FSW and MSM care based on lessons learned.</p>	<p>2 VICITs in Tegucigalpa to attend 73 MSM is not cost-effectiveness.</p> <p>Limited strategic information for decision making is generated from VICITs.</p>	<p>The implementation of the VICITs strategy for FSWs has increased condom use with clients. The program for FSWs has only been in place for 4 years and changes in STI prevalence and HIV have yet to be achieved.</p> <p>Incidence of HIV and STIs has not been measured to date.</p>	<p>100% (38) of health workers that provide clinical care in VICITs sites for MSM and FSWs are MOH employees.</p> <p>Each of the VICITs clinics have been implemented within existing MOH facilities.</p> <p>VICIT’s promotion relies mainly on NGOs. MOH efforts to find new clients and provide domiciliary follow-up to those not attending their checkups are weak.</p> <p>MOH staff, mainly nursing staff, rotate frequently. Trained personnel are moved from VICITs to other health facilities services as part of routine staff rotation.</p>

<sup>48</sup> Datos Epidemia del VIH y VICITs en Honduras. Freddy Tinajeros, Consultant Senior Epidemiologist Country Leader, HIV/AIDS in Honduras TEPHINET-CDC/GAP Cooperative Agreement, September 2010.

<sup>49</sup> Data from field interviews by Dr. Carlos Balcaceres to health workers of Manchen, Alonso Suazo, Hospital Atlantida, Miguel Paz Barahona and Crucitas VICITs and from *Datos Epidemia del VIH y VICITs en Honduras*.

Condom Social Marketing Summary Table Number of targeted condom service outlets				
Relevance	Effectiveness	Efficiency	Impact	Sustainability
<p>The social marketing condoms are readily available in high-risk outlets and 27% of VIVE social marketing sales and 68% of lubricants are from those outlets.</p> <p>Purchased by FSWs when the donated condom occasionally is not available. FSWs also report sometimes clients bring their own VIVE.</p> <p>They are by far the “preferred” condoms of MSM (80.5%) and FSWs (85.5%).</p> <p>Young MSM expressed a strong preference for colors.</p> <p>There is an unmet need and demand for lubricants as well as for more education-promotion as to their importance.</p> <p>84.7% of FSWs agree that condoms not expensive (TRaC 09)</p>	<p>FSWs (90.1%) and MSM (76.4%) can find a condom within 10 minutes of the high-risk venue. (TRaC 2009)</p> <p>Socially marketed condoms are widespread.</p> <p>Generally meeting (94% or better of targets) the goals for number of high risk outlets. However, the significance of this indicator is not clear.</p> <p>Lubricants are less available. Use by MSM and FSWs does not appear to have increased 2007- 2009 (except for use at some time in last month by FSWs). However, is up over the 2002 EMC when 90.6% of FSWs reported never having used them.</p>	<p>Distribution of condoms to high risk outlets is very labor-intensive and has high maintenance needs.</p>	<p>Condom use is high in higher risk sex activities with a lower usage with affective partners across all groups.</p> <p>Socially marketed condoms are readily available when there are localized stock-outs.</p> <p>The confidence in the brand and the attractiveness of some of the products, such as colored and flavored condoms, appears to be encouraging condom use.</p> <p>Increased use of lubricants should be contributing to condom effectiveness.</p> <p>HIV prevalence appears to be down across all groups (PENSIDA III). However, was still high prevalence of STIs in 2006 (ECVC).</p>	<p>The commercial marketing program (including purchase of condoms, distribution and promotion) appears to have full cost-recovery.</p> <p>Distribution to high-risk outlets still requires a subsidy, at least as long as there are so many donated condoms in the supply channels.</p> <p>Few commercial distributors routinely visit these points and the ones that do are not highly motivated to distribute social marketing condoms (lower margins).</p>

Evaluación de la estrategia de prevención de VIH de USAID/Honduras Componente de Prueba Voluntaria de VIH con Consejería				
Relevancia	Efectividad	Eficacia	Impacto	Sostenibilidad
<p>Facilita el acceso a la prueba y fortalece la voluntad en las poblaciones de realizarla.</p> <p>La confidencialidad manejada por las ONG les ha dado credibilidad para brindar el servicio.</p> <p>El resultado escrito de la prueba facilita el trabajo de las TFS ante dueños de negocios, la policía, clientes y familia.</p>	<p>Hay oferta efectiva para las poblaciones y también para sub-poblaciones: parejas afectivas y clientes.</p>	<p>La consejería de las pruebas rápidas ofrecidas por las ONG, refuerzan cambios de comportamiento en las poblaciones; y refirieren para atención de ITS y a los CAI.</p>	<p>Es muy pronto para conocer el impacto de la intervención, sin embargo favorece la detección de nuevos casos de VIH.</p>	<p>Se puede realizar la entrega de VCT, pero no es sostenible financieramente.</p> <p>La Secretaría de Salud y el Laboratorio Nacional han capacitado a personal de VCT. Sin embargo, las ONG no pueden brindar el servicio si no cuentan con fondos externos.</p>

Local Capacity-Building Summary Table				
Relevance	Effectiveness	Efficiency	Impact	Sustainability
<p>AIDSTAR-One and Two are the main local capacity-building mechanisms for NGOs working in HIV/AIDS. No duplicities were found.</p> <p>6 GFATM sub-recipients working with MARP and vulnerable populations have improved governance bodies though LDP training by AIDSTAR-Two.</p> <p>6 AIDSTAR-Two grantees finished MOST and Business Plan process. Latter process was a critical tool for bidding for AIDSTAR-Two's FY 2011 grants.</p> <p>Capacity building has facilitated a fluent coordination between USAID/Honduras and CHF/GFATM.</p>	<p>All NGOs have finished MOST, LDP, and Business Plan training/work plan. 2 GFATM sub-recipients quit CB due to external reasons.</p> <p>ASONAPVSI DAH went through a 2010-2014 Strategic Plan Design with AIDSTAR-One's technical assistance.</p>	<p>GFATM/Umbrella NGOs should replicate CB process with the rest of sub-recipients.</p> <p>Capacity building to ASONAPVSI DAH is mainly focused on enhancing technical execution and management procedures. Human development is missing.</p> <p>Capacity building should be more tailored to each NGO. Full and comprehensive strengthening should be provided to entities with high development potential, punctual assistance to highly effective and efficient NGOs, and basic TA to organizations with little prospect of sustainability.</p>	<p>Systematic and intensive Capacity Building is an ongoing process in an early stage. No impact can be evidenced yet.</p> <p>Due to LDP, 3 GFATM sub-recipients have initiated a legal process to obtain a juridical personality.</p>	<p>GFATM/NGOs require TA for proposal development, M&amp;E and fundraising.</p> <p>AIDSTAR-Two/NGOs require mentoring for fundraising, M&amp;E and research.</p> <p>Local NGOs have limited capacity for financial sustainability (exceptions of PASMO, Mary Stopes due to their cost-recovery and linkages to international PVOs).</p>



## APPENDIX F. POWERPOINT PRESENTATION



### EVALUCION DE PROGRAMAS DE PREVENCIÓN DE VIH-SIDA APOYADOS POR USAID/HONDURAS

#### Hallazgos Preliminares

October 13, 2010

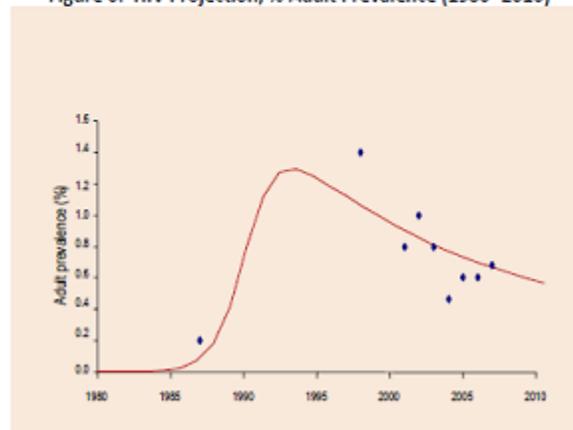
Dr. Stanley Tenell  
Dr. Carlos Balcázar  
Lic. Meliné Caal

GH Tech Project



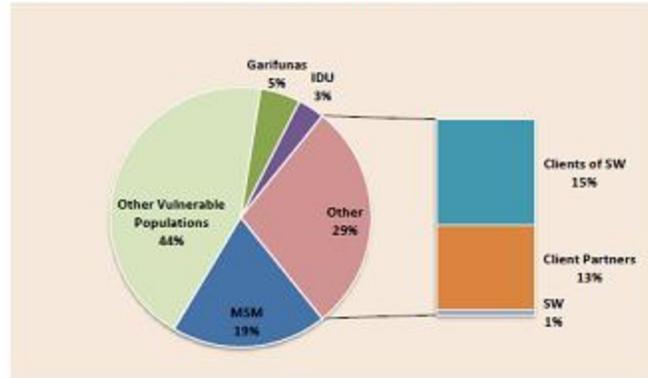
### Tendencia de Seroprevalencia en la Población General

Figure 6: HIV Projection, % Adult Prevalence (1980–2010)



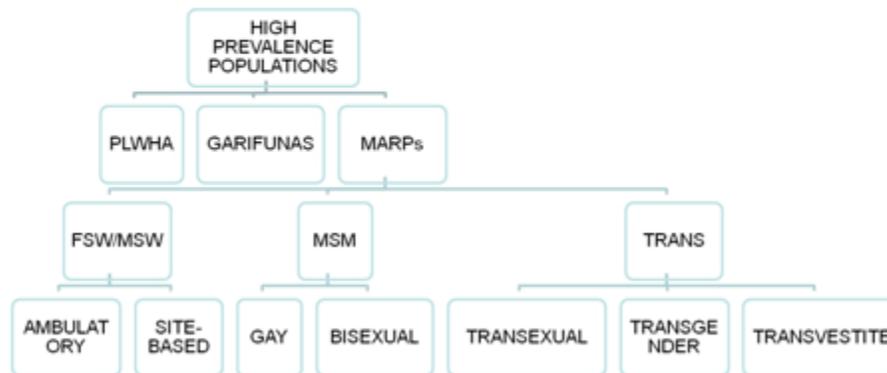
## Modos de Transmisión

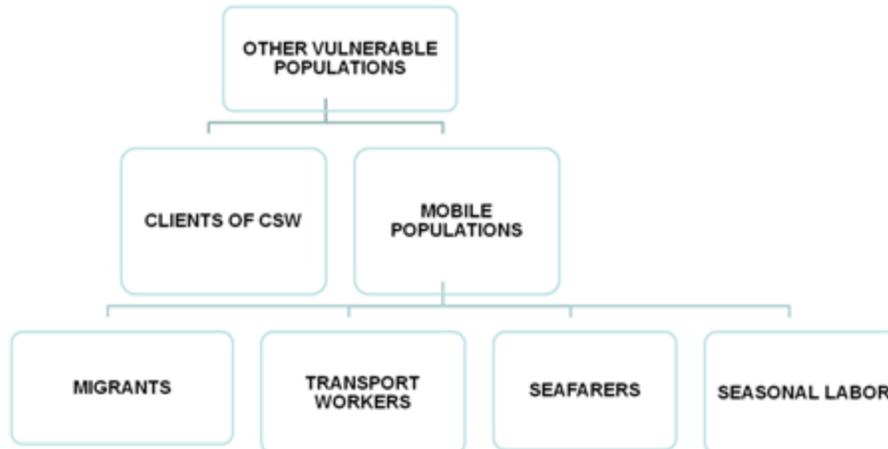
Figure 7: Modes of Transmission



Source: UNAIDS Modes of Transmission Model. SSH, Honduras. 2007

## PRIORITY POPULATIONS





### **Hallazgos BCC**

- **Hay evidencia preliminar del incremento en el uso del condón en Garífunas y con pareja afectiva en TSF y HSH. (Falla CAP 2010 y ECVC 2011)**
- **Mejores prácticas :**
  - **Facilitadoras/es en HSH y MTS.**
  - **Mentoras en MTS**
  - **Actividades con parejas afectivas y clientes en MTS y parejas femininas en HSH.**
  - **Radionovelas y grupos de teatro en Garífunas.**

### **Hallazgos BCC 2.**

- **No se está implementado sistemáticamente un abordaje de redes sociales. PASMO tiene experiencia pero no sistematizada.**
- **El subcomité de IEC de garifunas funciona bien.**
- **Ausencia del Comité Nacional Multisectorial de IEC/BCC.**

### **Hallazgos BCC**

- **Hay poblaciones escondidas que se desempeñan con nuevas formas de TS y que no acuden a los servicios de ONG.**
- **Falta sistematizar la estrategia de CCC en prevención primaria y secundaria para PVVS.**

### **Recomendaciones BCC**

- Continuar con metodologías de prácticas exitosas de CCC (COMCAVI – ULAT) Plan de negocios para grupo de Mentoras.
- Promover el intercambio de prácticas exitosas en cambio de comportamiento entre USAID/Honduras (AIDSTAR-Two) y CHF (uso de página web [www.comcavi.com](http://www.comcavi.com))
- Activación del Comité Nacional Multisectorial de IEC.
  - Redefinición de sus funciones y alcances a nivel nacional.
  - Intercambio de prácticas exitosas, encaminado a Estrategia Nacional de Cambio de Comportamiento
  - Campañas contra estigma y discriminación hacia la diversidad sexual

### **Hallazgos de VICITS (1)**

- Comité intersectorial VICIT
- Escasa contrarreferencia a ONG .
- Buena percepción de VICITS por parte de clientes/ONG.
- Limitada promoción de VICIT entre PEMAR (HSH)
- Limitada CCC durante la estancia del cliente.
- Actualización de conocimiento en ITS a personal de salud

### **Hallazgos de VICITS (2)**

- **Aumento en el uso de condón en MTS**
- **100% del personal y establecimiento son de SS**
- **La rotación de personal es una amenaza**
- **Limitado análisis de los datos epidemiológicos**
- **No hay auditoria social sistemática.**
- **Horario inconveniente para los clientes.**
- **¿ITS para Garífuna?**

### **Recomendaciones VICITS**

- **Fortalecer y sistematizar comités intersectoriales**
- **Sistematizar proceso de referencia/contrareferencia.**
- **Potenciar la promoción de VICITs.**
- **Involucrar a ONG para programa de CCC (intra/extramuros)**
- **Advocacy en SS para minimizar la rotación de personal.**
- **Establecer mecanismo de auditoria social.**

### **Recomendaciones VICITS**

- **Generación de información estratégica (incidencia)**
- **VICITS como lugares de entrenamiento**
- **Entrenamiento de personal pregrado en ITS**
- **Coordinar con Unidades Móviles de SS para hacer referencia y prueba rápida Sífilis.**
- **Evaluar factibilidad de programa ITS para Garifuna**
- **Tratamientos acortados**

### **Mercadeo Social del Condón - Hallazgos**

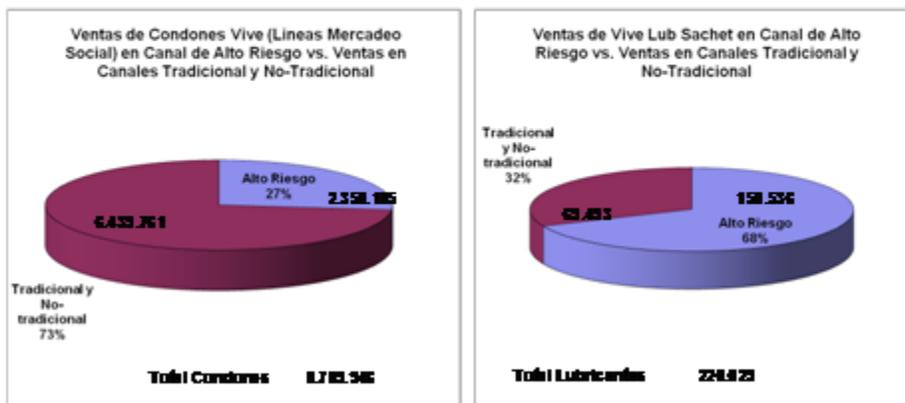
- **Condón preferido de TSF (81%) y HSH (86%)**
- **Logra sus metas de puntos de alto riesgo (1,573)**
- **Es 27% de sus ventas totales**
- **HSH jóvenes tienen preferencia para colores**
- **Demanda no satisfecha con lubricantes (problema con la presentación)**
- **Está disponible cuando no hay el condón regalado**
- **Aumenta práctica de sexo más seguro en PEMAR**



## Estimación Distribución de Condones

Country	Year	2006	2007	2008	2007	2008	2009
Honduras	Public Sector: Male Educ.	9,672,888	2,471,858	5,982,864	4,944,538	17,388,982	4,598,664
	<b>Total Public Sector:</b>	<b>9,672,888</b>	<b>2,471,858</b>	<b>5,982,864</b>	<b>4,944,538</b>	<b>17,388,982</b>	<b>4,598,664</b>
		2,888	2,885	2,888	2,887	2,888	2,888
	Public Sector	9,672,888	2,471,858	5,982,864	4,944,538	17,388,982	4,598,664
	<b>Female Marketing</b>	<b>1,887,348</b>	<b>1,488,348</b>	<b>1,587,348</b>	<b>2,088,348</b>	<b>2,387,348</b>	<b>2,388,348</b>
	Private Sector	2,728,381	2,889,888	9,948,258	9,488,988	9,881,258	9,255,888
	<b>Total Market:</b>	<b>7,442,615</b>	<b>7,859,593</b>	<b>18,885,482</b>	<b>17,725,279</b>	<b>19,656,688</b>	<b>17,488,938</b>
	<b>Total Private Sector:</b>	<b>9,428,615</b>	<b>4,388,958</b>	<b>5,888,988</b>	<b>5,888,958</b>	<b>4,357,888</b>	<b>4,888,888</b>

## Ventas VIVE en Puntos de Alto Riesgo 2006 - 2009



Fuente: Sistema de Información Business Vivas de PASMO

### **Mercadeo Social del Condón - Recomendaciones**

- Apoyar la calidad de distribución.
- Promocionar lubricante/introducir otra presentación.
- Trabajar en materiales POP.
- Apoyar campañas genéricas en los medios.
- Consolidar ECVC y TRaC.

### **Hallazgos VCT**

- La confidencialidad es la clave para el abordaje de VCT para el alcance de las poblaciones PEMAR.
- Los horarios de servicio son los preferidos por TS y HSH.
- Oferta efectiva también para parejas afectivas y clientes-TS.

### Hallazgos VCT

- Hay referencia activa para atención de ITS o CAI.
- Poca detección de nuevos casos de VIH.
- Cobertura limitada.
- Pocos consejeros

### Resultados del Programa de VCT AIDSTAR Two

Población	Hombr es	Mujere s (*)	Mujere s	Mujere s (*)	Mujere s Embaraza das	Mujere s Embaraza das (*)	Total pruebas realizadas	Puntos de VIH +
Garífunas	539	4	1307	1	98	0	1946	5
HSH	883	5	0	0		0	888	5
MIS	0	0	2,348	12	204	0	2564	14
Población General	1,410	15	151	1	15	0	1791	16
<b>Total</b>	<b>2812</b>	<b>24</b>	<b>4,304</b>	<b>14</b>	<b>317</b>	<b>0</b>	<b>7,116</b>	<b>36</b>

### **Recomendaciones VCT**

- Fortalecer el seguimiento para clientes de TSF y HSH.
- Probar el uso de incentivos (metodología PDI) para aumentar cobertura.
- Laboratorios portátiles.
- Coordinar con la Secretaría de Salud para ampliar las zonas de cobertura.
- Capacitar y certificar a nuevos consejeros.

### **Hallazgos Capacity Building**

- AS I and II son los principales mecanismos de CB.
- CB ha facilitado la coordinación fluida entre USAID/Honduras y CHF/GFATM.
- 13 ONG beneficiadas (ASONAPV/SIDAH, 6 ONG/GFATM y 6 ONG/AS-II)
- La percepción de las ONG es totalmente favorable a CB.
- ONG/GFATM requieren AT para elaboración de propuestas, M&E y gestión RR.
- ONG/AS-II requieren guía para gestión de RR.

### **Recomendaciones Capacity Building**

- Continuar CB.
- CB debería tener metas, más financiamiento para ONG y compromisos contractuales.
- Advocacy con CHF para que CB sea replicado por sombrillas a todas las sub-subreceptoras.
- TA y mentoreo para gestión de RR, M&E e investigación.
- Ampliar el fortalecimiento de ASONAPVSI DAH.

### **Mobilización Social Hallazgos**

- La iniciativa piloto tuvo gran aceptación de grupo núcleo y líderes HSH
- Sectores de salud, justicia, educación y municipalidades tuvieron apertura al proceso.
- 3 Productos: Plan Estratégico, Plan Operativo y Análisis de patrones sociales que afectan HSH
- Comisionado DDHH UNAH con plan de reivindicar los derechos de minorías en la Universidad.
- Iniciativa no sostenible por mecanismo actual

### **Movilización Social Recomendaciones**

- **Seguir con Movilización Social**
- **Solventar los compromisos adquiridos con ONG de AS-II**
- **Buscar nuevos mecanismos para continuidad de Mov. Soc. (PASCA?)**
- **Potenciar nuevos liderazgos y no desfigarlos de organizaciones.**

### **Otras Recomendaciones**

- **Coordinar próximas rondas de ECVC y TRaC.**
- **Estudio Etnográfico Usuarios de Drogas**
- **Dar mas importancia a diálogo político y incidencia para lograr sostenibilidad y la reducción de estigma y discriminación.**
- **"Peer networking" como eje transversal para reclutar nuevos clientes de poblaciones ocultas**

## Recommended Prevention Mechanisms

Mechanism I	Mechanism II
<ul style="list-style-type: none"> <li>•Policy Dialogue</li> <li>•Stigma and Discrimination</li> <li>•Social Mobilization-Strategic Alliances</li> <li>•Capacity Building</li> <li>•Garifuna</li> <li>•PLWHA (Only if there is not another care mechanism)</li> </ul>	<ul style="list-style-type: none"> <li>•MARPS (SW and MSM)</li> <li>•Condom Distribution in High-Risk Outlets</li> </ul>

4+ Years mechanisms to permit 2 year sub-grant cycles

## APPENDIX G. REFERENCES

AIDSTAR-One/Honduras. Report HIV Prevention for Serodiscordant Couples Technical Brief, February 2009.

AIDSTAR-One/Honduras. Reporte de Consultoría para coordinar la consolidación y sistematización del modelo de atención integral en ITS/VIH/Sida en los servicios de salud en Honduras - FASE I, 2009.

AIDSTAR-One/Honduras. Reporte de Consultoría para coordinar la consolidación y sistematización del modelo de atención integral en ITS/VIH/Sida en los servicios de salud en Honduras - FASE II, 2009.

AIDSTAR-One/Honduras. Work Plan for April 1, 2009 – September 30, 2010.

AIDSTAR-One/Honduras. Quarterly Report for April 1, 2009 – June 30, 2009.

AIDSTAR-Two Honduras. Convocatoria a Organizaciones no Gubernamentales (OMG) para aplicar a fondos para la prevención de ITS/VIH/SIDA dirigidos a la población garífuna, 2010.

AIDSTAR-Two Honduras. Convocatoria a Organizaciones no Gubernamentales (OMG) para aplicar a fondos para la prevención de ITS/VIH/SIDA dirigidos a Hombres que tienen sexo con otros Hombres, 2010.

AIDSTAR-Two Honduras. Convocatoria a Organizaciones no Gubernamentales (OMG) para aplicar a fondos para la prevención de ITS/VIH/SIDA dirigidos a Mujeres trabajadoras de sexuales, 2010.

AIDSTAR-Two/Honduras. Quarterly Progress Report April 01– June 30, 2010. Increasing Local NGO Capacity in Honduras to Improve AIDS-related Services and Address Structural Elements of the HIV/AIDS Epidemic, 2010.

AIDSTAR-Two/Honduras. Quarterly Progress Report January 01– March 31, 2010. Increasing Local NGO Capacity in Honduras to Improve AIDS-related Services and Address Structural Elements of the HIV/AIDS Epidemic, 2010.

AIDSTAR-Two/Honduras. Work Plan (October 01, 2009- September 30, 2010). Increasing Local NGO Capacity in Honduras to Improve AIDS-related Services and Address Structural Elements of the HIV/AIDS Epidemic, 2010.

Alianza para la Comunicación en Salud (Diciembre 2003). El nuevo proceso P, pasos en comunicación. Baltimore: Centro para Programas de Comunicación de la Facultad de Salud Pública Bloomberg de la Universidad Johns Hopkins, 2003.

Amirkhanian Y.A., J.A. Kelly, J. Takacs, A.V. Kuznetsova, W. DiFranceisco, L. Mocsonaki, T.L. McAuliffe, R.A. Khoursine, T.P. Toth. "HIV/STD prevalence, risk behavior, and substance use patterns and predictors in Russian and Hungarian sociocentric social networks of men who have sex with men." In AIDS Educ Prev. 2009 Jun;21(3):266-79.

ASONAPVSI DAH. Plan Estratégico Nacional (*preliminar versión*), 2010.

Broadhead R.S., D.D. Heckathorn, D.L. Weakliem, et al. "Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention." Public Health Rep. Jun 1998;113 Suppl 1:42-57.

Comunicando Cambio para la Vida (COMCAVI). Honduras HIV/AIDS Application for Extension (October 2008 – September 2009), 2008.

Comunicando Cambio para la Vida (COMCAVI). Honduras HIV/AIDS Program Continuing Application- (October 2006 – September 2007), 2006.

Comunicando Cambio para la Vida (COMCAVI). Honduras HIV/AIDS Program Continuing Application- (October 2007 – September 2008), 2007.

Comunicando Cambio para la Vida (COMCAVI). Reporte Investigación Conocimientos, Actitudes y Prácticas (CAP) Honduras, 2009.

Comunidad Gay Sampedrana Para La Salud Integral (CGSSI). Proyecto en Salud Comunitaria para el Valle de Sula “UNIENDO FRONTERAS” Curriculas de capacitación Reuniones con Líderes Mentores Modelos de conductas, sesiones I a 10, 2009 y 2010.

Corte Suprema De Justicia, República de Honduras, C. A. Ley especial sobre VIH/SIDA, 1999.

División de Investigaciones de PSI. Honduras (2007): Estudio TRaC de VIH/SIDA entre Trabajadoras Sexuales Femeninas en Atlántida, Cortés, Comayagua, Choluteca y Francisco Morazán, Serie de Investigación de Mercadeo Social de PSI, 2009.

Kelly J.A., Y.A. Amirkhanian, E. Kabakchieva, S. Vassileva, B. Vassilev, T.L. McAuliffe, W.J. DiFranceisco, R. Antonova, E. Petrova, R.A. Khoursine, B. Dimitrov B. “Prevention of HIV and sexually transmitted diseases in high risk social networks of young Roma (Gypsy).” *BMJ*, Nov 25;333(7578):1098. Epub 2006 Oct 13, 2006.

Latkin C.A., D. Donnell, D. Metzger, S. Sherman, A. Aramrattna, A. Davis-Vogel, V.M. Quan, S. Gandham, T. Vongchak, T. Perdue, D.C. Celentano. “The efficacy of a network intervention to reduce HIV risk behaviors among drug users and risk partners in Chiang Mai, Thailand and Philadelphia, USA.” *Soc Sci Med*. 2009 Feb;68(4):740-8. Epub 2008 Dec 13.

Organización Panamericana de la Salud. División de Promoción y Protección de la Salud. Municipios y Comunidades Saludables. Guía de los Alcaldes para Promover la Calidad de Vida.

PASMO/Honduras. Condom Availability Program: Uso de condón HSH con parejas masculinas, 2010.

PASMO/Honduras. Condom Availability Program: Uso de condón HSH con parejas Femeninas, 2010.

PASMO/Honduras. Estudio MAP. Evaluación de Cobertura, Calidad de Cobertura, Penetración, Calidad de Penetración en Zonas Rojas en Población Vulnerable, 2009.

PASMO/Honduras. Informe de Medición de Cobertura y Acceso de Condones y Lubricantes en Zonas Rojas de Honduras, 2007.

PASMO/Honduras. Programa de disponibilidad de Condón en puntos de Alto Riesgo, 2010.

PASMO/Honduras. PSP-ONE/PASMO Indicators Percentage, 2010.

Population Services International (PSI). Honduras: Estudio TRAC de VIH/SIDA Hombres que tienen sexo con otros Hombres en Francisco Morazán, Cortes, Comayagua, Choluteca y Atlántida, 2009.

Population Services International (PSI). Honduras: Estudio TRAC de VIH/SIDA trabajadoras sexuales femeninas en Francisco Morazán, Cortes, Comayagua, Choluteca y Atlántida, 2009.

President's Emergency Plan to Fight HIV/AIDS. Central América PEPFAR Partnership Framework-Marco de cooperación para apoyar la implementación de la respuesta regional de Centro América al VIH/Sida entre el Gobierno de Estados Unidos y los Gobiernos de la Región Centroamericana.

President's Emergency Plan to Fight HIV/AIDS. Planning and Reporting-Next Generation Indicators Reference Guide, 2009.

PSP-One. Operativo Pasmó. Mercadeo Social para el cambio de comportamiento "Prevención del VIH/SIDA en Honduras," 2008.

PSP-One. Plan Operativo Pasmó. Mercadeo Social para el cambio de comportamiento "Prevención del VIH/SIDA en Honduras," 2009.

Ramos R.L., N.L. Green, L.C. Shulman. "Pasa la Voz': using peer driven interventions to increase Latinas' access to and utilization of HIV prevention and testing services." *J Health Care Poor Underserved*. Feb; 20(1):29-35. 2009.

Republica de Honduras Comisión Nacional de SIDA (CONASIDA). III Plan Estratégico Nacional de respuesta al VIH y Sida (PENSIDA III), 2007.

Secretaria de Salud de Honduras, Dirección General de Promoción de la Salud, Departamento de ITS/VIH/SIDA. Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Población Vulnerables de Trabajadoras Sexuales, 2008.

Secretaria de Salud de Honduras, Dirección General de Promoción de la Salud, Departamento de ITS/VIH/SIDA. Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ ITS en Población Vulnerables Hombres que tienen relaciones con otros hombres, 2008.

Secretaria de Salud de Honduras, Dirección General de Promoción de la Salud, Departamento de ITS/VIH/SIDA. Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Población Vulnerables, Reporte de Personas con VIH, 2008.

Secretaria de Salud de Honduras, Dirección General de Promoción de la Salud, Departamento de ITS/VIH/SIDA. Encuesta Centroamericana de Vigilancia de Comportamiento Sexual y Prevalencia de VIH/ITS en Población Vulnerables, Reporte en Población Garífuna, 2008.

Secretaria de Salud Departamento de ITS/VIH/SIDA Banco Mundial. Medicón de3l Gasto en SIDA (MEGAS) Honduras, 2006.

Secretaria de Salud Pública. Departamento de ETS/HIV-SIDA/TB. Proyecciones de la Epidemia de VIH/SIDA, Honduras 1980-2010.

Secretaría de Salud, Unidad Local de Apoyo Técnico/ ULAT, Management Sciences for Health/ MSH, Agencia de los Estados Unidos para el Desarrollo Internacional/ USAID. Informe de Resultados Sondeo Rápido de la Radionovela Garífuna Waníchigu "Orgullo Garífuna," 2009.

Secretaría de Salud, Unidad Local de Apoyo Técnico/ ULAT, Management Sciences for Health/ MSH. Informe de Resultados Sondeo Rápido de la Retransmisión de la Radionovela Garífuna Waníchigu "Orgullo Garífuna," 2010.

Secretaría De Salud. Departamento De ITS/VIH/SIDA. Unidad Local De Apoyo Técnico/Management Sciences For Health. Subcomité De Iec/Garífuna Para La Prevención del VIH. Agencia De Los Estados Unidos Para El Desarrollo Internacional (USAID). Informe de Resultados de la Evaluación de Impacto de las Radionovelas Garífunas “Los Ancestros no Mueren” y “Larubeya,” 2008.

Secretaria de Salud-Departamento de ITS/VIH/SIDA. Perfil Epidemiológico de ITS/VIH/SIDA en Honduras, 2007.

Sherman, S.G., C. Sutcliffe, B. Srirojn, C.A. Latkin, A. Aramratanna, D.C. Celentano. “Evaluation of a peer network intervention trial among young methamphetamine users in Chiang Mai, Thailand.” *Soc Sci Med.* 2009 Jan;68(1):69-79. Epub 2008 Nov 3.

USAID. Technical ISSUE Brief - HIV Counseling and Testing, 2010.

USAID/Honduras. Guiding principles for the relationship between the partnership framework and the strategic parameters defined by the Council of Ministers of Health (COMISCA).

USAID/Honduras. Evaluation of COMCAVI HIV/AIDS Umbrella Grant Program in Honduras, 2008.

USAID/Honduras. Evaluation of the AIDS/STD Prevention and Control Project (522-0216), 1999.

USAID/Honduras. Implementation of the Global Health Initiative Consultation Document, 2010.

USAID/Honduras. Partnership Framework Implementation Plan to Support the Execution of the Central America Regional HIV/AIDS Partnership Framework, 2010.

USAID/Honduras. Report of Analyses and Assessments, Stake holder consultations and Policy work, 2009.

USAID/Honduras. Technical ISSUE Brief Condom use: How it relates to HIV and STI prevention.

Valente, T.W. “Opinion leader interventions in social networks.” *BMJ*, Nov 25;333 (7578):1082-3, 2006.

Weeks, M.R., J. Lij, J. Dickson-Gomez, M. Convey, M. Martinez, K. Radda, S. Clair. “Outcomes of a peer HIV prevention program with injection drug and crack users: the Risk Avoidance Partnership.” *Substance Use Misuse* 2009; 44 (2):253-81.

World Bank Global. The Global HIV/AIDS Program and Latin America and The Caribbean Region- Planning for results the case of Honduras, 2009.

Zhang H., Z. Wu, Y. Zheng, J. Wang, J. Zhu, J. Xu. “A pilot intervention to increase condom use and HIV testing and counseling among men who have sex with men in Anhui, China.” *J Acquir Immune Defic Syndr.* Feb; 53 Suppl 1:S88-92. 2010.

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