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# **A.I.D.'s Family Planning Program in Honduras**

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## **PREFACE**

In October 1990, the Agency for International Development (A.I.D.) Center for Development Information and Evaluation (CDIE) initiated a series of field studies of A.I.D. family planning programs with an examination of the A.I.D. program in Kenya. In all, CDIE will look at Agency program efforts in six countries: Kenya, Ghana, Pakistan, Tunisia, the Philippines, and Honduras. This report presents the results of CDIE's study of family planning in Honduras. The studies will examine completed projects and programs, focusing above the project level, and will use a common scope of work and format to identify broader accomplishments in each country. Less attention will be given to inputs and outputs and more attention will be given to results.

CDIE wishes to thank the staff of USAID/Honduras, the Honduran Family Planning Association, and the Honduran Ministry of Health for their outstanding cooperation and assistance; and Management Systems for Health, the Academy for Educational Development, and Foster Parents in Honduras for their help. The team's contacts in Honduras seemed to all understand the objective of the assessment-to identify lessons from experience-and freely shared information concerning difficulties and setbacks as well as successes and progress.

## SUMMARY

The Agency for International Development's (A.I.D.) support for family planning in Honduras began in 1965. Since then, A.I.D. has given priority to population and family planning activities despite periods of fierce political and religious opposition, policy indifference, and implementation setbacks. Overall, the program has resulted in significant progress. In 1976, the national contraceptive prevalence rate<sup>1</sup> was 12 percent. Today, thanks in part to A.I.D. assistance, the national contraceptive prevalence rate has risen to over 46 percent.

A.I.D. supports two separate providers. The principal recipient of A.I.D. assistance is the Honduran Family Planning Association (ASHONPLAFA), a private nonprofit organization affiliated with the International Planned Parenthood Federation. ASHONPLAFA offers services through a national network of family planning clinics, community-based distributors, and pharmacies. The other major A.I.D.-supported provider is the Ministry of Health, which offers family planning services through its national system of hospitals and health posts.

Early attempts by A.I.D. and aggressive A.I.D. advisors to install highly visible, separate family planning services in the Ministry of Health backfired. Unconvinced Ministry staff ignored the programs, while political and religious leaders blasted A.I.D. in the press. Gradually, A.I.D. shifted to a lower profile approach and moved the bulk of its support from the politicized and unpredictable Ministry of Health to the more committed and professional ASHONPLAFA.

In recent years, A.I.D. and the Ministry have lowered the level of controversy by casting family planning strictly as a health intervention that reduces maternal and infant mortality by cutting high-risk births. But even this appealing rationale has not moved the Honduran Government to concerted action.

The A.I.D. Center for Development Information and Evaluation's (CDIE) case study found that the number of Honduran families using modern methods of family planning is steadily growing. Moreover, the CDIE evaluation team

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<sup>1</sup>Contraceptive prevalence rate is the percentage of women of reproductive age using contraceptive methods

estimated that between 60 and 70 percent of the improvement in the number of users and in the contraceptive prevalence rate since the 1970s is attributable to A.I.D. assistance.

However, in recent years, the growth of contraceptive prevalence has leveled off, in part because of the rapid increase in the population of women of reproductive age. The use of oral contraceptives has declined, while voluntary sterilization has increased. A puzzling trend is that the use of traditional contraceptive methods (rhythm and withdrawal) is growing faster than use of modern methods.

Important reasons for the A.I.D. program's inability to increase the contraceptive prevalence of modern methods more rapidly are weak promotion and inadequate information and education support services. It appeared to the CDIE evaluation team, based on focus group interviews with users, that the cautious and circumspect information, education, and communication efforts of A.I.D.-supported family planning providers may be losing ground to negative information about family planning that circulates in interpersonal networks and the national news media.

In terms of program *effectiveness*, CDIE found that the quality of care provided to beneficiaries varies greatly, from first-rate quality to very deficient. In ASHONPLAFA clinics the quality of services is good, but the clinical services offer inadequate coverage for women in remote areas. Ministry of Health services offer good geographic coverage, but the quality of attention they give to clients is often poor. Almost all Ministry facilities have A.I.D.-supplied contraceptives available, but Ministry medical staff are overworked. In the Ministry's crowded facilities, family planning consultations are often shortchanged in the clamor for other, more urgent curative services. Information given to clients was better in ASHONPLAFA clinics than anywhere else, but it was generally inadequate throughout the system.

Both ASHONPLAFA and the Ministry of Health are dealing with *sustainability* issues. In terms of institutional sustainability, A.I.D. is supporting institution-building activities designed to make the family planning services of both ASHONPLAFA and the Ministry operate efficiently on their own. In terms of financial sustainability, ASHONPLAFA, at A.I.D.'s urging, has raised prices and increased revenues considerably. However, ASHONPLAFA feels caught between the push to generate more income and the need to expand services to

needy families and wishes it had another independent source of income, such as a business or an endowment. The Ministry of Health charges token fees, but mainly hopes to sustain its services financially by increasing the share of the national budget it receives for maternal and child health services, including family planning.

The program's long-term *impact* has been measurable and significant. In demographic terms, the country's total fertility rate has declined from over 7.3 children per family in the 1960s and 1970s to 6.4 in 1981 and to about 5.1 in 1992. Some of this decline in fertility is due to the growing availability of A.I.D.-supported family planning services, along with improved education and economic growth. However, given the contraceptive prevalence rate of 46.7 percent, fertility should be lower than it is. The extensive use of ineffective traditional contraceptive methods, high discontinuation rates, relatively low use-effectiveness of contraceptives, as well as the early onset of childbearing and low levels of exclusive breast feeding are some of the factors that may explain the continuing high fertility rate. In addition to the demographic impact, the program appears to be having an important health impact of better birth spacing in Honduras. The infant mortality rate is 42 deaths per 1,000 live births when births are spaced more than 2 years apart, compared with an infant mortality rate of 89 deaths per 1,000 live births—over twice as high—when births are less than 2 years apart.

In terms of *efficiency*, CDIE found that ASHONPLAFA costs increased during the 1980 to 1991 period, and that expenditures for facilities and equipment grew faster than expenditures for personnel and administrative activities. Fortunately, the number of couple-years-of-protection (CYPs) that ASHONPLAFA produces grew even faster. As a result, the efficiency of the ASHONPLAFA, as measured by cost-per-CYP, improved. The rapid expansion of physical facilities has created underutilized capacity, setting the stage for further improvement in the efficiency of ASHONPLAFA operations. With improved information, education, and communication activities, ASHONPLAFA can generate new demand for existing services and facilities, increasing its volume of business without having to further expand physical capacity. Comparing services, CDIE found that medical and clinical services are the most cost-effective ASHONPLAFA services in terms of cost-per-CYP. The cost-per-CYP of community-based distribution is twice as high as medical and clinical services and social marketing is three times as high. Comparing methods, voluntary sterilization is the most cost-effective method, followed by intrauterine devices. Oral contraceptives are considerably more costly per CYP.

Overall, CDIE found a generalized feeling among A.I.D.-supported family planning providers that the fear of public attacks from opponents of family planning has made the program overly cautious. In terms of coverage, the program is barely keeping ahead of the growth in the population of women of reproductive age. The use of ineffective traditional methods, in the meantime, is growing rapidly. Family planners had resolved that a somewhat more aggressive approach to promotion is needed and should be tried. Exactly how aggressive the approach should be is a tactical question that should be answered promptly in the field. The institutional conditions for a larger and stronger program have been created by A.I.D. If the public information battle can be won, the program appears to be poised for greater success during the remainder of the 1990s.

The following are some of the key conclusions of the Honduras country case study:

- A.I.D.-supported family planning programs can achieve acceptable results even when confronted with the kind of strong cultural and political obstacles found in Latin America.
- Programming A.I.D. family planning assistance in the public and private sectors simultaneously is a sound strategy provided that activities in both sectors are complementary.
- Although government policies favoring family planning undoubtedly strengthen family planning program performance, A.I.D. family planning services can get acceptable results if the policy environment is merely neutral.
- In a potentially hostile political environment, A.I.D. can most effectively promote family planning exclusively as a health intervention designed to reduce high-risk births.
- Weak information, education, and communication activities have negative consequences for both the coverage of family planning services and quality of care.
- Charging fees high enough to cover most costs does not appear to be an obstacle to widespread use of family planning services.
- In the long run, private family planning providers would benefit from an independent source of revenue, such as an income-generating business or an endowment, to help achieve financial sustainability.

- **Progress in the area of population in a country like Honduras is slow and uneven, requiring patience and long-term commitment from A.I.D.**

The following are some important questions that were not fully answered by the case study:

- **What are the causes and consequences of the growing popularity of traditional contraceptive methods (i.e., rhythm and withdrawal)?**
- **Can A.I.D.'s support for family planning be linked more directly with other A.I.D. activities in related areas, such as basic education and health?**
- **How can policy dialogue in the family planning area be made more effective?**

## GLOSSARY

<b>A.I.D.</b>	—	<b>U.S. Agency for International Development</b>
<b>ASHONPLAFA</b>	—	<b>Asociacion Hondureña de Planificación Familiar, the Honduran Family Planning Association</b>
<b>CDIE</b>	—	<b>Center for Development Information and Evaluation, Agency for International Development</b>
<b>CESAMO</b>	—	<b>Centro de Salud con Medico-Health Centers with a Student Physician on Staff</b>
<b>CESAR</b>	—	<b>Centro de Salud Rural-Health Centers Staffed by Auxiliary Nurses with no Physicians</b>
<b>CYP</b>	—	<b>couple-year-of-protection</b>
<b>GDP</b>	—	<b>gross domestic product</b>
<b>IE&amp;C</b>	—	<b>information, education, and communication</b>
<b>IPPF</b>	—	<b>International Planned Parenthood Federation</b>
<b>IUD</b>	—	<b>intrauterine device</b>
<b>Lempira</b>	—	<b>Honduran unit of currency</b>
<b>L-M</b>	—	<b>Lapham Mauldin Family Planning Program Effort Scale</b>
<b>Pulpereas</b>	—	<b>home-based general stores</b>
<b>PVO</b>	—	<b>private voluntary organization</b>
<b>TQM</b>	—	<b>total quality management</b>

**USAID/Honduras** — **A.I.D. Mission in Honduras**  
**VSC** — **voluntary surgical contraception**

## **HISTORICAL RECORD OF FAMILY PLANNING IN HONDURAS: KEY EVENTS**

- 1961** The Honduran Family Planning Association (ASHONPLAFA) is founded in San Felipe General Hospital in Tegucigalpa
- 1963** ASHONPLAFA opens its first two family planning clinics in Tegucigalpa and San Pedro Sula
- 1965** The Government of Honduras begins offering family planning services through the Ministry of Health
- 1965** Agency for International Development (A.I.D.) support for family planning begins with a grant to establish a separate family planning unit in the Ministry of Health
- 1975** ASHONPLAFA begins community-based distribution in urban neighborhoods
- 1977** Voluntary surgical sterilization is offered for the first time in Ministry facilities with ASHONPLAFA staff
- 1980** A.I.D. begins providing funding to ASHONPLAFA
- 1984** ASHONPLAFA begins Contraceptive Social Marketing Program with the oral contraceptive, Perla
- 1988** A.I.D. Health Sector II Project begins with integrated family planning and reproductive risk focus

## **1. INTRODUCTION**

Family planning in Honduras began with the founding of a nongovernmental organization called the Honduran Family Planning Association (ASHONPLAFA) in Tegucigalpa in 1961. Four years later, with financial support from the Agency for International Development (A.I.D.), the Honduran Ministry of Health began offering some family planning services. However, the Government was reluctant, if not unwilling, to actively promote population activities over the subsequent 15 years, with the result that, in 1980, A.I.D. started supporting ASHONPLAFA as well. The Agency has carried the burden of family planning ever since.

This study of the Honduran family planning program is the third of six country case studies that A.I.D.'s Center for Development Information and Evaluation (CDIE) is conducting to assess A.I.D.'s achievements in family planning and population. The major audiences for this Technical Report are professionals identified with the population sector and individuals concerned more broadly with the role of development assistance. Like all Technical Reports, CDIE will use this country study as a resource document for the final published Assessment Report.

Fieldwork took place from May 11 to June 5, 1992. The evaluation team consisted of two A.I.D. evaluators from CDIE and two technical specialists from Research Triangle Institute—a demographer/statistician and a family planning expert. The case study is based on information compiled from secondary sources as well as original research by team members. Documents from the CDIE database describing A.I.D.'s family planning activities in Honduras were gathered and reviewed before initiating fieldwork. In Honduras, team members visited and observed activities in facilities around the country, gathered additional data, interviewed field personnel who provide family planning services, and conducted focus group discussions with women who use these services.

## **2. HONDURAS: COUNTRY BACKGROUND**

**Honduras is the second largest of the seven countries on the Central American Isthmus. It has an area of 43,000 square miles (roughly the size of Tennessee), 11,000 of which are arable. The two major cities in Honduras are Tegucigalpa, the capital (population 686,000), and San Pedro Sula (population 316,000). The urban percentage of the Honduran population has grown from 31 percent to 40 percent in the last 20 years.**

**Agriculture employs over 60 percent of the work force, generates 80 percent of exports, and accounts for 24 percent of gross domestic product (GDP). The country's principal exports are bananas and coffee. According to 1990 World Bank estimates, Honduras' per capita GDP was only \$481, one of the lowest in the Western Hemisphere.**

**Despite Honduras' poor economic performance during the 1980s, the Government of Honduras has given high priority to making progress in the social sectors. In recent years, there has been a dramatic increase-to 60 percent-in the percentage of homes having access to water and sanitation services. Over 90 percent of Honduran school-age children are enrolled in primary schools.**

**Nevertheless, a large proportion of the population suffers from poverty, which is especially pronounced among families of landless laborers and small-scale farmers. About 62 percent of Honduran households receive less than \$100 in monthly wage earnings. According to a 1990 United Nations Development Programme Human Development Report (USAID/Honduras 1991), 55 percent of the rural population and 35 percent of the urban population live in poverty. This represents approximately 47 percent of the total population, or 2.2 million Hondurans.**

**During the 1980s, Honduras was of considerable strategic and political importance to U.S. foreign policy. Because of the country's proximity to war-torn Nicaragua and El Salvador, Honduras became home to thousands of refugees and a staging area for military, paramilitary, and intelligence-gathering operations.**

In the 1990s, Honduras continues to represent a foreign policy priority for the United States, even beyond the welcome achievement of peace and democracy in Central America. Honduras is struggling to consolidate a fragile democratic political system and implement an aggressive economic adjustment program based on free and open markets. These major structural changes reflect priorities being promoted by U.S. foreign policy throughout much of the developing world. For both political and humanitarian reasons, therefore, Honduras' success is important to the United States.

### **3. DEMOGRAPHIC AND HEALTH CONDITIONS**

The population of Honduras more than tripled between the census years of 1950 and 1988, growing from 1,368,605 in 1950 to 4,639,853 in 1988. In 1991 the population was estimated to be 5,052,100. The United Nations projects the population of Honduras by the year 2020 to be between 8.9 million and 13.9 million, depending on fertility trends. The population is still primarily rural; in 1988, 60.5 percent lived in rural areas. The population is also very young, with a median age in 1988 of 17.

The infant mortality rate is estimated to have declined from about 140 per 1,000 births in the early 1960s to about 54 per 1,000 births in the early 1980s—more than a 60 percent reduction in 20 years. As a result of mortality declines, the average life expectancy at birth increased from about 42 years in the early 1950s to 51 years in the late 1960s and to 65 years in 1988.

During the 1950s and 1960s, the crude birth rate held steady at about 51 births per 1,000 and the total fertility rate remained unchanged at about 7 or more births per woman. During the 1970s, fertility began to decline.

In 1988, the rate of natural increase of the population was 3.0 percent annually. At that rate of growth, more than 150,000 people are added to the total population each year. In 23 years, the population will double. In 1951, the rate of natural increase was about 2.9 percent annually. Thus, despite a decline in the total fertility rate (from nearly 7.5 in the late 1960s to around 5 currently), the population was growing at about the same percentage rate in 1988 as in 1951. In population terms, however, only about 40,000 people were being added to the population annually in 1951, while in 1988 about 150,000 people were being added annually.

## **4. THE POLICY ENVIRONMENT AND A.I.D.'s ROLE**

### **The Contentious Political Environment for Family Planning**

Lack of a firm Honduran public policy commitment to family planning is a constraint to family planning in general and to the performance of A.I.D.'s population program in particular. Historically, the Honduran public sector has been ambivalent about family planning. The main factor that has kept policymakers reluctant to endorse family planning has been the Catholic Church hierarchy, which fiercely opposes family planning. Typically, once or twice a year, the Church hierarchy makes a highly visible public attack on some aspect of the family planning programs. In these attacks, family planning is equated with abortion, and the side effects and risk factors associated with contraception are exaggerated. Honduras' energetic news media feature these attacks prominently, and the political damage to anyone caught in the line of fire can be serious. As a result, most politicians prefer to remain noncommittal on the subject of family planning. Recently, for example, the National Congress was preparing to pass a Population Law that would not have changed existing practices, but would have formally legalized voluntary family planning. The Catholic Church hierarchy unleashed a blistering attack in the press, threatening that any member of congress who voted for the bill, and the President if he signed it, would be excommunicated and would "roast in hell." These attacks produced banner headlines, and the Congress backed away from the bill without it ever coming to a vote.

Another limiting factor has been the political left, which has often scored points with Honduran public opinion by attacking U.S. interference in Honduran affairs. Honduras' history as a "banana republic," a victim of economic, political, and military intervention from the north, has created a legacy of suspicion and resentment, and "Yankee imperialism" is an exposed nerve easily exploited by demagogues of any political persuasion. Moreover, because it is so

closely associated with the U.S. foreign assistance program, family planning has been a particularly attractive target for political activists in the medical school. As a result, the medical establishment in Honduras has tended to be opposed to family planning, and, until recently, family planning and reproductive health have not been part of the medical and nursing curricula.

In spite of these constraints, official public policy in Honduras has never been explicitly opposed to family planning and the Ministry of Health has offered limited family planning services for the last 25 years. Because of the fear of political consequences, however, Ministry programs have been very small and have not been actively promoted. Since the mid-1960s, then, A.I.D. and the Ministry of Health have both looked to ASHONPLAFA to be the principal provider of family planning services in Honduras. The Government has permitted ASHONPLAFA to work freely, without political opposition or legal difficulties. The Ministry of Health has depended on ASHONPLAFA for training Ministry staff in family planning medical skills and for providing voluntary surgical contraception services in Ministry hospitals.

### **Formal Policy**

The Government of Honduras does not have a formal policy or consistent position on population or family planning. There are no constitutional or other legal guarantees of the rights of Honduran citizens to determine the number of children they will have. Abortion is illegal.

However, a few official documents exist that seem to demonstrate official endorsement of family planning activities. The Government of Honduras National Health Strategy for 1986-1989 mentions the adverse effect of rapid population growth on development in Honduras and calls for family planning programs to reduce family size and the overall population growth rate. The National Development Plan for 1987-1990 calls for decreasing the rate of population growth by providing more education and supporting family planning programs of the Ministry of Health and the Social Security Institute.

### **A.I.D.'s Quiet Diplomacy**

A.I.D. has worked quietly over the years to make the policy and public opinion environments more favorable for family planning. Because of the political sensitivities to U.S. pressure and interference, A.I.D. has usually preferred to let ASHONPLAFA take the lead in policy dialogue activities. Every new Minister of Health is briefed by ASHONPLAFA on demographic trends and

on family planning activities taking place in the country. ASHONPLAFA ran an important A.I.D.-funded "Leadership Training" program for 3 years that presented demographic statistics and information about reproductive health issues to hundreds of public and private sector leaders. A.I.D. is presently sending groups of national leaders to observe the successful Mexican family planning program. A total of 35 people has traveled to Mexico and reportedly returned better informed and more committed to improving family planning services in Honduras.

Overall, it appeared to the CDIE team that the efforts of A.I.D. and ASHONPLAFA to influence the Government's policy with regard to family planning are producing agonizingly slow results. When A.I.D. comes calling, politically astute Ministry officials state that they support family planning and discuss their plans for strengthening the Ministry's program. However, public endorsements of the program or more proactive family planning services do not materialize. Some informants told CDIE that the Ministry does the minimum amount of family planning necessary to keep A.I.D. happy, so that A.I.D. funds will keep flowing to other health sector activities, to which family planning is linked.

### **An Evolving Consensus: The Reproductive Risk Focus**

During the 1980s, an unsuccessful A.I.D. project attempted to install a "vertical" family planning program in the Ministry of Health. When this approach failed, A.I.D. and the Ministry decided to integrate family planning services into the Ministry's primary health care services to women. However, once family planning became integrated, it virtually disappeared. Competing priorities, lack of interest and knowledge on the part of medical staff, and opposition to family planning on the part of some midlevel Ministry officials contributed to its disappearance.

Then, in 1990, a study of maternal mortality found that the maternal mortality rate was a shocking 211 per 100,000 live births (a rate four times higher than the officially reported figure). This study generated considerable media attention and public concern. At the same time, a newly elected government was just taking office and was looking for new directions and programs. Overnight, reducing maternal mortality became a new national priority, and family planning, to reduce high-risk births, acquired new currency in the Ministry of Health.

Family planning is now part of a "reproductive risk" focus in a unit called "health care for women," located in the Ministry's Department of Maternal/Child Health. There appears to be somewhat more enthusiasm for the reproductive risk focus in the Ministry than there was for any previous family planning program. For the first time, there seems to be a growing consensus among Ministry personnel that family planning, used to reduce high-risk births, is really a service that is justified and needed in Honduras. The reproductive risk focus fits comfortably with the cultural, religious, and political norms of the country and is something everyone can believe in and support without reservation. Also, the reproductive risk focus is viewed by the Honduran medical and political establishments as a Honduran initiative, not a U.S. imposition.

Seeing the political and public opinion advantages of the reproductive risk focus, A.I.D. has accepted reproductive risk as the exclusive rationale for its family planning program. As a result, there is now a "nationwide collusion" (in the words of an A.I.D. official) to do family planning, but call it reproductive risk.

Another factor that has apparently improved the policy climate for family planning is AIDS. Honduras was one of the first countries in Central America to have AIDS cases, and it has developed a comparatively aggressive program to combat the epidemic. The Government has initiated publicity campaigns openly promoting condom use, and, so far, the Catholic Church hierarchy has chosen not to take issue with this emphasis.

### **What Next?**

The current Minister of Health reported to the CDIE evaluation team that he is, as a matter of personal conviction, a strong advocate of family planning. He criticized the present Ministry's program as "fearful" and "timid" and reported that the Government is preparing to embark on a bigger, more forceful program. While he is convinced that the country is facing demographic problems of growing proportions, he shares the view that the reproductive risk approach is the best way to sell the program to the country.

It was reported to CDIE by several other sources that the current Minister, on orders from the President, has negotiated a cease fire with the country's Catholic Church hierarchy, which has permitted the Government to pursue its family planning program without militant Church opposition, provided the program is not too aggressively promoted or expanded. For Honduras, 1993 is an election year, and no national political figure or party wants to make powerful enemies like the Catholic Church hierarchy and the right-to-life organizations.

The current "plateauing" in the prevalence of modern contraceptive methods and the growth of traditional methods might indicate that the reported truce is working to the benefit of the Catholic Church authorities who oppose family planning modern methods more strongly. Although both the Catholic Church hierarchy and the Government of Honduras are silent in public on the subject of family planning, both sides have information, education, and communication (IE&C) activities that are active at the grassroots level throughout the country. The Catholic Church's community-level IE&C, including Sunday sermons and obligatory marriage counseling, may be checkmating the Government's half-hearted program and ASHONPLAFA's cautious promotional efforts. A firmer Government commitment on the policy level, manifested specifically in stronger IE&C activities supporting the Ministry's reproductive risk program, is needed to keep the Government's slow-moving program from stalling completely.

## **5. A.I.D. AND ASHONPLAFA**

### **ASHONPLAFA: History and Activities**

Since its founding in 1961, ASHONPLAFA has been the major provider of family planning services in Honduras. ASHONPLAFA began as a small experimental family planning service operated by the International Planned Parenthood Federation (IPPF) in the Ministry of Health's San Felipe General Hospital in Tegucigalpa. Until 1985, ASHONPLAFA remained a small operation that received most of its operating funds from the IPPF.

During the 1960s and 1970s, while A.I.D. and the Government of Honduras wrestled over the sensitive issue of family planning, ASHONPLAFA gradually expanded its activities. With support from the Population Council and then the Pan American Health Organization, a postpartum education program was launched. In the 1970s, ASHONPLAFA opened two clinics of its own, one in Tegucigalpa and the other in San Pedro Sula. It then began expanding into smaller cities and rural areas. In 1975, a community-based distribution program was developed with unsalaried distributors who received commissions on their sales. In 1977, voluntary female sterilization services were made available in Ministry of Health hospitals and private clinics with ASHONPLAFA support. A Contraceptive Social Marketing Program was instituted in 1984 to market the oral contraceptive, Perla.

Today, ASHONPLAFA is a large, national organization with employees and facilities throughout Honduras. ASHONPLAFA family planning services are now available in over 2,200 locations in all 18 states and all but 26 of Honduras' 263 counties. Its central office is in Tegucigalpa, with clinical and administrative functions, and six regional clinics are located throughout the country.

ASHONPLAFA has three major service delivery programs: Clinical Services, Community Services, and Social Marketing. Each is described briefly below.

**Medical/Clinical Services.** ASHONPLAFA's six regional clinics are fully equipped, outpatient clinics offering a range of reproductive health services, including education, counseling, temporary contraceptive methods, voluntary surgical contraception, cancer screening, and training. ASHONPLAFA also subsidizes sterilizations performed by private physicians in cities where there are no ASHONPLAFA clinics.

**Community Services.** Previously called "community-based distribution," Community Services comprise a network of 1,728 distributors in all 18 states of the country. ASHONPLAFA recruits local women, often operators of home-based general stores called *pulperias*. The local distributors receive one or two training courses per year, advertising materials, and contraceptives. The responsibilities of the local distributor are to promote family planning in the community, sell contraceptives, provide advice and assistance to users, and refer users needing other services to other ASHONPLAFA or Ministry facilities. Every 3 months, each local distributor is visited by an ASHONPLAFA promoter who collects ASHONPLAFA's share from sales and resupplies the distributor. The program currently has 54,200 users, about 5 percent of all women of reproductive age, representing an average of 31 users per distributor.

**Social Marketing.** ASHONPLAFA has a contract with a large Honduran pharmaceutical distributor for the commercial distribution of contraceptives. Sales, concentrated in the metropolitan areas of Tegucigalpa and San Pedro Sula, have reached 385 of the country's 421 pharmacies and 178 of the 272 other stores that sell medicines in 17 cities around the country. Most of the sales points offer ASHONPLAFA's Perla pill and Guardian condom.

ASHONPLAFA's IE&C department provides services to all three programs. It includes a staff of 46 people, 25 of whom work outside of Tegucigalpa. IE&C coverage by radio programs is nationwide. Between August 1, 1989 and December 31, 1991, 316,754 radio spots with messages about ASHONPLAFA's programs were broadcast. The IE&C department also prints pamphlets and posters and performs public relations and policy dialogue activities.

## **A.I.D. Support for ASHONPLAFA**

Initially, A.I.D. support for family planning in Honduras was directed principally to the public sector. However, by the late 1970s, the Ministry of Health was blocking these efforts almost totally. ASHONPLAFA, meanwhile, had more commitment and enthusiasm for family planning than it had resources.

In this context, A.I.D. began providing support to ASHONPLAFA. Direct A.I.D. support began in August 1980 and now totals nearly \$30 million. A.I.D.'s projects supporting ASHONPLAFA are described in detail in Appendix A.

A.I.D.'s support for ASHONPLAFA is currently provided through the 1989-1993 Private Sector Population II Project. This project provides \$16 million in grant funds, of which \$12.6 million is designated for ASHONPLAFA, \$1.1 million for support of other private voluntary organization (PVO) family planning activities, and \$2.3 million for technical assistance buy-ins.

An external evaluation of A.I.D.'s Private Sector Population II Project was completed in April 1992, 3 years into the project. Overall, the evaluation concluded that, with the help of the A.I.D. project, ASHONPLAFA was continuing to expand the coverage of its services and improve its operations. With the Community Services Program producing 50,000 couple-years-of-protection (CYP) in 1991, the Social Marketing Program producing 23,000 CYPs, and the Medical/Clinical Program producing 158,000 CYPs, the total output was about 86 percent of the CYPs targeted for midproject. At the same time, the evaluation found that ASHONPLAFA had increased the level of locally generated funds by 54 percent, largely through client charges. The evaluation found that ASHONPLAFA was behind in spending its budget. The areas where underspending had been detrimental to program performance were promotion and advertising for the Social Marketing Program, use of mass media IE&C, in-country training, transportation and field support for promoters, and assistance of rural clients to clinics.

ASHONPLAFA reported to the CDIE evaluation team that it is presently reexamining its IE&C strategy. ASHONPLAFA has traditionally used a low-key approach to mass media promotion, fearing that a more aggressive, explicit approach might offend some people and reignite destructive opposition. ASHONPLAFA bases its marketing strategy and messages on a family planning knowledge, attitudes, and practices study that was carried out 8 years ago. The IE&C department has decided that much has changed in 8 years and is preparing to do a new study that will serve as the basis for a new communication and marketing strategy.

## **6. A.I.D. AND THE MINISTRY OF HEALTH**

### **Ministry of Health**

The Ministry of Health is the Government of Honduras' principal institution for providing health services to the population of the country. A detailed description of the Ministry of Health, its family planning program, and its relationship with A.I.D. is contained in Appendix B.

Administratively, the Ministry has divided the country into nine health *regions*. Each of the nine regions has a regional administrative office and staff, a regional director, and a regional hospital. Each region, in turn, is divided into health *areas*, which are further divided into *sectors*. Each sector runs a network of local health centers. The health centers are of two kinds. Health centers that have a student physician on their staff are called *Centro de Salud con Medico*, or *CESAMO*. There are 183 CESAMOs throughout Honduras. Lower level rural health centers that are staffed by an auxiliary nurse, with no physician, are called "Centro de Salud Rural," or "CESAR." There are 521 CESARs. At the lowest level of the Ministry's structure are local community health volunteers. The 1987 National Epidemiology and Family Health Survey showed that 90 percent of Honduran homes are within 3 hours of a Ministry health facility using normal means of transportation. The Ministry of Health routinely charges patients a nominal fee equivalent to US\$0.20 for each consultation. Medications are free.

### **A.I.D. Support for Ministry Family Planning Services**

The Government of Honduras decided to begin offering family planning services through the Ministry of Health in 1965. USAID/Honduras responded by funding the 1965-1976 Maternal Child Health/Family Planning Project, which covered practically all of the direct costs of the new Ministry of Health's family planning services. That marked the beginning of a long and difficult A.I.D. effort to support the development of effective public sector family planning services in Honduras.

Initially, during the late 1960s and early 1970s, A.I.D. provided funding for a separate family planning unit in the Ministry of Health. Thirty-four separate family planning clinics were created and staffed within the regular Ministry clinics. At that time, A.I.D. felt that a vertical and separate project structure was necessary to avoid bureaucratic entanglements, ensure proper control of funds, and achieve quick results.

The commitment of the Ministry of Health to this project was half-hearted, at best. The project was seen essentially as A.I.D.'s project, not the Ministry's. The project's vertical and separate structure plus inequities between the project and other less well-funded Ministry programs caused resentment. The Catholic Church hierarchy attacked it, and critics within the university and medical school branded it as imperialistic.

As the project proceeded, the notion of integrating its services into the regular Ministry of Health's structure was widely discussed. Formal integration was accomplished by 1975; however, only half of the family planning personnel were ultimately integrated. The effect was to essentially dismantle the project and greatly reduce family planning activities, while reallocating resources to other maternal and child health priorities. Those personnel integrated into the Ministry no longer worked on family planning activities. Indeed, following this integration there effectively was no Ministry family planning *program* (although some service delivery did continue) until the 1980s. The project extended over a 10-year period and, at its conclusion, had only 38,000 users enrolled. There is no evidence that the project had any significant impact on population growth.

Based on the unsuccessful effort to establish a vertical program, A.I.D.'s next effort was the 1976-1981 Integrated Rural Health/Family Planning Project, designed specifically to support *integration* of family planning and public health services. Ultimately, the Ministry did not implement the family planning components of the project, although other maternal and child health components were successful. The project created three permanent training sites and trained many auxiliary nurses, midwives, and volunteer community health workers. This training capability, which still exists, has probably been one of A.I.D.'s most successful health sector undertakings in Honduras. However, the 10-month training course developed for auxiliary nurses spends only 4 of its 1,600 hours of instruction on family planning.

In 1980, A.I.D. initiated a series of large, comprehensive health sector projects that included, among many activities, family planning components. In 1980, the Health Sector I Project was launched with ambitious objectives. Most of the health and child survival components were highly successful. The family planning component, continuing to struggle against indifference in the Ministry,

managed to achieve some, but not all, of its objectives. Eight years later, the end-of-project evaluation found that the family planning component had accomplished the following:

- Increase in contraceptive use from 27 percent to 35 percent of women in the reproductive age group
- Official approval of a Government of Honduras population program
- Significant improvement in the training of personnel in the use of family planning methods and in making family planning commodities available at the health centers (in 1988, 95 percent of the centers had oral contraceptives available and 75 percent had condoms)
- Standardization of voluntary surgical sterilization procedures
- Training of over 5,000 midwives in improved birthing techniques and in the rudiments of family planning
- Increased use of mass media to support family planning activities
- Creation of a new family planning unit in the Maternal and Child Health Division
- Creation of a new breast-feeding program with personnel at central and regional levels

In 1988, A.I.D. initiated an \$83 million Health Sector II Project. The birth-spacing subcomponent was designed to support an integrated program of maternal care. Attention was to be focused on women at high reproductive risk (women under 18, over 35, with children under 18 months, or with 4 or more children). Contraceptives, considerable delivery room equipment, and cytology lab supplies were to be provided and the logistics system was to be improved. The project had the following family planning objectives:

- Decrease the percentage of births with intervals fewer than 2 years from 30 percent to 15 percent
- Increase contraceptive-use prevalence nationwide from 35 percent (1984) to 45 percent in 1990 and to 50 percent in 1993

- Attend to 90 percent of pregnant women detected in the high-risk group by the health system (40 percent in 1986)
- Have 90 percent of CESARS distribute temporary contraceptive methods (40 percent in 1986)
- Have 60 percent of the voluntary personnel (midwives and *guardianes*) distribute oral contraceptives and condoms (none presently)
- Make 50 percent of fertile-age women aware of the health risks of short intervals (fewer than 2 years) between pregnancies

At present, the A.I.D. contribution to the project's birth-spacing subcomponent is \$3 million, or about 5 percent of A.I.D.'s total contribution to the Health Sector II Project.

In 1991, 3 years into the Health Sector II Project, A.I.D. did a midterm evaluation. While many project components were making good progress, the women's health care component, including family planning, was floundering. Only 17 percent of the allocated funds had been expended through June 1991 and many activities were considerably behind schedule. The availability of services continued to be quite limited. Condoms, vaginal tablets, and pill refills were generally available at the CESARs, but not from midwives or community volunteers. Intrauterine device services at the CESAMO level were extremely limited. Male and female voluntary sterilization services were essentially unavailable from the Ministry of Health directly. Considerable regional variation in availability of services was observed.

A hopeful sign, observed during A.I.D.'s midterm evaluation, was renewed commitment to the reproductive risk approach that emerged following a study of reproductive and maternal mortality. Also on the positive side, a health education and communications plan was being developed, and a plan to incorporate hospitals more effectively into the delivery of family planning services had been formulated and the Ministry's commodities and logistics system considerably strengthened, enabling it to distribute contraceptives more effectively.

Historically, then, the picture that emerges of the Ministry's family planning services is mixed. The Ministry is willing to provide services in its facilities, but is unwilling to promote them actively. If it really wanted to, the Ministry could do much better. The Ministry is capable of effectively reaching almost the entire population of Honduras, as shown by its extremely successful national vaccination campaigns and other strong child survival services.

However, family planning is a passive service, provided to women when requested, but actively promoted only occasionally when individual field employees take the initiative. Family planning has been a constant source of friction between the Ministry and A.I.D., but both sides have been anxious to avoid a confrontation that might be destructive to a generally strong and collaborative health sector program. In the balance, the CDIE evaluation team concluded that poor performance by the Ministry is better than no performance. The Ministry is providing services to clients who otherwise would not have access to family planning. By linking family planning services to other more popular health programs, A.I.D. has created the conditions for continued gradual improvement of Ministry family planning services and greater acceptance of family planning on the policy level in the future.

## **7. A.I.D. STRATEGY AND IMPLEMENTATION**

### **Strategy**

**A.I.D. has worked in the population sector in Honduras for 27 years and has had to periodically change its approach in response to shifting political currents and lessons learned from experience. Under these circumstances, it would have been difficult for the program to adhere to a long-term strategy. A flexible approach to programming in the sector has permitted A.I.D. to cut its losses when there have been setbacks and to seize opportunities when they have arisen. While there has been continuous A.I.D. activity in the population sector in Honduras reflecting different de facto strategies at different times, there has never been a formal A.I.D. population strategy paper.**

**Conceptually, A.I.D. has shifted from a demographic rationale to a health rationale for its family planning activities in Honduras. Population programming is discussed in A.I.D.'s 20-year Health Sector strategy. A.I.D.'s health sector strategy envisions three consecutive health sector projects running from 1980 to 2000. These major sectorwide projects are designed to improve administration and service delivery of the Honduran public health system, with greatest emphasis placed on primary care for mothers and children. Included in each health sector project is a family planning component.**

**In its Action Plan, the A.I.D. Mission in Honduras identifies the achievement of "equitable and sustainable economic growth and development" as one of its country program goals. One of the strategic objectives associated with this goal is "healthier, better-educated Hondurans." Family planning is seen as one activity accomplishing this strategic objective. The narrative in the Action Plan makes it clear that A.I.D. is supporting family planning for health, not demographic, reasons. The Action Plan argues that "smaller families are not an end in themselves but will contribute to healthier children." This position makes A.I.D.'s strategy fully consistent with the Government's reproductive risk focus.**

One of the program outputs under the "healthier, better-educated Hondurans" strategic objective in the Action Plan is "increased percentage of Hondurans who practice family planning." Performance and program output indicators selected to track the program's progress are shown in Table 1.

**Table 1. Performance and Program Output Indicators**

Indicator	Unit	Baseline 1987	Target 1992	Target 1995
Reduced Total Fertility Rate	Total Average Live Births per Women of Fertile Age	5.6	5.1	4.7
Increased Contraceptive Prevalence	Percentage Women of Reproductive Age in Union Using Family Planning Methods	41.0	47.0	52.0
Reduced Age-specific Fertility Rates for Women	Live Births per 100 Women Aged 15-19	13.5	11.5	10.0
	35-39	16.0	14.5	12.5

A.I.D. documents and A.I.D. program officials agree that the most culturally and politically sensitive way to justify family planning activities in Honduras is as a means of reducing infant and maternal mortality by reducing high-risk births. Although demographic issues also concern most A.I.D. staff in Honduras, all agree that articulating any kind of demographic objective, such as reducing the population growth rate, could provoke controversy that would damage the program.

Demographic conditions in Honduras also seem to favor the health rationale over the demographic rationale. The country has a population of only about 5.052 million (1991 estimate), with a relatively low population density of 115 persons per square mile. For this reason, population pressures are not yet being felt in Honduras as acutely as they are in more densely populated Latin

American countries, such as Haiti and El Salvador. Most informants felt that Honduras' high population growth rate of 2.8 percent has serious long-range implications for development, but they agree that tactically it is best to articulate only a health-related rationale for A.I.D.'s assistance to the population sector.

A.I.D.'s current de facto family planning strategy has several important features. First, A.I.D. plans to continue to support a diversity of providers. In addition to A.I.D.'s traditional cooperating agencies-ASHONPLAFA in the private sector and the Ministry of Health in the public sector-A.I.D. has begun providing support to other local PVOs. A.I.D. feels that the PVOs have more of a grassroots community orientation, more credibility with potential village users, and complementary relationships with the big traditional providers. Second, A.I.D. has added an increased emphasis on sustainability. Third, if the Ministry of Health proves able to improve its performance soon, A.I.D. would like to gradually shift a greater share of the responsibility for expanding services to the Ministry, which has the advantage of infrastructure and staff already in place throughout the country. Fourth, the program will continue to concentrate on improving services in rural areas. Fifth, more emphasis on IE&C activities is planned to expand coverage more effectively.

Staff of A.I.D.'s population program in Honduras feel that A.I.D., in its 27 years of work in the sector, has produced significant results. They feel that A.I.D., the only major donor supporting population activities in Honduras, has almost single-handedly turned Honduras around in terms of family planning. However, they see considerable work left to be done in expanding coverage to rural areas, building effective public sector services, and achieving sustainable institutions. As a result, population programming is seen as an ongoing part of A.I.D.'s development assistance program for Honduras.

## **Implementation**

A.I.D. recently reorganized the Office of Human Resources Development in its Honduras Mission, removing the population program from the Health Division and making it a separate division. The effect was to give the population program greater stature and independence of action. The new Population Division has an A.I.D. U.S. direct hire population officer as division chief. The chief supervises two Honduran personal services contractors and a division secretary.

The Honduran personal services contractors are both physicians. One is assigned responsibility for managing the ASHONPLAFA private sector project. The other manages the reproductive risk component of the Health Sector II Project with the Ministry of Health.

A.I.D.'s Population Division takes an active, "hands on" role in project implementation. Particularly with the family planning activities under the Health Sector II Project, activity progresses too slowly or not at all unless A.I.D. takes some initiative. A.I.D. often grows impatient with the slow pace of activities, but has found that confronting Ministry of Health counterparts concerning poor performance can be counterproductive. Instead, A.I.D. has developed ways to work around reluctant or uninterested individuals and units in the Ministry. The A.I.D. project manager for the public sector program, a Honduran physician, works directly and personally through Ministry of Health field staff located outside of Tegucigalpa in the Ministry's regional offices. When a regional office proves particularly supportive of reproductive risk interventions, that region quickly becomes a focal point for A.I.D. project activities and resources. This selective approach reduces the amount of time and resources that would otherwise be lost in trying to deal with other, less committed Ministry staff members or units.

Given the Ministry's decentralized administrative structure, dealing directly with field units is consistent with Ministry delegations of authority and with the Project Grant Agreement. The Minister of Health has approved all the activities that have been initiated in this way. However, the approach does sometimes irritate midlevel officials in the Ministry's central bureaucracy who feel that they have been circumvented and would like to have control over project resources and activities. There is, therefore, an element of risk that offended midlevel officials might find ways to manifest their displeasure by harming the project. Ultimately, A.I.D. has concluded, reasonable risks must be taken or the program will not perform.

A.I.D. has been disappointed that its U.S. institutional contractors, who have performed strongly on other components, have not provided more leadership in the reproductive risk component. These contractors value their good working relationships with Ministry of Health counterparts and are reluctant to jeopardize good relationships by aggressively pushing a small component that could cause controversy and bad feelings. Furthermore, the contractors feel that the present pace of activities, although slow, is about as fast as things can move under the

circumstances. They fear that trying to push activities much faster could rekindle opposition and be counterproductive. Nevertheless, A.I.D. is likely to try to define a somewhat more active role in the reproductive risk component of the Health Sector II Project for its institutional contractors in the future.

## **Monitoring and Evaluation**

A.I.D. uses the following three different information-gathering techniques for tracking its population program in Honduras and reporting its results: (1) field monitoring, (2) project evaluations, and (3) national surveys. The CDIE evaluation team was impressed with the thoroughness and rigor of these instruments and the use of the results by A.I.D. program managers in tracking and improving program activities.

## **8. EFFECTIVENESS: COVERAGE**

The term "effectiveness" in this case study has both quantitative and qualitative dimensions. The quantitative dimension, discussed in this section, refers to the coverage of A.I.D.-supported family planning services-the extent to which they are reaching significant and growing numbers of beneficiaries. The qualitative dimension of program effectiveness, discussed in the following section, deals with the quality of care offered by A.I.D.-supported providers and with the overall national program effort.

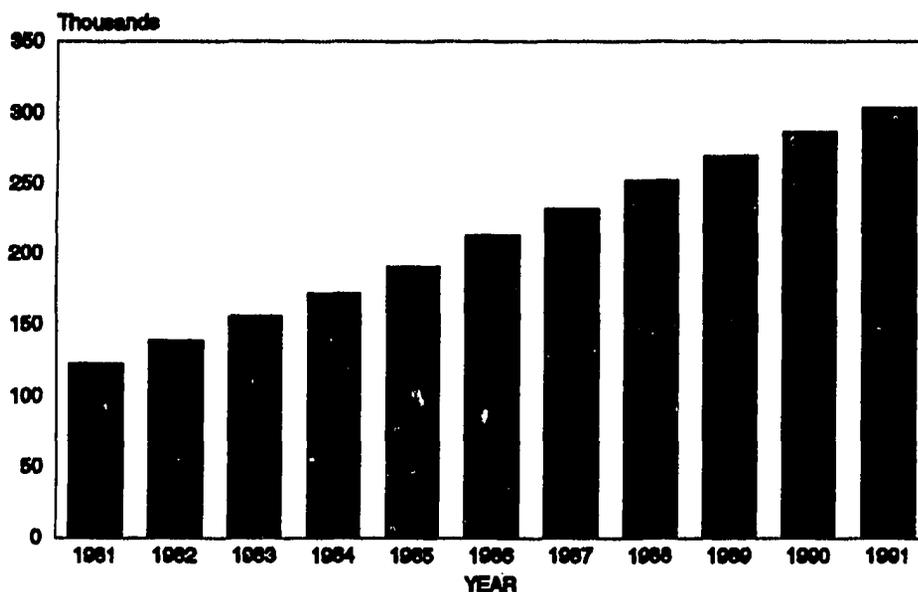
Over the last decade, four national reproductive health surveys (1981, 1984, 1987, and 1991) were conducted in Honduras with A.I.D. support. Similar in methodology to A.I.D.'s Demographic and Health Survey, these reproductive health surveys gathered information from representative national samples of women of reproductive age. This section reports findings from the surveys concerning the coverage of the program, including its effectiveness in promoting the adoption of family planning (contraceptive prevalence) and its effects on knowledge and attitudes about family planning.

### **Practices: Contraceptive Prevalence**

The most straightforward indicator of coverage of services in Honduras is the number of users of family planning. Figure 1 shows that the number of users has increased steadily during the period covered by the surveys, more than doubling during the 1980s. Since almost all of the contraceptives and services in Honduras are A.I.D.-supported, this is a direct indication of A.I.D. program effects.

However, in rapidly growing populations like Honduras', the total number of users does not fully represent the extent of coverage. Since the population of women of reproductive age is fast increasing, contraceptive prevalence-the percentage of all women of reproductive age who are using family planning-is also an important indicator of coverage.

**Figure 1. Number of Users of Contraceptives, Honduras 1981-1991**

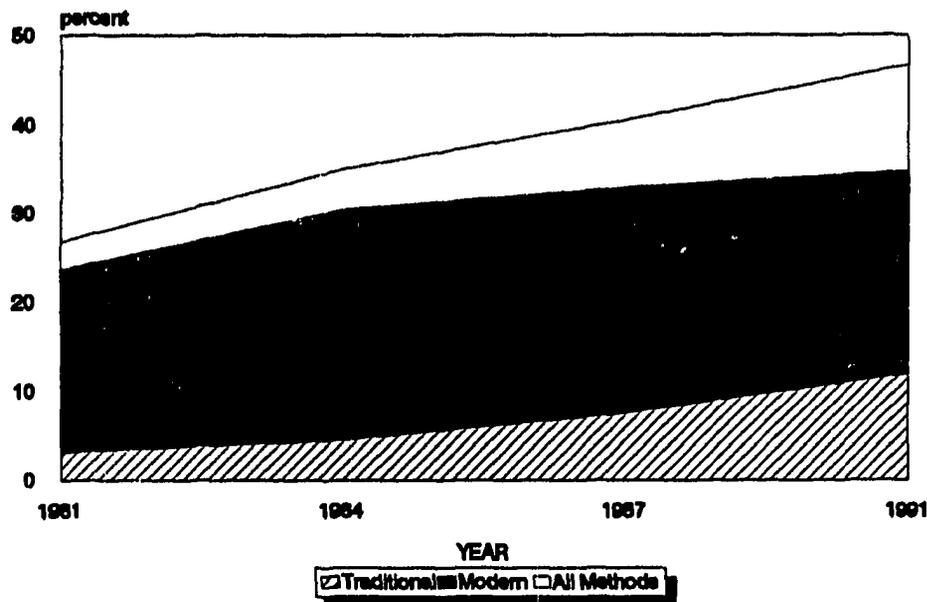


Source: CDIE estimates based on survey results.

In 1976, the contraceptive prevalence rate in Honduras was 12 percent. As shown in Figure 2, the overall contraceptive prevalence rate (modern and traditional methods) increased to 26.8 percent in 1981 and then to 46.7 percent in 1991. The prevalence rate for all modern methods increased from 23.6 percent in 1981 to 34.7 percent in 1991. However, there has been little increase in modern method prevalence between 1987 and 1991.

During the same period, total prevalence (modern and traditional methods) increased from 47.4 percent to 60.9 percent in urban areas and from 16.2 percent to 36.1 percent in rural areas. Modern method prevalence in urban areas increased from 43.6 percent in 1981 to 51.6 percent in 1987, declining to 49.4 percent in 1991. Modern method prevalence in rural areas increased from 13.3 percent in 1981 to 22.5 percent in 1987, with a small increase to 23.7 percent in 1991.

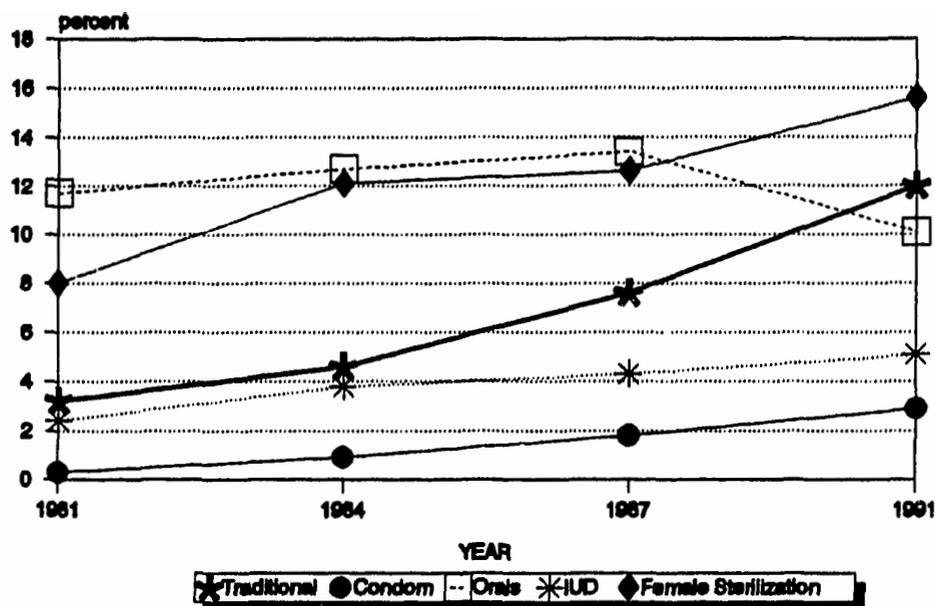
Figure 2. Contraceptive Prevalence  
Honduras, 1981, 1984, 1987, 1991



Source: CDIE compilation from four surveys.

Figure 3 summarizes the changing mix of contraceptive methods in Honduras. In each of the four reproductive health surveys (1981, 1984, 1987, and 1991), oral contraceptives and female sterilization were the two most popular modern methods. However, the prevalence of oral contraceptive use declined significantly, while prevalence of female sterilization increased. Between 1981 and 1991, among all users of modern methods, the proportions using female sterilization, IUDs, and condoms all increased. In contrast, the proportion using oral contraceptives declined between 1981 and 1991.

Figure 3. Method Mix, Honduras,  
1981, 1984, 1987 and 1991

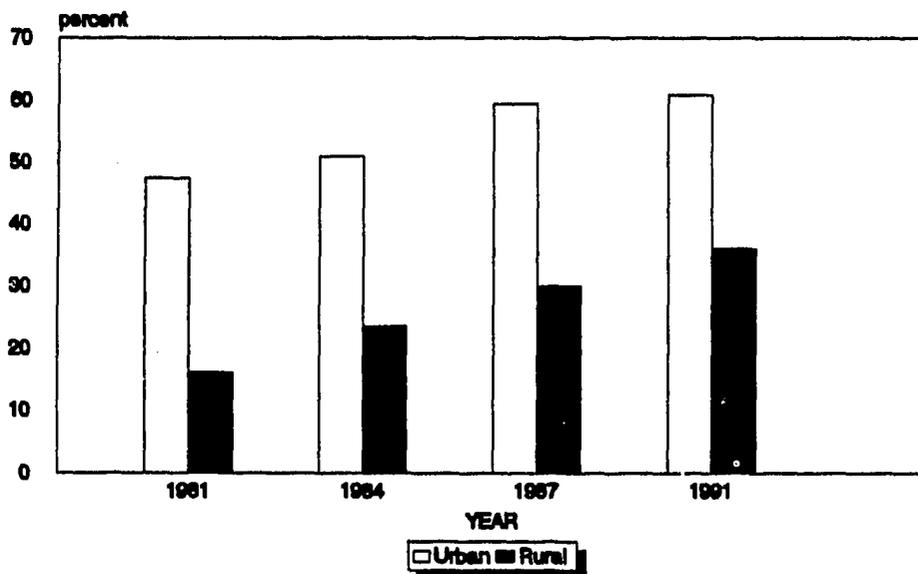


Source: CDIE compilation from four surveys.

The most surprising finding of the surveys is that the use of traditional contraceptive methods (primarily withdrawal and rhythm) increased markedly between 1981 and 1991. The prevalence of traditional methods increased from 3.2 percent (11.9 percent of all contraceptive users) in 1981 to 12.0 percent (25.7 percent of all users) in 1991. In other words, prevalence of traditional methods increased by about 9 percentage points (nearly a quadrupling from 3.2 percent in 1981). In comparison, prevalence of modern methods increased 11 percentage points (from 23.6 to 34.7 percent). Between 1987 and 1991, prevalence of traditional methods increased from 7.6 percent to 12.0 percent, or 4.4 points. Prevalence of modern methods increased only 1.8 points. In urban areas, prevalence of traditional methods increased from 7.8 percent to 11.5 percent, or 3.7 points. Meanwhile, prevalence of modern methods declined 2.2 points.

Socioeconomic and demographic factors are associated with the uneven coverage of family planning services in Honduras. Figure 4 shows that the coverage of services is higher in urban areas than in rural areas, although the urban-rural disparity appears to have diminished somewhat since 1987 as a consequence of increased program effort in rural areas. Another factor that affects coverage of family planning services is education of women. Table 2 shows the strong relationship among education, contraceptive prevalence, and number of children.

**Figure 4. Contraceptive Prevalence, Urban and Rural Honduras, 1981, 1984, 1987, and 1991**



Source: CDIE compilation from four surveys.

How do these contextual factors influence a woman's use of family planning services? The economic analysis conducted by the CDIE evaluation team (see Section 12) found that the cost of services apparently does not strongly determine access to family planning services. Therefore, geographic (e.g., urban-rural) and socioeconomic (e.g., education) conditions do not limit access to family planning simply because of income levels. The urban-rural disparity probably is caused by less convenient access to facilities in rural areas, lower educational levels among rural women, and the more traditional culture and

economy that exist in rural communities. The disparity associated with education most likely reflects the fact that education causes women to be less traditional and fatalistic, better able to process family planning IE&C messages, and more favorably disposed to deal with modern institutions and change agents. Also, higher levels of education are associated with other phenomena that make families inclined to want fewer births, including women's employment, fewer infant deaths, and migration to urban areas.

**Table 2. Contraceptive Prevalence and Average Number of Births by Level of Education, Honduras, 1991**

Level of Education	Contraceptive Prevalence			Average Number of Births
	Any Method	Modern	Traditional	
None	28.7	18.9	9.8	5.4
Primary 1-4	40.0	27.1	12.9	4.4
Primary 5-6	52.3	41.5	10.7	3.1
7 years or more	66.7	52.8	13.9	2.3

Source: CDIE estimates based on preliminary data from the 1991 Epidemiology and Health Survey.

### Sources of Services

The three major sources of services-ASHONPLAFA, the Ministry of Health, and private commercial providers-provide services to roughly equal numbers of family planning users. In other words, each cares for about one-third of the total number of women who are planning their families. However, further analysis of 1987 survey data shows that this statistic is misleading because ASHONPLAFA provides contraceptives and services through the other two major providers as well as directly through its own outlets. ASHONPLAFA actually provides more than 70 percent of voluntary sterilizations, but most of the operations are performed in Ministry of Health hospitals or private clinics through

contractual arrangements with the association. In other words, ASHONPLAFA supplies the service even though another provider supplies the physical facility. Similarly, oral contraceptives and condoms sold in private commercial pharmacies are actually, for the most part, provided to retailers from ASHONPLAFA's Social Marketing Program. Table 3 shows an approximate distribution of contraceptive goods and services in Honduras, corrected for the fact that ASHONPLAFA is the initial provider of goods and services that other organizations subsequently deliver.

**Table 3. Source of Contraception, Honduras, 1987**

	ASHONPLAFA %	Ministry of Health %	Commercial %	Other %
Orals	58	17	21	4
VSC	71	1	15	13
Condom	75	6	19	0
IUD	29	43	21	7

Source: Honduran Ministry of Health. "Epidemiology and Family Health Survey; Honduras 1987, Final Report" Table VI, B14-18, P. 194-198.

### Knowledge About Family Planning

The national surveys of women of reproductive age asked respondents if they had heard of each of the different contraceptive methods. If respondents answered "yes," they were considered to have knowledge of the method. Defined in this way, knowledge of contraceptive methods is high in Honduras. In both urban and rural areas, knowledge of oral contraceptives and female sterilization as contraceptive methods is virtually universal; over 99 percent of married women in urban areas and over 96 percent of married women in rural areas reported knowing about oral contraceptives and female sterilization in both 1987 and 1991.

Knowledge of other methods is less widespread. Over 90 percent of respondents in urban areas knew about IUDs, condoms, and injectable methods in both 1987 and 1991. Corresponding percentages were 80 percent or lower in rural areas.

In contrast to modern methods, which showed little change in awareness levels between 1987 and 1991, awareness of both rhythm and withdrawal increased by almost 10 percentage points during the same period. For these two traditional methods, the increase in knowledge about each method was associated with an increase in use of each method.

Among respondents who have never tried to limit pregnancies, lack of basic knowledge about methods does not appear to be the overriding reason. For every modern method, except vasectomy and vaginal methods, at least 70 percent of nonusers reported knowing about the method; 94 percent knew about oral contraceptives and 94 percent also knew about female sterilization. Respondents who reported knowing about rhythm and withdrawal were 47 and 35 percent, respectively.

The coverage of family planning IE&C messages is not great. Only 26.6 percent of urban respondents and 14.8 percent of rural respondents reported hearing or reading a family planning message in the month prior to the survey. Radio was the most important source for both urban and rural respondents. Nearly half of all urban respondents and nearly two-thirds of all rural respondents mentioned radio. Television was also a major source for urban respondents (39 percent), but it was mentioned by only 10 percent of rural respondents. Health personnel were relatively important information sources for both urban (23 percent) and rural (30 percent) respondents.

Although knowledge levels, measured by simply asking respondents if they have heard of different methods, are high, CDIE's focus groups of users revealed that users' knowledge about family planning is often very incomplete and full of errors. Section 9 reports more detail concerning users' knowledge of family planning.

### **Attitudes About Family Planning**

Only a few attitudinal items were included in the national surveys that were administered in Honduras. The items reported in the following discussion are complemented by additional attitudinal information gathered by CDIE in focus groups with family planning users, reported in Section 9.

One attitudinal factor that is measured in national surveys is women's perception of an "ideal" family size. The trends over the 1984, 1987, and 1991 survey years are surprising. Respondents' mean ideal number of children remained about constant over the three surveys: 3.4, 3.2, and 3.5. However, among younger women-especially women aged 15 to 19-ideal family size actually

appears to have increased. In 1984, women in this young group reported a mean of 2.7 children as an ideal number; in 1987 and 1991 this mean increased to 3.2 children. The only age group that showed a decline in the mean ideal number of children was women aged 35 to 44, in which the ideal declined from 4.4 in 1984 to about 3.8 in 1991. There was essentially no variation by residence or by education.

In CDIE's focus groups, all participating users reported being motivated to use family planning for economic reasons. Repeatedly, in group after group, women expressed a desire for large families but said that today it simply is not possible to feed and clothe a large family. They said that although their parents had 6 to 10 children, and it was good to grow up in such a family, 2 to 4 children was the ideal family size in the current economy. Even women with many children spoke of the hardship of trying to feed and clothe many children adequately.

Nearly half (48.4 percent) of the survey respondents reported that they believe there are health risks associated with family planning. In 1987, nearly half (47 percent) of all women in union who had used the pill reported undesirable side effects, and most of these women (43.5 percent) sought medical attention for the side effects.

### **Attribution of Effects to A.I.D.**

Resources come to the Honduran family planning program from different sources, including the IPPF, the Government of Honduras, user fees and purchases, and A.I.D. The CDIE evaluation team calculated that around 60 to 70 percent of total resources spent on family planning in Honduras come from A.I.D. Lacking any other more precise empirical basis, it is reasonable to estimate that at least 60 percent of the direct effects of the national program can be attributed to A.I.D. This estimate might actually be even higher due to other qualitative inputs from A.I.D. and related A.I.D. programming in other sectors. For example, A.I.D. provides leadership and important political support for family planning policy, performs a coordinating role among the different family planning providers, and works (through other projects) in complementary areas, such as improving basic education for girls, generating employment for women, and strengthening the national economy. All of these activities contribute to the coverage and utilization of family planning services.

## **9. EFFECTIVENESS: QUALITY**

To assess different qualitative aspects of A.I.D.'s population program in Honduras, the CDIE evaluation team used three different rating instruments. The first instrument is a set of categories developed by Judith Bruce of the Population Council for measuring quality of care. Using these categories, CDIE organized focus groups of Honduran family planning users to determine their views about the quality of care provided by A.I.D.-supported services. The second instrument, used to assess management quality, is a set of categories taken from the total quality management (TQM) literature designed to evaluate institutional structures and practices. The third instrument is the Lapham-Mauldin (L-M) Family Planning Program Effort Scale, an internationally validated measure of a country's overall commitment to family planning.

### **Quality of Care: Beneficiary Views**

The framework developed by Judith Bruce of the Population Council for evaluating quality of care defines quality in terms of the treatment individuals and couples receive by the family planning program or service. The definition includes (1) choice of contraceptive methods, (2) technical competence of staff, (3) information given to clients, (4) interpersonal relations, (5) mechanisms to encourage continuity, and (6) appropriate constellation of services.

The CDIE evaluation team held eight focus groups with Honduran family planning users—rural and urban, Ministry and ASHONPLAFA—to hear their views on service quality. Questions were structured following the previous six elements of quality of care. The following are some representative results.

### ***Choice of Methods***

Little real choice was apparent to clients. Women had restricted their choice of methods because of rumors and fears within the community. In rural and periurban areas, many women had used only one method of contraception in their lives. They saw their particular method as the only safe choice; all other

methods were identified as having major problems. The rumors and fears were the same in rural and periurban areas. Boxes 1-3 relate some of the misconceptions.

***Box 1. Comments That Oral Contraceptives Cause White Spots on the Face (Manchar la Cara). This Belief was Expressed as Fact in All Eight Focus Groups and by Sales Attendants in the Pharmacies.***

"Yes, I took the pill for a while, but it caused white spots all over my face. Boy, did it ever make me ugly. I stopped taking the pill and they all went away immediately."—*a 25-year-old woman.*

"All oral contraceptives cause pale spotting on the face"—*a pharmacist who sells subsidized oral contraceptives through the ASHONPLAFA Social Marketing Program.*

"Yes, it is true. Pills do cause pale spotting on the faces of women in Honduras—everybody knows it. It is because the sun is so bright here and we have dark skin; somehow it creates a problem."—*a well-educated young woman and graduate of an American university.*

"Oral contraceptives do not cause spotting. What is happening here is that the people are receiving false information. Many doctors in our country receive only a minimal education in family planning in our country; they are not able to give correct information to women; sometimes they don't give it nor a proper medical checkup... People, particularly those in poor and rural areas, need more information on the pill."—*medical director of ASHONPLAFA.*

***Box 2. Many Women Said that Female Voluntary Surgical Contraception (VSC) Is Often Not Effective.***

"I know three women in this area who had the operation and 6 months later had children."—*a nurse at a rural CESAMO.*

"Isn't it true that you can never tell for whom the operation will be successful—you just have to wait and see whether you get pregnant?"—*a woman in a rural focus group.*

"What is the operation? What did the doctor really do? Can I get pregnant?"—*a rural woman who had had VSC several months previously in an ASHONPLAFA regional clinic.*

**Box 3. Comments that Male VSC Leaves Men Impotent.**

"But after men have the operation, they can't have sex any more."—*a woman in a rural focus group.*

"What is the operation for men? Is it castration?"—*a woman in a rural focus group.*

"No, we don't refer any men for VSC. I don't care what people say, I am sure it impairs sexual functioning."—*a male physician in a large urban CESAMO.*

Women, particularly rural women, tend to be limiters rather than spacers. In rural areas women were limiters; most used no family planning until they decided they had had all the children they wanted, or more than they wanted. Then VSC was the method of choice (Box 4).

**Box 4. Comments That VSC Was the Method of Choice**

"No, I never used family planning. The men don't like it. For example, my husband wouldn't let me. I just kept having children until one day, after the birth of the last child, he got angry and said, 'Why don't you go get cured.' So I did."—*from a woman with eight children.*

"I got operated on when I was 45-years old after my 11th child. I had 10 living children; 1 had died. I realized I could still have one or two more before I was done so I had the operation."—*a rural woman.*

"I started using family planning when I was 28 after I had my four children."—*an urban ASHONPLAFA client.*

The prices of services compared with the high costs of raising a large family were considered, both by Ministry of Health and ASHONPLAFA clients, to be a bargain. Even VSC at ASHONPLAFA, the most expensive method, was considered a bargain in light of the alternative, more children. The rural woman who went to ASHONPLAFA for VSC at the age of 45 after 11 children said, "It was a bargain; I still could have had one or two more children."

### *Information Given to Clients*

Clients were not fully informed and stated they had never been so. Clients of both the Ministry of Health and ASHONPLAFA recalled being given information on only the specific method they were using; they stated they had never been given information on other methods. Box 5 gives a few excerpts from interviews concerning the misinforming of patients.

**Box 5. Comments From ASHONPLAFA and Ministry Clients About not Being Informed.**

"When I went to be operated on, I said they could give me the form to sign and then they asked how many children I had and if I had problems with low blood pressure... That's all the information they gave me. No, they didn't give me information about other methods."—*from a rural woman who had had VSC at an ASHONPLAFA regional center.*

"Yes, the information was sufficient. A friend of mine (another woman who had had VSC) asked the nurse if this operation was permanent because we had heard in the community that there are operations that are permanent, and others in which they cut you but aren't, and others in which they close the tubes... Well, the nurse was very sincere and said they only closed tubes, but to have faith that it would be secure and safe. We said yes (go ahead) and thanked her because she had spoken clearly."—*a woman who had had VSC at an ASHONPLAFA regional clinic.*

"I asked the doctor how I could plan—could I use the pill? He said no, I would have to use an IUD."—*from an urban woman with a 4-month old nursing infant who had gone to an urban CESAMO.*—Asked if the doctor explained why the pill wouldn't be good for her or if he explained other methods, she continued, "No, he just put in the IUD."

"No, I have never heard a talk on family planning, seen a film, or had a medical exam. We come here to buy pills, and she tells us how to use them."—*a group of ASHONPLAFA community-based distribution users in a small town.*

"I have never heard a talk on family planning. One of the reasons I came here today was I thought I might get some information."—*another ASHONPLAFA community-based distribution user.*

### *Interpersonal Relations*

Interpersonal relations were reassuring and supportive at ASHONPLAFA (see Box 6); they were not so at the Ministry of Health. Privacy is very important. The one ASHONPLAFA client who commented unfavorably about ASHONPLAFA said that as the doctor was about to insert an IUD, two nurses came in to watch the procedure and she was very embarrassed.

**Box 6. Comments About ASHONPLAFA Treatment.**

"They treated me very well. I have tried to encourage my neighbors [to go]. There is a woman who lives near me; she has eight children and is very poor. I have tried to encourage her and tell her she doesn't have to be afraid. I tell her how they treated me."—*a rural woman who had gone to ASHONPLAFA for VSC.*

"One is so scared and nervous when you enter there. I was so afraid of the knife. But in reality the nurses at ASHONPLAFA were so attentive."—*another rural woman who had gone to ASHONPLAFA for VSC.*

Women spoke of long waits, of being turned away because the quota was filled, and of little privacy at Ministry facilities.<sup>1</sup> Box 7 shares some of their experiences.

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<sup>1</sup>Physicians from the Ministry of Health work on a quota basis—36 patients in a 6 hour shift. Each morning the CESAMO multiplies the number of physicians in the clinic that day by 36 and issues that number of "cupos." Clients state that, to be sure of getting a cupo, they arrive at the CESAMO by 5 a.m. Physicians say that when they are fully staffed they usually are able to see every one who had arrived by 8 a.m. However, there are real problems when a physician is out for even a day, and more so for longer periods. There are no replacements for physicians who are on sick leave, maternity leave, or vacation.

**Box 7. Women Discuss Treatment at the Ministry of Health.**

"The Center opens at 8 a.m. and is open until 3 p.m., but the quota is filled by 9 a.m. and if you get there late (after 9 a.m.), you have to return another day real early."—*an urban woman.*

"You have to get in line by 6 a.m. to get a place in line and then wait and wait all day."—*another urban woman.*

"Anyone enters the room who wants to and you are lying there feeling embarrassed and afraid."—*an urban woman.*

"When one goes to have an IUD inserted at the health center, the center has a window through which the people can look. When I was there a man entered the room with records. I was miserable because nobody likes to be looked at."—*an urban woman.*

"I said to the doctor, don't examine me; I'd rather pay and go to Juticalpa because I am embarrassed with you." The doctor replied, "How rude the people are in Corcordia."—*a rural woman who was embarrassed by being examined by a male doctor.*

***Continuity and Followup***

Only one woman in the eight focus groups stated she had ever had followup on a missed appointment, whether from the Ministry of Health or ASHONPLAFA. All other women stated that they had discontinued going to ASHONPLAFA or the Ministry at some point and there had been no followup.

***Constellation of Services***

Integrated services are appreciated. The Ministry's clients described services as accessible and convenient because all services are offered. ASHONPLAFA users commented they wished ASHONPLAFA offered other services (Box 8).

**Box 8. Comments That ASHONPLAFA Should Have More Services.**

"I wish ASHONPLAFA would offer prenatal and postnatal care and checkups for children, too. You know, pregnancy, birth, and family planning are all parts of the same thing in a woman's life."—*an urban woman in an ASHONPLAFA focus group.*

"I wish ASHONPLAFA would offer more groups like this. There is no place you can go and talk about sex. Sometimes you have questions or problems with sex and there is no one to talk with."—*an urban woman.*

*ASHONPLAFA community-based distribution users viewed the post as a sales point rather than a service point.*

"If I wanted to use another method, what would I do? I don't know. I guess I would have to go the health center... No, she (the community-based distribution worker) just sells us pills."—*a rural woman who buys pills from an ASHONPLAFA worker in a small town.*

## **Quality of Care: Providers' Views**

To complement the beneficiaries' views on quality of care reported in the CDIE evaluation team also visited a number of different service facilities and interviewed provider staff for their views on quality of care. The following summarize some of the results of these visits and interviews.

### ***Ministry of Health***

To observe quality of care in Ministry of Health facilities, the CDIE team conducted observations and provider interviews in two rural and two urban CESAMOs and one urban hospital. While not representative of the whole national system, these observations and interviews nonetheless provided a general picture of the variability that exists in the quality of A.I.D.-supported, Ministry-provided family planning services in Honduras.

A general conclusion is that the quality of Ministry facilities, staff, and supplies varies tremendously from facility to facility. Location and leadership seem to account for most of the variability. In general, the level of quality was higher in urban facilities than in rural facilities. There was a greater choice of

methods, full-time trained staff, and better record keeping in urban sites. Leadership, however, was also critical in determining not only the quality of services, but if services were offered. If someone on the medical staff was convinced of the value of family planning, better quality services were provided regardless of location of the facility.

Structural factors, beyond the control of individual Ministry service delivery staff, also influenced the quality of the family planning services that were offered. The physical infrastructure and equipment of most CESARs and CESAMOs was minimal and used at overcapacity. Ministry of Health facilities were understaffed to meet the demand for maternal and child services during the 7 a.m. to 1 p.m. shift. Physicians had a quota of 36 patients in that 6 hour shift. It was impossible to provide a medical exam, full information on a variety of methods, and counseling in an average of 10 minutes.

The quality of Ministry family planning services has apparently improved since an A.I.D. evaluation of the Ministry's family planning program in 1988. The Ministry of Health reports that contraceptives were continually in stock in 95 percent of CESARs and CESAMOs in 1991. The oral contraceptive for lactating women has been approved and is available throughout the country in Ministry facilities. The CDIE team confirmed that A.I.D. contraceptives appear to be available in all Ministry facilities, rural and urban, although sometimes in small quantities. In terms of staff qualifications, A.I.D.-supported technical training in IUD management was provided to 81 physicians and nurses in 1990-1991, most of whom are now working in rural and urban CESAMOs.

### ***ASHONPLAFA***

Overall, the CDIE evaluation team found the services offered in A.I.D.-supported ASHONPLAFA facilities to be of good quality. ASHONPLAFA offers the full range of A.I.D.-approved methods in its six regional clinics. A more limited range of services is available through ASHONPLAFA's Social Marketing and Community Services Programs, but these programs can refer clients to the six clinics for additional services. ASHONPLAFA's technical competence is high. Physicians, nurses, promoters, and auxiliary personnel are trained and retrained. Facilities are clean, well kept, well equipped, and provide safe sterile procedures.

CDIE observed that ASHONPLAFA has IE&C materials available in its facilities and that staff are trained to use them. Counseling and informed consent procedures are apparently well observed. Patient privacy is respected and waiting time averages 45 to 60 minutes.

**ASHONPLAFA keeps good client records. Staff inform clients about the need for followup visits. A home-visiting program promotes continuity.**

**Most pharmacies in Honduras offer contraceptives, and the great majority of the contraceptives they sell are provided by the A.I.D.-supported ASHONPLAFA Social Marketing Program. In 1987, 34 percent of the women who used oral contraceptives reported buying them in pharmacies or health shops. Fifty-three percent of these oral contraceptives were A.I.D.-subsidized provided through the ASHONPLAFA Social Marketing Program. ASHONPLAFA has established the Social Marketing network, supplied contraceptives, and provided training to pharmacies.**

**To evaluate the quality of care in pharmacies, especially the completeness and accuracy of information given to clients, a female Honduran member of the CDIE evaluation team, posing as a new user, went to six pharmacies, three of which offered Social Marketing contraceptives. She bought oral contraceptives and tested when, how much, and what type of information was offered. She found that the pharmacies offered information only when requested. All six pharmacies offered erroneous information on side effects and counterindications. The information provided by the pharmacies affiliated with the ASHONPLAFA Social Marketing Programs was on a par with other pharmacies. Examples are provided in Box 9.**

***Box 9. Examples of Contraceptive Information Women Receive from Pharmacies in the ASHONPLAFA Social Marketing Program.***

Asking a pharmacist whose pharmacy was in the ASHONPLAFA Social Marketing Program which pill she should take because she was nursing her baby, the pharmacist replied that it didn't matter: "In general they all reduce milk production." The same pharmacist added that any woman of any age could take orals. A sales person at another pharmacy within the ASHONPLAFA Social Marketing Program recommended to the interviewer, who expressed concern about orals giving her white facial spots, that she buy a nonsubsidized oral contraceptive because it was gentler and less likely to give her white spots. The sales person commented that Perla, one of the two oral Social Marketing contraceptives, was very strong for someone just beginning contraceptives and would be likely to give her varicose veins.

Still another sales person at another pharmacy within the Social Marketing Program told the interviewer that all oral contraceptives were the same. Asked about facial spots, the sales person replied that all oral contraceptives caused facial spotting. The sales person, when asked which would be better for a nursing mother, called upon the pharmacist who stated there would be no problem with any of the four pills they carried. In fact, only one of them would be recommended for a lactating woman.

## **Management Quality**

The TQM framework, along with CDIE's application of the TQM categories to the A.I.D.-supported family planning service providers in Honduras, is summarized briefly below and reported in more detail in Appendix C. The two major providers, the Ministry of Health and ASHONPLAFA, were rated by the CDIE evaluation team on the following TQM elements: (1) technology and systems, (2) culture, (3) structure, (4) employees, (5) management, (6) service design, and (7) physical environment.

Judged by the TQM criteria, the Ministry of Health was found to have appropriate infrastructure covering the entire country. Structurally, the Ministry is well suited to provide good services, with decentralized service delivery and management. Health and family planning services are efficiently integrated. There is an effective structure of local, regional, and national facilities with patient referral arrangements. Employees are a mixed group, including career health professionals, political appointees, medical students, and community volunteers. Professionalism and commitment are extremely variable from facility

to facility. In cultural terms, there is internal disagreement in the Ministry concerning the priority of family planning that hampers the program in many subtle ways. Many of the Ministry's facilities are seriously underfunded, underequipped, and understaffed, badly restricting the availability and quality of services.

ASHONPLAFA provides a stronger institutional base for family planning services. Its supply, logistics, and management information systems are modern and efficient. Its institutional culture comes from IPPF, combining strong family planning values with a strong Honduran identity. Structurally, ASHONPLAFA is centralized, although an effort to decentralize is under way. Employees are professional, well trained, and highly committed. Facilities are less numerous than Ministry of Health facilities, but they are better equipped and more comfortable. The schedule of services is still doctor-oriented rather than client-oriented, with most services offered only on weekday mornings.

To maximize program effectiveness, the CDIE evaluation team concluded that it is a good strategy for A.I.D. to program family planning assistance in both the public and private sectors because of different advantages and disadvantages that make them complementary. In Honduras, CDIE observed that private sector providers are able to (1) focus all their resources on family planning without having to compete with other priorities, (2) have stable, permanent career staff at most levels, (3) make use of private sector marketing techniques, such as advertising and market research, (4) limit coverage to provide high quality services, and (5) have modern, efficient management and administrative systems. The disadvantages of private sector providers are (1) limited coverage and infrastructure, (2) dependence on external funding, and (3) fees may exclude very poor clients from obtaining services.

In contrast, public sector providers have (1) national coverage and extensive infrastructure, (2) political legitimacy, (3) permanent budget allocations from the national treasury, (4) access to low salary staff, including medical students, and (5) accessible free services to even the neediest user. Disadvantages of public sector providers are (1) competing priorities and a lower priority for family planning, (2) the lack of stable professional career staff at most levels, (3) requirement to serve the whole population, causing providers to spread themselves thin and sacrifice quality, (4) subjection to unpredictable changes in politics and policies, and (5) cumbersome and inefficient administrative and management systems.

## **National Program Effort: The Lapham-Mauldin Scale**

The internationally recognized Lapham-Mauldin (L-M) Program Effort Scale has been applied twice previously to Honduras, in 1982 and 1989. The L-M scale has four components: (1) policy and stage-setting activities, (2) service and service-related activities, (3) record keeping and evaluation, and (4) accessibility and availability of methods and services. Of a possible 120 points on 30 specific items, Honduras' overall score was a "weak" 30.30 in 1982. In 1989, it more than doubled to a "strong" 75.42.

The CDIE evaluation team reviewed the previous L-M scale ratings and attempted to reapply the scale to the Honduras program as evaluated in 1992. Recognizing that its rating procedures were probably different from those used for previous ratings, CDIE nonetheless found the attempt informative in terms of identifying elements that represent strengths, weaknesses, and changes in the program. CDIE applied the scale three times-to the full national program, to ASHONPLAFA's program, and to the Ministry of Health program.

The results and full discussion of CDIE's findings on the 30 specific items are contained in Appendix D. Briefly, CDIE's observations are summarized below.

*Policy and stage-setting activities.* The 1992 judgment was that Honduras' effort in national policy was still weak by L-M criteria. Within the Ministry of Health there is disagreement on family planning policy. Recently a Population Law failed to pass in the face of Catholic Church opposition and the unwillingness of the Ministry's family planning supporters to come forward. Current national leaders privately support family planning, but neither publicly endorse it nor give it high priority. No restrictions on the importation of family planning supplies exists. The team noted that although contraceptive advertising is allowed, fear of political or religious criticism causes family planning providers to self-censor, and their advertising is so circumspect it is almost unrecognizable as family planning.

*Service and service-related activities.* The Ministry of Health has a weak community-based distribution program, no social marketing, and has had virtually no family planning IE&C. The administrative structure has been transitioning from a centralized to a decentralized one and, as yet, does not reliably ensure that effective family planning resources, supervision, and support reach the different

Ministry levels of service delivery. ASHONPLAFA, on the other hand, is strong as a service provider. ASHONPLAFA has good Community Services and Social Marketing Programs. The administrative structure functions to support ASHONPLAFA's policies and strategies and to get personnel and resources where they are needed. Staff are trained and carry out their jobs.

*Record keeping and evaluation.* Although the Ministry of Health has established a new service statistics system, the CDIE team felt the data it produced were not accurate or useful. Service indicators are not standard family planning indicators. Ministry facilities interpret the formats differently and erratically. Logistics supply and usage data could not be reconciled with the service statistics; sometimes a pharmacy within a CESAMO or CESAR reported distributing more contraceptives than there are users and other times considerably less. ASHONPLAFA, on the other hand, has an efficient management information capability provided by IPPF. It effectively maintains patient records, financial information, and other management information needed for operations, planning, and evaluation. It has a well-staffed evaluation office.

*Availability and accessibility of fertility-control services and supplies.* All methods of contraception are available in Honduras; however, there are still some obstacles restricting women's access to family planning services. The costs of transportation and time are the impediments to access by rural women. Ready and easy access to pills and condoms other than through Community Services and Social Marketing Programs is through the six ASHONPLAFA clinics and the many Ministry of Health facilities. Cost may be a factor for ASHONPLAFA services, where fees are two to three times those of the Ministry. In the Ministry facilities, time (2 to 6 hour waits for service) is an impediment.

## **10. SUSTAINABILITY**

**Sustainability, in this discussion, has two dimensions. The first is institutional sustainability, which considers whether a provider has the capability and resources-infrastructure, staff, administrative systems, stature, and so forth-to provide effective services on a permanent basis without outside help. The second dimension is financial sustainability, the ability of a provider to generate enough income to support itself when A.I.D. funding is no longer available. In this section, sustainability issues for ASHONPLAFA and the Ministry of Health are discussed separately.**

### **ASHONPLAFA**

**With regard to institutional sustainability, the CDIE evaluation team concluded that ASHONPLAFA is in good shape. The organization has expanded its facilities and staff at a measured pace, not compromising the quality of services it provides by expanding too rapidly or spreading itself too thin. Its infrastructure is well situated, well designed, and well maintained. Staff members are recruited and promoted based on merit and are, for the most part, career professionals. The work force is productive, with no signs of featherbedding or corruption. The organizational structure is clear and logical, and leadership is experienced, professional, and committed. ASHONPLAFA does not depend on outside advisors. Systems (i.e., accounting, personnel, management information, evaluation) are modern and efficient. Finally, ASHONPLAFA has earned the respect and confidence of the medical and political establishments of the country, giving it legitimacy and stature. Overall, CDIE concluded that ASHONPLAFA, in terms of institutional capability, is permanently sustainable at its present level of development. Alternatively, it represents a solid institutional base for continued growth.**

**In terms of financial sustainability, however, ASHONPLAFA is in a more precarious position. Expansion over the last decade, financed principally by A.I.D., has left the organization very dependent on A.I.D. grant funding.**

Neither A.I.D. nor ASHONPLAFA is happy with this situation, and the program is giving priority to increasing revenues locally so that ASHONPLAFA's financial dependence on A.I.D. can be gradually reduced.

ASHONPLAFA, under the A.I.D. Private Sector Population II Project, has established formal financial sufficiency targets for some of its services. Its current A.I.D. grant requires that the Social Marketing Program generate revenues through sales to cover 100 percent of its direct costs, excluding contraceptives. The Community Services Program is required to finance 50 percent of its direct costs, excluding contraceptives, by the end of the project. The Medical/Clinical Program is also supposed to increase its revenues, but there is no specific target level it has to reach.

ASHONPLAFA agreed to these goals in its negotiations with A.I.D. and is working earnestly to meet them. But it was clear to the CDIE evaluation team that this financial sustainability requirement has created confusion in ASHONPLAFA, causing it to make some errors that have been harmful to the program. The confusion results from the fact that A.I.D.'s sustainability and coverage objectives appear to ASHONPLAFA to be contradictory, pulling it in two opposite directions. Expanding coverage to Honduran families who still do not use family planning services requires greater effort to reach low-income, rural families, who make up the largest share of nonusers. Unfortunately, these families are the most costly to serve and the least able to pay. Expanding coverage, therefore, appears to ASHONPLAFA to reduce the prospects of improving financial sustainability.

Nevertheless, ASHONPLAFA has made progress in meeting sustainability objectives. Prices for most ASHONPLAFA products and services were doubled in 1990, and, as a result, ASHONPLAFA revenues swelled by 54 percent. ASHONPLAFA's policy is that prices can be 1 to 1.5 percent of minimum wage and should not exceed one-third the price of commercial brands. The new, higher prices were probably within reach of most working Hondurans, but may be beyond the means of the very poor. When prices were raised in 1990, initial "sticker shock" caused a sharp drop in sales. The Community Services Program, for example, abruptly lost 16,635 users, almost one-third of its total customers. In 1991, however, sales gradually recovered and in 1992 sales were almost back up to their 1990 level. Although provisions have been made for a sliding scale of fees, the pressure on ASHONPLAFA to be self-sufficient forces it to make few exceptions to the rule that all users must pay. A full CYP of the cheapest

condoms costs 50 lempiras (about US\$9.25), and a CYP of the cheapest pills costs about 16 lempiras (about US\$3.00). A.I.D. is preparing to finance an operations research study in rural communities that will test the effect of different pricing policies on demand and usage of family planning services.

Progress to date in generating revenues from ASHONPLAFA's different services is shown in Table 4.

**Table 4. Comparison of Generated Income and Costs for ASHONPLAFA's Major Service Programs, 1991**

Project Element	1991 Cost	1991 Income	Income as % of Costs
Social Marketing	613	708	115
Community Services	1,673	1,129	67
Medical/Clinical	3,475	718	21
<b>TOTAL</b>	<b>5,761</b>	<b>2,555</b>	<b>44</b>

Note: Costs are in thousands of lempiras and exclude contraceptives.

Source: Blair 1992, Appendix G.3, p. 45.

ASHONPLAFA's locally generated income figures show an upward trend, going from 939,505 lempiras in 1989 (a 5-month period) to 2,003,414 lempiras in 1990 and to 3,048,442 lempiras in 1991. In percentage terms, local revenues paid 3 percent in 1989 and will pay 12 percent in 1992. At present, ASHONPLAFA depends on A.I.D. for 62 percent of its budget, on IPPF for 11 percent, and on other donors for 2 percent. It generates 26 percent of its budget locally.

All locally generated funds are put into the ASHONPLAFA budget. Units can only influence the use of the funds in the annual programming and budget planning meeting. Exceptions to this rule are the social marketing distributor and pharmacy owners who receive their normal commercial markups for all

contraceptives sold, and the Community Services Program distributors who receive a percentage of the sale price. Because of financial incentives, these particular groups have made strong efforts to improve contraceptive distribution.

The extent to which utilization of family planning services is sensitive to the prices of products and services is uncertain and is the subject of controversy in the Honduran family planning community. ASHONPLAFA believes that its higher prices since 1990 are a factor in the recent slowing in the growth of contraceptive prevalence. However, CDIE's focus groups with users showed that price is not reported to be a major constraint, at least for current users. Furthermore, CDIE's economic analysis revealed low demand elasticities associated with price changes. Since expenditures for family planning represent a very small proportion of families' budgets, increasing prices would probably not result in a proportional decrease in demand. It appears, therefore, that raising prices could increase ASHONPLAFA's revenues and improve its financial sustainability.

In its rush to improve its performance in the sustainability area, ASHONPLAFA has tried to cut costs by limiting some important activities, such as advertising. A.I.D.'s 1992 evaluation of ASHONPLAFA was critical of these decisions, which were detrimental to the objective of expanding coverage and to the long-term prospects of achieving greater sustainability at a higher level of contraceptive prevalence.

Neither A.I.D. nor ASHONPLAFA believes that ASHONPLAFA can achieve 100 percent financial sustainability through sales of family planning products and services. While progress has been made by raising prices, ASHONPLAFA executives feel that another independent source of income is needed to prepare for eventual cutbacks in A.I.D. support. One possibility is to look for other donors. Another idea is to sell family planning services to large corporations for use by their employees. These approaches could generate some additional income, but probably not enough.

ASHONPLAFA's leadership is attracted by the idea of having other income-generating units that could permanently cross-subsidize its family planning services. It has toyed with the idea of opening a printing plant or hardware store. The ASHONPLAFA director would like to construct an office building on a well-situated property next to ASHONPLAFA's Tegucigalpa headquarters and earn income from rent. Having some sort of profitable business, he believes, would not only help permanently solve the financial sustainability problem but would also introduce elements of competitiveness and diversification, which would

invigorate the institution and its employees. Another possibility that interests ASHONPLAFA is establishing a permanent endowment to generate interest income. A.I.D. has established such an endowment for the Panamerican Agricultural School in Honduras.

ASHONPLAFA does not have expertise in business development. A.I.D. will have to provide additional technical assistance to ASHONPLAFA in assessing the feasibility of different business and endowment possibilities if it wishes ASHONPLAFA to approach full sustainability over the next 10 to 20 years.

## **Ministry of Health**

In terms of institutional sustainability, the family planning services offered by the Ministry of Health's reproductive risk unit are shaky. The Ministry, of course, is a large, permanent unit of the Honduran Government. Its big advantage over ASHONPLAFA, in terms of institutional capability, is its national infrastructure. However, it became clear in the course of CDIE's site visits and interviews that a number of other institutional weaknesses negatively affect the family planning part of the reproductive risk program. One weakness is staff. Senior management consists of political appointees who are often seeking personal political advancement, and health center physicians are mostly medical students putting in their required year of social service. The Ministry's permanent physicians practically all moonlight, dividing their time between Ministry facilities and private practices. Administrative structures (personnel and financial management, management information, planning, supervision) are cumbersome, bureaucratic, and underfunded. Medical supplies are scarce. The A.I.D. Health Sector Projects are addressing many of these institutional weaknesses, but progress is slow and the benefits seem to reach the family planning activities only after other, higher priority, health activities have been helped.

Financial sustainability, on the other hand, is somewhat less of a problem for the Ministry than it is for ASHONPLAFA. The Ministry has a permanent, fairly predictable budget from the Honduran Government. The main problem, then, is getting an adequate share of the Ministry's tight budget for family planning services in the reproductive risk unit.

Ministry of Health leadership expressed concern to CDIE about the sustainability of all donor-financed health projects, including A.I.D.'s. Ministry officials feel that too many projects terminate when external funding ends; thus,

the Ministry is trying to make key projects sustainable. For example, a Ministry official pointed proudly to the fact that the national vaccination program is now 80 percent locally financed.

The Ministry has begun to charge a little bit for some services. But there is internal debate about the wisdom and ethics of charging for primary care for mothers and babies. Also, raising prices would be politically unpopular. According to Ministry officials, income from fees jumped by 29.8 percent in 1991 and is projected to increase by another 35 percent in 1992. At the health center level, there was an increase of 62 percent in revenues in 1991. The A.I.D. Health Sector II Project is providing technical assistance to the Ministry in this area. Cost recovery in 1985 by all Ministry hospitals averaged about 12 percent of their nonpersonnel operational cost budgets. In two hospitals, however, cost recovery reached 19 and 20 percent, suggesting that more could be recovered throughout the system with some assistance. Cost recovery is accomplished by charging fees for such services as maternity care, laboratory work, X-rays, minor surgery, dental care, and blood transfusions. At present, family planning services through the Ministry of Health are essentially free. The user pays a 1 lempira (US\$0.20) fee for each visit to the health center. Contraceptives are free of charge.

A.I.D.'s objective is that "through wider and more regularized use of fees for services, cost recovery by hospitals will increase on the average by 2 percent per year, reaching 25 percent of nonpersonnel operating budgets" (USAID/Honduras 1988). As this practice evolves and becomes more systematic, it is likely that higher fees will be charged for an expanding list of curative services, while primary care and child survival services will remain free or very cheap. Since family planning services are seen as part of the reproductive risk program of primary care, the Ministry will probably not try to charge higher fees for these services.

Ideally, Government budgetary resources provided for health services would increase in the future, with a growing proportion of the health budget supporting preventive and primary care, including reproductive health and family planning. Increasing Government revenues, coupled with growing income from fees charged by the Ministry for curative services, could make the overall public health system financially independent of outside donor support in the future. However, the CDIE evaluation team felt that budget austerity, competing demands for funds, and lingering political wariness concerning family planning make it unlikely that Ministry-supported family planning activities will receive adequate Government funding for good quality, national-scale services in the foreseeable future. Furthermore, rural poverty, administrative complications, and popular opposition to fees will limit cost recovery from user charges.

Overall, with regard to the prospects of achieving sustainable family planning programs in both ASHONPLAFA and the Ministry of Health, the CDIE team concluded that A.I.D. will probably have to accept the reality that sustainability is a long-term objective. Continuing A.I.D. support for a number of years will be required if A.I.D.'s family planning objectives, including permanent insitutional and financial sustainability, are to be met.

## 11. IMPACT

Although A.I.D.'s family planning program in Honduras defines its objectives as improving the health of children and mothers, the A.I.D. population program worldwide is concerned with demographic impact as well. In this section, evidence concerning the long-term impact of the A.I.D. family planning program in Honduras is presented, using both demographic indicators (fertility and population growth) and health indicators (infant mortality and child spacing).

### Fertility

Table 5 shows that the total fertility rate declined overall from 6.4 births in 1981 to about 5.1 in 1991, or about 1.3 births. In urban areas, the total fertility rate declined only about 0.5 births over this same period, from an estimated 4.3 in 1981 to about 3.8 in 1991. In rural areas, the total fertility rate is estimated to have declined about 1.7 births, from 7.8 in 1981 to a still quite high level of 6.1 in 1991. Figure 5 shows how the fertility rate has changed over a longer period of time.

### Population Growth

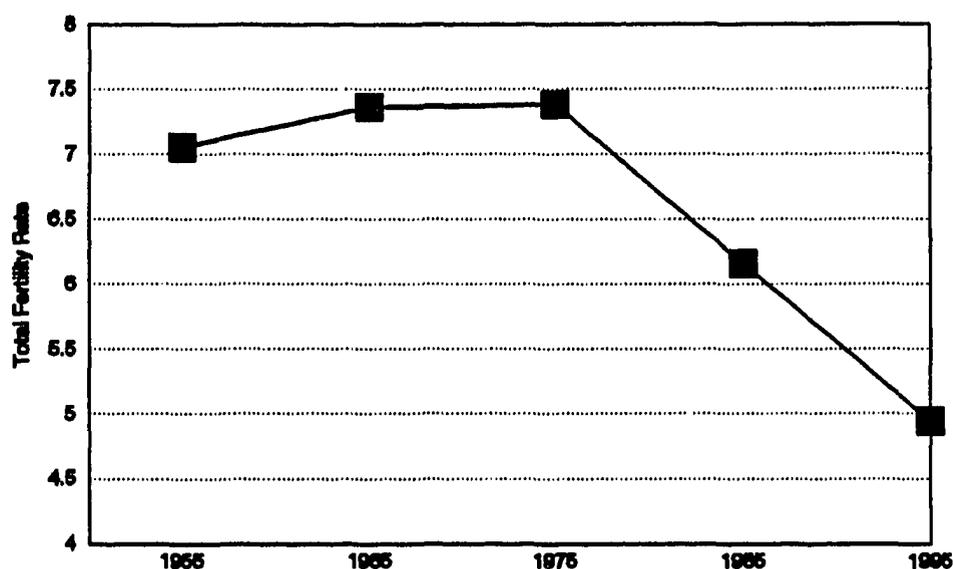
The rate of natural increase, which is identical to the population growth rate if net international migration is zero, was about the same in 1988, 3.0 percent, as in the early 1950s, 2.9 percent. However, in the early 1950s the crude birth rate was about 51 and the crude death rate was about 22. In 1988 the crude birth rate was 38 and the crude death rate was 8. Assuming the same mortality decline but *no* fertility decline over that period, the population would have become about 6 million in 1991 instead of 5 million, increasing annually by more than 250,000 in 1991 instead of by 150,000. Thus, by 1991 there had been about 1 million fewer births in Honduras than there would have been had the birthrate not begun to fall.

**Table 5. Total Fertility Rate and Contraceptive Prevalence Rate in Urban and Rural Honduras, Survey Years.**

	Total		Urban		Rural	
	TFR	CPR	TFR	CPR	TFR	CPR
1981	6.4	26.8	4.3	47.4	7.8	16.0
1984	5.3	34.9	3.9	50.9	6.6	23.8
1987	5.6	40.0	3.9	59.3	6.9	29.9
1991	5-5.2	46.7	3.8	60.9	6.1	36.1

Sources: 1981 Encuesta Nacional del Uso de Anticonceptivos, Ministerio de Salud Publica y Asistencia Social  
 1984 Maternal and Child Health and Family Planning Survey, Honduras  
 1987 Epidemiology and Health Survey Final Report  
 1991 Estimates based on preliminary data from the Epidemiology and Health Survey

IMR = infant mortality rate  
 TFR = total fertility rate  
 CPR = contraceptive prevalence rate

**Figure 5. Total Fertility Rate, Honduras**

Sources: United Nations Economic Commission for Latin America and the Caribbean, report presented at the First Inter-American Summit of Heads of State, Guadalajara, Mexico, July 18-19, 1991, p. 13, Table 2.

## Why Is Fertility Still So High?

Fertility is still relatively high in Honduras compared with other countries, despite the current level of contraceptive prevalence. For example, in 1987, the total contraceptive prevalence rate in Guatemala was 23.2 percent with a total fertility rate of about 5.8. In Honduras, the 1991 prevalence rate was 46.7 percent—twice as high as Guatemala's—while the total fertility rate was 5.1, only 12 percent lower than Guatemala's. The following four factors were hypothesized by the CDIE evaluation team to partially explain the fact that fertility is still higher than expected, given the contraceptive prevalence rate.

1. *Most women commence childbearing at a young age in Honduras.* Couples marry young (including consensual union) especially in rural areas where over 60 percent of the population resides.

2. *Breast feeding may have only a limited fertility inhibiting effect in Honduras.* Lengthy breast feeding is common, and survey results show that the duration of breast feeding is increasing. However, it is common in Honduras for mothers to begin supplementing with solid foods at an early age. According to the 1987 Family Health Survey, only 4.7 percent of children 3 to 5 months of age were being exclusively breast fed. Among women who were both breast feeding and providing supplemental feeding (to a child 3 to 5 months of age), only 19 percent reported using contraceptives, and only 7 percent were using modern methods. Perhaps many of the others were not practicing contraception in the mistaken belief that partial breast feeding was an effective contraceptive.

3. *Contraceptive discontinuation may be unusually high in Honduras.* Although the surveys did not produce estimates of method discontinuation, Janowitz (1992) estimates discontinuation rates in Honduras of 35 percent for the pill, 15 percent for the IUD, and 50 percent for injectable contraceptives. These estimates are quite high compared with conventional ones. Moreover, there is evidence of widespread negative attitudes toward both the pill and IUD, which might be expected to result in an unusually high discontinuation rate for those methods.

4. *Incorrect utilization of contraceptives may be high in Honduras, causing failure and discontinuation.* The CDIE team found some evidence that average "use-effectiveness" of contraceptives may be lower in Honduras than it is worldwide. Because of inadequate information support for family planning users, there may be a tendency for women to use methods incorrectly and to unexpectedly find themselves pregnant in spite of trying to use family planning.

## **Impact on Health**

High-risk births are a major factor in infant and maternal mortality. A growing body of evidence worldwide indicates that infant mortality is lower when the mother is at least 20 years of age, birth intervals are longer than 2 years, and there have been fewer previous births. Survey data show that these relationships also exist in Honduras. In the early 1980s, the infant mortality rate was 77.4 deaths per 1,000 live births for young women under the age of 20, compared with only 48 for births to women aged 20 to 34. Birth order has a similar effect. The infant mortality rate for children of birth order 6 or higher was 61, compared with around 50 for children of birth order 1 to 5, showing that health risks increase as a mother has more children.

With regard to birth spacing, the survey data reveal a strong birth interval effect. From 1980 to 1984, the infant mortality rate for children born after a long-birth interval (24 months or more) was 42.0 deaths per 1,000 births. In contrast, the infant mortality rate for children born following a short-birth interval (less than 24 months) was 67.6 deaths per 1,000 births. In other words, the mortality risk is 61 percent higher for closely spaced births than for births spaced 2 years or more apart.

It is reasonable to surmise that through the early and mid-1980s oral contraceptives—as the leading contraceptive method during the 1970s and early 1980s in Honduras—had contributed to reducing infant mortality by lengthening birth intervals. It seems likely that the decline of oral contraceptive use since the mid-1980s may have slowed the improvement in infant mortality. The two most important fertility-related factors affecting infant mortality in Honduras appear to be the age of the mother at first birth and interval between births. More widespread use of effective birth-spacing methods, such as IUDs, could be expected to further reduce infant and maternal mortality in Honduras.

## **Attribution of Impact to the A.I.D.-Supported Family Planning Services**

A circumstantial case can be made that the decline in birthrate, fertility, and infant mortality is being caused in part by the growth of family planning services in Honduras. First, as was shown in Figure 5, the total fertility rate in Honduras was high and steady for at least two decades before the 1980s. In 1980, A.I.D. significantly increased its population programming and shifted most of its support from the weak Ministry of Health family planning services to ASHONPLAFA. Figure 5 shows that the pattern of high fertility changed soon

thereafter, suggesting that the growing availability of family planning services may have begun to influence fertility. Corroborating evidence was provided by CDIE's focus groups with users, most of whom reported that they had chosen to adopt family planning techniques to limit the number of children that they plan to have. Since nearly half of women of reproductive age are now attempting to limit their family size or space births, mostly using program-supplied modern methods, it is reasonable to infer that the national family planning program is helping to produce the decline in fertility in Honduras. Of course, other factors, such as improved education for girls, better health conditions, urban migration, and economic improvement interact with family planning services to change fertility. Because of these interactions, the impact of the family planning program on fertility, independent of other influences, cannot be calculated with precision.

A similar circumstantial case can be made for the impact of A.I.D. family planning assistance on health and child survival. The strong statistical relationship between high-risk births and infant mortality makes it logical to suppose that the growing use of family planning is contributing to improving infant mortality in Honduras. Again, a number of factors interact to change the infant mortality rate, and the magnitude of the impact of family planning on the infant mortality rate cannot be measured accurately. However, the strong statistical correlation that exists coupled with reports of impact from key informants and family planning users make a convincing case that family planning is having positive health impacts in Honduras.

If the inference that family planning is having a long-term impact on fertility and health in Honduras is accepted, how much of that impact can be attributed to A.I.D.? Since A.I.D. provides 60 to 70 percent of the total resources for family planning activities in the country, a plausible estimate might be that 60 to 70 percent of family planning's impact on fertility and health can be credited to A.I.D. assistance. Nevertheless, although the magnitude of the impact can be debated, the evidence is quite convincing that A.I.D. family planning assistance is having an important long-term impact on both health and demographic conditions in Honduras.

## **12. EFFICIENCY**

### **Purpose and Methodology**

The primary objective of CDIE's economic analysis of the A.I.D. family planning program in Honduras was to examine the relative efficiency with which resources have been allocated for different family planning institutions and programs. Based on the findings, the analysis makes recommendations concerning how potential future allocations for population programs might be more efficient. The discussion concentrates mainly on the costs of different services offered by ASHONPLAFA, because ASHONPLAFA was the only family planning provider supported by the A.I.D. program with usable cost data. The basic approach used in this analysis is economic cost-effectiveness and the main unit of effectiveness is CYP (i.e., a year of protection from pregnancy provided by a contraceptive technique).

No consensus exists among specialists regarding whether fast population growth is bad or good for development. The linkages are complex, theoretical issues are unresolved, and empirical evidence has been inconclusive and controversial. For this reason, an economic benefit-cost analysis geared to determining whether resources allocated to family planning have a higher return than alternative allocations was not attempted.

CDIE's review of the available evaluation literature found no compilation of cost data for the various family planning services and providers that receive A.I.D. support in Honduras. It was therefore necessary for the CDIE evaluation team to piece together, as best it could during 4 weeks of fieldwork, information on costs and CYPs. Sources of cost information included providers' budgets, observation of family planning interventions to determine the costs of their components, and interviews with providers in a sample of family planning facilities.

## Findings

### *Disbursements by Program*

ASHONPLAFA's outlays, at constant and economic prices, have grown at a compound annual rate of 8.02 percent. *Sterilization* accounts for a relatively small proportion of total outlays, averaging only 4 percent of annual expenditures.

*Community Services* outlays have grown at an annual compound rate of 2.25 percent. The slower than average rate of growth of these expenditures is reflected in a substantial drop in their respective share of total expenditures from 21 to 14 percent during 1990 and 1991. It is interesting to note that the proportion of total outlays allocated to Community Services peaked in 1981 (at 44 percent) and has tended to fall steadily thereafter. Allocations to *Medical Services* through clinics grew at a compound rate of 1.98 percent annually between 1980 and 1991, averaging 23 percent of total allocations. The proportional allocations were highest in 1980 and 1981, reflecting high levels of investment in equipment. Allocations to *Social Marketing* started in 1985 and peaked in 1987. Social Marketing's share ranged from 15 to 18 percent from 1985 to 1988 and fell thereafter.

### *Disbursements by Cost Group*

*Personnel* is by far the single most important category of disbursement. In several years it accounted for more than 50 percent of total outlays. An implication of the large outlays on personnel is that efforts to raise efficiency should concentrate initially on either reducing personnel costs for the same level of output (which would help sustainability) or on raising output for the same level of personnel costs.

*Administrative* outlays is the program category that has grown fastest, at an annual compound interest rate of 17 percent. In 1989, administrative expenditures grew to 41 percent, partially as a result of a near tripling in physical facilities (which for the most part are charged to administrative outlays). For most years, the proportion of administrative expenditures ranged from 22 to 28 percent of the total. It is noteworthy that the proportion of administrative expenditures grew from 13 percent in 1983 to 22 percent in 1984 and remained at higher levels during the following years. The increase in 1984 was due largely

to a near tripling of personnel expenditures. The proportion of resources going into *evaluation* has tended to rise since 1986. The share of general *support services* has been relatively stable, oscillating between 4 and 9 percent of total outlays.

Amounts charged to *contraceptives* were extremely low from 1980 through 1986-zero in several years. In 1987, contraceptives accounted for 14 percent of total costs, and their share in costs fluctuated between 4 and 8 percent for subsequent years. The year-to-year changes may reflect stocking practices-replenished stocks may last several years-as well as increased demand for certain services after 1987.

As is to be expected, allocations to *physical facilities* have been uneven. They were high in the initial years, tapered off from 1983 to 1985, and tended to rise after that with a peak in 1989. An analogous pattern occurs with investment in *equipment*. As is shown later, the annualized allocations to fixed capital, physical facilities, and investment in equipment have grown most rapidly among the cost groups.

Surprisingly, IE&C accounted for very small proportions of total outlays from 1980 through 1983. One would have conjectured that a program aimed at promoting family planning, in a country where modern family planning practices were relatively new and not widely accepted, would have placed greater emphasis on educational and awareness campaigns from the start. A partial explanation is that the Social Marketing Program, to which much of the IE&C outlays are charged, did not start until 1985. IE&C outlays grew considerably in 1984 (from 2 to 9 percent of total disbursements) and remained at even higher levels through 1988. In 1989, a new reversal occurred with the proportion of IE&C outlays falling from 11 to 4 percent, followed by a rise to 8 percent in 1990 and a dramatic fall to zero in 1991.

### *Cost-effectiveness of the Overall ASHONPLAFA Program*

During 1980 to 1991, total CYPs grew from about 87,000 to nearly 231,000, an average annual compound rate of about 9.3 percent. ASHONPLAFA's average annual compound rate of growth of costs for the same period was 7.83 percent. Thus, the cost-to-CYP ratio decreased at an annual rate of -1.35 percent, meaning that the overall cost-effectiveness of ASHONPLAFA has been improving on the average, although there has been year-to-year variation

in this trend. It is noteworthy that cost-per-CYP has fallen steadily since 1987. While CYPs fell over 3 years, costs fell much faster. This is indicative of a rise in the average productivity of resources and may be related to more effective management and the achievement of economies of scale.

A detailed analysis of costs showed that during the 1980s ASHONPLAFA rapidly expanded production capacity, especially its buildings and equipment. Personnel costs, on the other hand, grew more slowly. The average cost of labor-per-CYP fell at an annual rate of -5.4 percent. In other words, the fall in average personnel costs tended to be offset by the fast rise in the cost of physical facilities and equipment, indicating that ASHONPLAFA may now have underutilized physical facilities and equipment along with more fully utilized labor resources. This conjecture was supported by information from interviews and a visual examination of the facilities by the CDIE evaluation team.

The high ratio of physical facilities and equipment to other resources means that ASHONPLAFA is in a good position to achieve further economies of volume (i.e., economies that result from achieving higher volumes of production) without significantly adding to physical facilities and equipment. To achieve such economies of volume, the association may want to redirect its annual outlays from more physical facilities and equipment to other uses.

### *Cost-effectiveness of ASHONPLAFA's Different Services*

This section focuses on the efficiency of the three key CYP-generating programs of ASHONPLAFA-Medical Services, Community Services, and Social Marketing.

In terms of cost-per-CYP, CDIE's analysis found that the *Medical Services Program* has been the most cost-effective, while the *Social Marketing Program* has been the least cost-effective. For the period studied, the cost-per-CYP in the *Community Services Program* was about twice as high as in the *Medical Services* one. The *Social Marketing* cost-per-CYP was three times as high. One factor for the higher productivity of the *Medical Services Program* has probably been the higher proportion of permanent or quasi-permanent methods (sterilization and IUDs) in the program. Such methods result in larger numbers of CYPs and have been shown to entail relatively low costs-per-CYP in other studies.

Overall costs for the *Community Services Program* (some 25.5 million lempiras) during the period were similar to overall costs for Medical Services (28 million lempiras). However, the total amount of CYPs produced by the Community Services Program was less than half the amount produced by Medical Services.

*Social Marketing* began in 1985 and was functioning for only 6 of the 11 years reviewed by this analysis. However, if total CYPs from the Social Marketing Program through 1991 were used as a basis for estimating the CYPs that would have resulted had the program taken place from 1980, the Medical Services Program would still account for over 50 percent more than the two other programs combined (1,216,072 CYPs versus 796,445 CYPs).

Program performance over time is of interest. For *Medical Services*, a much faster rate of CYP growth than of growth in costs means that cost-per-CYP in Medical Services fell at an annual rate of -6.5 percent. In other words, there have been significant gains in cost efficiency, probably reflecting the increasing acceptance of the permanence of quasi-permanent methods, plus the achievement of economies of scale or volume.

With cost-per-CYP falling at an annual rate of -3.62, *the Community Services Program*, like the Medical Services Program, experienced improving cost effectiveness over the years. But the improvement, while positive and significant, was only 56 percent as high (3.62 versus 6.51) as in Medical Services. Thus, the Community Services Program is not only less cost-effective in terms of cost-per-CYP, but slower in terms of productivity improvements. Community Services could be considered intrinsically more costly than Medical Services because such services do not involve permanent methods and tend to be low-volume and low-scale operations. To the extent that the Community Services reach lower income population groups than the Medical Services (a proposition that could not be verified empirically due to time constraints), this difference suggests a trade-off between efficiency and welfare concerns. More CYPs per dollar could be achieved by investing in the Medical Services, but perhaps more CYPs among the most needy would be obtained through Community Services. This hypothesis deserves further study. Regardless, even if a trade-off in fact exists, its importance should not be exaggerated a priori. As was observed during visits to ASHONPLAFA's facilities, both programs reach low-income groups.

Regarding *the Social Marketing Program*, the cost-per-CYP has fallen at an annual rate of -2.22 percent as a result of declining costs along with a rise in CYPs. The gain in cost-effectiveness for Social Marketing was weaker than in

either the Medical or Community Services Programs. The comparison, however, is not totally valid as the latter have had a much longer timespan than Social Marketing.

An interesting aside is that the Social Marketing Program is the only one that recovers all of its costs through sales. In spite of its relatively low cost-effectiveness, it is the most successful program in terms of financial sustainability.

### *Cost-effectiveness of Different Family Planning Methods*

How does relative cost effectiveness compare as given by cost-per-CYP for the three main contraceptive methods used in Honduras—female sterilization, IUDs, and oral contraceptives? Overall, CDIE found that sterilizations and IUDs (the permanent or longer duration methods) are more cost effective than the pill (the short-term method).

In terms of *labor costs*, IUDs are slightly more cost-effective than sterilizations. The major reason is that sterilization requires more skilled, higher paid personnel and is a more time-consuming intervention. Compared with IUDs and sterilizations, the labor costs-per-CYP of oral contraceptives are much higher—more than four times for IUDs and more than three times for sterilizations.

In terms of *product costs*, oral contraceptives are also less cost-effective than IUD insertions. Product costs-per-CYP with oral contraceptives are some six times higher than with IUDs. When *administrative costs* are considered, sterilizations are clearly the most cost-effective method. Administrative costs-per-CYP for sterilizations are less than one-third what they are for IUD insertions, and one-tenth of what they are for oral contraceptives. When both labor and administrative costs are considered, sterilizations are the most cost-effective; IUDs follow (only 50 percent as cost-effective as sterilizations); and oral contraceptives are last. When labor and product, or labor and product plus administrative costs are considered, IUDs come out as more cost-effective than oral contraceptives.

In conclusion, the empirical evidence indicates that, assuming cost patterns observed in the past are a good predictor of future patterns and assuming adequate medical controls, A.I.D. programs would gain in cost-effectiveness by relying more on sterilizations and IUDs.

### *Other Cost-effectiveness Factors*

The CDIE evaluation team performed cost-effectiveness analyses of two other factors—a comparison of the efficiency of services in different geographical regions of Honduras and a comparison of the efficiency of the public sector provider with the private sector. These detailed analyses revealed large variations in costs, CYPs, and cost-per-CYP within and between institutions and at different points in time, but clear, consistent empirical trends and conclusions were not found. In general, the public sector was judged by the team to be less cost-effective than the private sector, a conclusion that reflects not only the cost information gathered but also the overall quality of services they provide.

### **Conclusions and Management Implications Concerning Efficiency**

What is the operational relevance of these findings? If A.I.D. wants to raise the cost-effectiveness of additional resources that it may allocate to family planning, it should focus more on ASHONPLAFA than on the Ministry of Health. However, the Agency will have to balance cost-effectiveness considerations with the need to reach certain segments of the population that, for geographical reasons, have access only to public sector services. Therefore, the Agency should continue to encourage the public sector to improve its overall efficiency in family planning and provide limited financial support to the extent public authorities are responsive. A first step in this direction would be to improve the managerial, accounting, and statistical methods with which the public sector operates.

Analysis of cost-effectiveness by method confirmed what is by now a generally accepted conclusion. Permanent or quasi-permanent methods (sterilizations and IUDs) are more cost-effective than temporary methods. However, the implications of this conclusion for future resource allocations should be tempered with concern for clients' preferences for different methods.

Overall, A.I.D.'s approach of supporting the gradual expansion of ASHONPLAFA's facilities has set the stage for further improvement in the cost-effectiveness and coverage of ASHONPLAFA's services. However, current low levels of spending on IE&C appear to be limiting improvements in ASHONPLAFA's performance. A clear recommendation is that IE&C activities be enhanced to generate new demand for services, greater coverage and impact, and improved cost-effectiveness.

## 13. CONCLUSIONS

CDIE's main objective in this Technical Report was to gather information and insights that could be compared and combined with information from other country studies to arrive at broad, programwide conclusions and recommendations in a later synthesis report. Most of the overall conclusions reported in this section, although derived from A.I.D.'s experience in Honduras, were considered by the CDIE evaluation team to have relevance in one way or another to worldwide A.I.D. programming. Since Honduras was the only Latin American case study in the CDIE Family Planning Assessment series, the conclusions may apply most directly to programs located in other Latin American or similar countries.

- **Cultural and political barriers**

- The Honduran study shows that family planning programs can achieve acceptable results, although slowly and with difficulties, in the face of the strong cultural and political obstacles often found in Latin American countries. Honduras, like much of Latin America, is often characterized as having a male-dominated culture ("machismo") that favors large families and does not empower women. Politically, there is resistance to U.S. interference in local affairs, and family planning has been one of the most sensitive and resented aspects of U.S. foreign assistance. Catholic Church doctrine, to which most Hondurans subscribe at least nominally, strongly opposes family planning. Clearly, such obstacles make family planning programs slower and more expensive than they otherwise would be, but Honduras shows that A.I.D. can still get results under such conditions.

- **Public versus private sector**

- Programming family planning assistance in the public sector and the private sector simultaneously can be an effective strategy because the different characteristics of each type of program can be complementary.

● **Policy environment**

- While explicit government policy favorable to family planning is desirable, simple acquiescence on the part of national leadership is all that is necessary for an A.I.D.-supported national family planning program to have acceptable results.
- In the absence of a strong profamily planning government, A.I.D.'s best strategy is to concentrate resources on private sector providers.
- In a pronatalist culture and sensitive political environment, A.I.D. can most effectively promote family planning as a health intervention designed to reduce high-risk births.

● **Contraceptive methods**

- VSC is the most cost-effective method for increasing CYPs.
- Temporary methods are best suited for producing health and child survival benefits by reducing high-risk births. In Honduras, the IUD appears to have considerable potential for increasing the impact of the program in the future.
- Oral contraceptives are unpopular and their use is declining. Real and imagined side effects and the relatively complicated demands they make on the user appear to limit the acceptability and effectiveness of oral contraceptives in Honduras.

● **Quality of care**

- Mass media public information and individual client counseling information about family planning are essential but neglected elements of good care. In Honduras, inadequate information for users is a weakness of the different Honduran family planning providers and of the whole national system. Users are not well informed about methods and side effects, making it easy for rumors, unfounded fears, and misinformation to frighten off women who would like to plan their families.
- Privacy is a need of many users not adequately appreciated by many providers, especially public sector clinic staff.

- **Sustainability**

- In the private sector, charging fees does not appear to be a serious obstacle to widespread use of family planning services.
- Private, nonprofit providers of family planning services would benefit from an independent source of revenue, such as an income-generating business or endowment. Developing a permanent income generator should be a part of A.I.D. support.
- A.I.D.'s new priority on financial sustainability is causing confusion and errors on the part of A.I.D.-assisted providers. A.I.D. and its cooperating agencies are unclear about how much priority and how great a sense of urgency should be given to financial sustainability. Design of clear, achievable long-term sustainability plans should be given priority by A.I.D.

- **A.I.D. implementation**

- A.I.D.'s experienced in-house technical staff, including both U.S. direct hire staff and Honduran physicians, is necessary to effectively manage a technically complex and politically sensitive family planning program.
- Progress in the population area can be slow and uneven. A.I.D.'s patience, persistence, and flexibility have been essential in producing positive results. In the Honduran environment, insistence on quick results could have been counterproductive.
- A focus on institution building is as important as subsidizing the operating costs of family planning services. A.I.D.'s support for expanding facilities and training staff in Honduras has created favorable conditions for greater coverage, improved cost-effectiveness, and growing sustainability in the future.

- **IE&C**

- A modern, coordinated program of IE&C activities is badly needed to improve the performance of A.I.D.-supported services in Honduras. The CLIE evaluation team was convinced that the somewhat disappointing performance of the program in terms of increasing the national contraceptive prevalence rate is due, in large part, to weak IE&C.

## 14. UNRESOLVED QUESTIONS

Several important questions arose in the course of the case study, which the CDIE evaluation team could not fully answer. Unresolved issues include the following:

*What are the causes and consequences of the growth of traditional family planning methods?* The surprising finding that ineffective traditional methods are spreading more rapidly than are the more effective modern methods supported by the A.I.D. program could not be fully explained. The extent to which traditional methods are being actively promoted by family planning opponents could not be determined. Furthermore, it is not clear whether the growing use of traditional methods, in the long term, will be beneficial or detrimental to the family planning services A.I.D. supports.

*Can A.I.D.'s population programming be linked to programming in other A.I.D. sectors?* The powerful relationship between education, family planning, and health is clearly important, but its program implications need more study. The question remains whether there are ways in which A.I.D. programming in education, population, and health can be synchronized to capitalize more effectively on the interactions among these areas.

*What kind of policy dialogue works?* The agonizingly slow progress in public sector family planning activities in Honduras stands in stark contrast to the speed of progress in other countries, such as Mexico, where national leadership has strongly endorsed family planning, resulting in dramatically improved program performance. What more could A.I.D. do that might produce a policy breakthrough in Honduras?

## Appendix A

### History of Bilateral A.I.D. Support to the Honduran Family Planning Association (ASHONPLAFA)

This appendix provides additional detail concerning the history and nature of A.I.D. support to ASHONPLAFA.

Initially, A.I.D. support for family planning in Honduras was directed principally to the public sector. However, by the late 1970s, the Ministry of Health was blocking almost completely A.I.D.'s effort to support family planning within the Ministry of Health. ASHONPLAFA, meanwhile, had more commitment and enthusiasm for family planning than it had resources. In this context, A.I.D. began providing support to ASHONPLAFA.

Direct A.I.D. support to ASHONPLAFA began in August 1980 and has included the following projects:

Dates	Title	A.I.D. Support (US \$)
1980-1982	Family Planning/ PVO Project (522-0175)	440,000
1982-1984	Clinic Expansion Program (522-0197)	1,000,000
1982-1983	Project Development and Support Project (522-9108, 9104)	9,443
1983-1985	Commercial Retail Sales Project (522-0201.1)	925,000
1983-1985	Headquarters Expansion Project (522-0201.1)	280,000
1984-1985	Family Planning Service Delivery Support Project (522-0225)	775,000
1983-1986	Leadership Education Project (522-0240)	320,000
1983-1985	Project Development and Support Project (522-9104.1)	93,291
1985-1989	Private Sector Population Project (522-0286)	9,810,000
1989-1994	Private Sector Population II Project (522-0369)	16,000,000
<b>TOTAL</b>		<b>29,652,734</b>

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**Family Planning/PVO Project (522-0175), 1980-1982:**

A.I.D.'s first project with ASHONPLAFA provided \$440,000 for vehicles, additional staff, and administrative support. During this initial period of A.I.D. support, ASHONPLAFA expanded its staff and facilities, but its effectiveness, in terms of coverage, did not expand correspondingly. The additional staff included ten urban promoters, a supervisor, and eight two-person teams for rural areas. The number of distribution posts increased from 437 to 706. However, the number of users (27,000) was essentially unchanged. For this reason, at least during the project period (1980-1982), the ratio of users per post actually decreased from 62 to 38. The target had been 54,000 users by December 1981, which would have been 7 percent of the women of reproductive age in Honduras. The 1981 Contraceptive Prevalence Survey showed only 2-3 percent of women using the community-based distribution program as their source of oral contraceptives.

In fact, early in the project period there was a large drop in users due mainly to commodity distribution problems caused by a delay in purchasing project-supplied vehicles. By the end of the project period, user numbers were finally increasing. It was noted, however, that while new users were being recruited, old users were dropping out. It was recognized also that, in general, the distributors were not adequately prepared to respond to side effect problems.

Clinic Expansion Program (522-0197), 1982-1984, Project  
Development & Support (522-9108, 9104), 1982-1983  
Commercial Retail Sales Project (522-0201.1), 1983-1985  
Headquarters Expansion Project (522-0201.2), 1983-1985  
Family Planning Service Delivery Project (522-0225), 1984-1985  
Leadership Education Project (522-0240), 1983-1986

With A.I.D. support, ASHONPLAFA grew rapidly during the early 1980s. In 1978, ASHONPLAFA had 67 employees; by 1984 it had grown to nearly 150 employees and over 1,000 unsalaried community-based distributors. By 1984, the distribution program was providing subsidized contraceptives to 40,900 users, a 58 percent increase since 1980. In 1983, ASHONPLAFA had provided or supported 6,620 voluntary sterilizations, a 76 percent increase since 1980.

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According to a 1984 audit, A.I.D. direct support covered nearly 60 percent of ASHONPLAFA's \$2.2 million budget, the remainder coming from the International Planned Parenthood Federate (IPPF) and what is now the Association for Voluntary Surgical Contraception. Only 4 percent of the budget was locally generated. The budget and staff had grown at such a pace that there was concern in A.I.D. about ASHONPLAFA's capacity to absorb additional resources. A 1983 IPPF study reportedly concluded that ASHONPLAFA had an "improvised, if not paternalistic" management system, that there were few formal standards or procedures, and that the executive director delegated little authority to the department chiefs.

### **Private Sector Population Project (522-0286), 1985-1989**

In the 1980s, public attitudes toward family planning began to change. To capitalize on this improvement in the political climate, A.I.D. in 1985 began providing significantly increased amounts of support to ASHONPLAFA to help it improve and extend its services. The goal and purpose of the 4-year Private Sector Population project, was "to expand family planning coverage and services in Honduras through the private sector." Achievement was to be measured by an increase in contraceptive prevalence from 35 percent in 1984 to 44 percent in 1989. A.I.D. life-of-project funding totaled \$9.81 million. The project close-out report describes project objectives (in italics) and actual outputs as follows:

- *ASHONPLAFA's clinical and voluntary sterilization services were to be decentralized and regionalized by establishing and equipping five regional centers.* Centers were established in San Pedro Sula, Choluteca, La Ceiba, and Juticalpa with the Santa Rosa de Copan center nearly completed.
- *The volume of sterilization procedures was to increase from 32,000 in 1984 to a cumulative total of 90,000 by 1989.* The cumulative total was 73,000, an increase of 41,000 rather than the targeted 58,000. It was recognized in retrospect that the target number was unrealistic for the clinic capacity being created.
- *The number of regional clinic users, other than sterilization acceptors, was to increase to 19,500 in 1989.* The number reached was 10,500. In late 1988, the number reached had been 18,000, at which time an intensive campaign against family planning was waged by the Catholic Church and other antifamily planning groups. A rumor that IUDs caused cancer was widely spread. Reportedly, many women had their IUDs removed and clinic attendance plummeted nationwide. It was

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noted that ASHONPLAFA remained silent during these attacks, consequently, the development of a communications strategy was to be included in the follow-on project.

- *Administrative and management functions were to be decentralized to the regional levels. This component was not fully implemented and was to remain as an area still requiring emphasis in the follow-on 1989-1994 Private Sector Population II project (522-0369).*
- *The community-based distribution program was to be expanded by increasing the number of distribution posts from 1,100 in 1984 to 1,500 in 1989. Also, the number of active users was to increase from 39,000 to 54,000 in 1989. The number of distribution posts increased to 1,478 and the number of active users to 46,000.*
- *The effectiveness of the Contraceptive Social Marketing program was to be improved by increasing the level of awareness and effective demand for contraceptive products among lower socioeconomic segments of the population not presently served by the existing service delivery network. This was to be accomplished through intensive mass media advertising, mass retail distribution of all program products, training of distributor and retail personnel, and market research. Reportedly ASHONPLAFA's products were the best known and most widely used contraceptives in Honduras. Also, the number of active users in the Contraceptive Social Marketing program was to increase from 7,000 in 1984 to 40,000 in 1989. The number reached was 45,500 active users. In 1986, a survey of oral contraceptive purchasers found that the program was indeed reaching its target population of lower and middle income women.*
- *ASHONPLAFA's information, education, and communications (IE&C) department was to be expanded and strengthened. The department went from a regional activity to a national program utilizing mass media and promoting all ASHONPLAFA programs. The pretesting of audiovisual materials was institutionalized.*

Technical assistance was provided by several long-term advisers and by the TRITON Corporation to the Contraceptive Social Marketing component. Additional assistance came from the Centers for Disease Control and the Family Planning Logistics Management project. Price Waterhouse conducted a major institutional analysis of ASHONPLAFA in January 1989, which concluded that ASHONPLAFA needed to better define its role, increase decentralization efforts, and develop a medium-and long-term agency strategy. The internal structure of



ASHONPLAFA was still considered to be rigid with cumbersome procedures. Evidence that improved operating procedures were being implemented was to be made a special condition of the follow-on project.

The 1987 Epidemiology and Family Health Survey showed that ASHONPLAFA was the source of over 58 percent of family planning services in Honduras, followed by the Ministry of Health which was providing 17 percent. At the end of the project, the national contraceptive prevalence rate was estimated to be 44 percent.

### **Private Sector Population II Project (522-0369), 1989-1993**

Designed to build on the achievements of the 1985-1989 Private Sector Population project (522-0286), the goal of A.I.D.'s ongoing 1989-1993 Private Sector Population II project (522-0369) is "to reduce the total fertility rate from 5.6 to 4.7." The purpose is "to contribute 50 percent of the increase in national contraceptive prevalence from 41 percent in 1987 to 50 percent in 1994." Funding is also included to finance buy-ins to centrally-funded population projects and for complementary private voluntary organization (PVO) family planning activities in Honduras. The A.I.D. life-of-project contribution is \$16 million in grant funds, of which \$12.6 million is designated for ASHONPLAFA, \$1.1 million is for PVO support, and \$2.3 million is for technical assistance buy-ins.

The project directly supports three ASHONPLAFA service delivery programs: (1) Community Services, ASHONPLAFA's renamed community-based distribution program, (2) Contraceptive Social Marketing, and (3) Medical/Clinical Services. To improve rural services, the project is supporting expansion of the ASHONPLAFA community-based distribution program and improvement of outreach services offered by the five regional ASHONPLAFA clinics, which offer voluntary sterilization services as well as temporary methods. Additional sterilization services are provided in eight private semirural clinics. Vasectomy clinics are being established in Tegucigalpa and San Pedro Sula. The Contraceptive Social Marketing program has been reorganized and is working to improve the availability of temporary methods in rural as well as in urban areas. Increased emphasis is being placed on IE&C activities.

The project also addresses a number of ASHONPLAFA institutional constraints, particularly the regionalization and decentralization program. Although improved cost recovery and cost effectiveness are objectives, it is recognized that ASHONPLAFA is not likely to achieve overall self-sufficiency. Revenue increases are expected especially from the Social Marketing and surgical contraception services. The Cooperative Agreement commits ASHONPLAFA to

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specific performance levels in cost recovery and cost containment. Progress in lowering costs per unit of service provided and increasing income generated by services is to be closely monitored.

To measure achievement, the Project Paper sets out the expected temporary method Couple-Years-of-Protection (CYP) and number of voluntary sterilization procedures to be generated by program by year. The Community Services program is expected to expand nearly 30 percent over the life of the project by establishing new distribution points, adding Social Marketing program products (Perla and Norminest pills, Guardian condoms) to their line, and increasing sales per distributor. The community-based distribution program generated 35 percent of its direct operating costs in 1988; this percentage is expected to rise to 50 percent by the end of the Private Sector Population II project.

The Contraceptive Social Marketing program is expected to increase its CYPs by 67 percent and to achieve self-sufficiency by 1994. To do this, the 1,700, mostly rural, distributors are to serve as additional distribution points for the Social Marketing program lines of contraceptives to supplement sales made in the existing distribution network of pharmacies. In early 1989, as this project was being developed, ASHONPLAFA had reorganized its Social Marketing program. The ASHONPLAFA commercial distributor, Drogueria Nobel, had been unable to reduce the cost per CYP or increase its level of self-sufficiency despite large funding inputs. Finally, with technical assistance from SOMARC, ASHONPLAFA entered into a contractual agreement with MANDOFER, S.A., the largest commercial wholesale drug distributor in Honduras.

A consistent pricing policy for all ASHONPLAFA contraceptive products, across programs, is to be instituted based on operations and market research.

The Medical/Clinical Services program is expected to have all six centers operational and to increase considerably the number of procedures performed. In 1988, ASHONPLAFA supported 7,290 female sterilization procedures in their clinics, Ministry of Health hospitals, and private clinics. By 1994, that number is expected to be 14,523. The possibility of opening four additional centers will be explored as will the possibility of offering transportation in rural areas. A men's clinic will be opened on a pilot basis to offer vasectomy and sexually transmitted disease services. Natural family planning, breastfeeding promotion, and increased attention to methods compatible with breastfeeding (including the mini-pill) will be provided. A sliding fee scale is to be instituted and greater efforts at cost recovery made.

The Private Sector Population II project also provides support to *Plan en Honduras* and other private groups to enable them to initiate family planning services or upgrade their referral relationships with ASHONPLAFA. The PVOs in Honduras were surveyed to determine which groups had the interest and the potential to do this successfully. ASHONPLAFA will carry out IE&C activities to promote family planning in general and to provide training for the private groups as well as its own staff. *Plan* will have its own Cooperative Agreement. The other PVOs will be coordinated by a centrally funded contractor through a buy-in. A separate buy-in to the A.I.D. Technical Information on Population for the Private Sector project will support limited employee-based family planning activities.

The Project Paper specifies that a project goal is to reduce the total fertility rate from 5.6 to 4.7, including a reductions from 6.9 to 5.8 for rural women and from 3.8 to 3.0 for urban women. In addition, very specific numerical targets are set for the various ASHONPLAFA programs—community-based distribution, Social Marketing, Medical/Clinical, IE&C, training, and monitoring and evaluation.

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## **APPENDIX B**

### **A.I.D. Support for Ministry of Health Family Planning Services**

**Section 5 of the report describes the Ministry of Health and summarizes the program of A.I.D. support for the Ministry's family planning program. This appendix provides additional detail concerning the Ministry, A.I.D. project support that it has received, and the Honduran Social Security Institute (IHSS).**

#### **Ministry of Health Facilities and Staff**

**Health facilities at the different levels are staffed and equipped according to their functions and the demand that exists for their services. The seven national hospitals, six of which are located in or near Tegucigalpa, are staffed with specialized physicians and are equipped for surgery and intensive care. The regional hospitals, of which there are also seven, are all located outside of Tegucigalpa. The regional hospitals also try to offer a complete range of specialized medical personnel and services. The thirteen area hospitals are mostly staffed with general practitioners, gynecologists, pediatricians, and surgeons. They have laboratories and X-Ray equipment, but no intensive care units. The 183 CESAMOs throughout the country have one or more physicians apiece (usually only one in rural CESAMOs and more than one in urban CESAMOs). They also have auxiliary nurses and sometimes licensed professional nurses. Some have observation beds, but none offers round-the-clock hospitalization. The 521 CESARs normally have one or more auxiliary nurses who can provide primary care and a limited range of curative services and medications. At the community level, there are four different kinds of volunteer personnel. First is the Guardian de Salud, who offers oral rehydration therapy, provides local support and followup for vaccinations, identifies cases of respiratory infections, and go on. Another local volunteer is the partera capacitada, or trained midwife, who attends births. A third volunteer is the colaborator, who mainly takes samples and watches for malaria. Fourth is the Health Representative, who mainly works on motivating and organizing the community for water and sanitation infrastructure activities.**

**The Ministry routinely charges patients a nominal fee equivalent to US \$.22 for each consultation. Medications are free.**

## A.I.D. Support

Direct A.I.D. support to the Ministry of Health for family planning activities has included the following projects:

Dates	Title	A.I.D. Support (US \$)
1965-1976	Maternal and Child Health/Family Planning Project (522-0065)	3,774,000
1976-1981	Integrated Rural Health/Family Planning Project (522-0139)	1,464,000*
1981-1988	Health Sector I Project (522-0153)	34,750,000
1988-1995	Health Sector II Project (522-0216)	57,253,200

\*Family planning component not fully implemented.

A.I.D.-supported family planning activities with the Ministry of Health have tried three fairly distinct approaches. The initial Maternal and Child Health/Family Planning project (522-0065) from 1965 to 1976 was largely vertical and managed by A.I.D. The 1976-1981 Integrated Rural Health/Family Planning project (522-0139) was highly integrated, with family planning almost a negligible component. The 1981-1988 Health Sector I project (522-0153) and its follow-on, the current 1988-1995 Health Sector II project (522-0216) have used a matrix design wherein specific activities (subcomponents) are targeted for focused attention, but a large management and planning function integrates the subcomponents within the Ministry structure. Activities related to family planning are included among the subcomponents.

### Maternal and Child Health/Family Planning Project (522-0065), 1965-1976

The goal of the 1965-1976 Maternal Child Health/Family Planning project (522-0065) was to reduce the number of births in Honduras by 50,000 by 1974,

reducing the birth rate from 42/1000 to 36/1000 and reducing the population growth rate from 3.6 percent to 2.9 percent. The A.I.D. contribution to the project was \$3.774 million.

Under this project, a separate family planning unit was set up in the Ministry of Health and 34 separate family planning clinics were created and staffed within the regular Ministry clinics. At that time, A.I.D. felt that a vertical and separate project structure was necessary to avoid bureaucratic entanglements, to assure proper control of funds, and to achieve strong results.

The commitment of the Ministry of Health to the project was half-hearted, at best. The project was seen essentially as A.I.D.'s project, not the Ministry's. The project's verticality and separateness plus the inequities between it and other less well funded Ministry programs caused some resentment and criticism within the Ministry. The Catholic Church attacked it. Some within the university and medical school considered it imperialistic.

As the project progressed, the notion of integrating the project into the regular Ministry structure was widely discussed. Finally an agreement was reached whereby the Ministry would gradually assume all costs for the project from its regular budget. Formal integration was accomplished by 1975. However, only half of the family planning personnel were ultimately integrated and the effect of this integration was to essentially dismantle the project and greatly reduce family planning activities, while reallocating resources to other maternal and child health priorities. Those personnel integrated into the Ministry no longer worked on family planning activities. Indeed, following this integration there effectively was no Ministry family planning *program* (although some service delivery did continue) until the 1980s.

The project extended over a 10-year period and at its conclusion had only 38,000 users enrolled. There is no evidence that the project had any significant impact on population growth.

Despite the Government's lack of support for the A.I.D. initiative, there are signs that the official attitude toward family planning during this period was not uniformly hostile. In fact, for the first time, the Government included a discussion of population in its 1974-1978 National Development Plan. The Plan stated that the Government intended to "achieve a demographic situation in accordance with the economic development needs and the resources available to the society."

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## **Integrated Rural Health/Family Planning Project (522-0130), 1976-1981**

The 1976-1981 Integrated Rural Health/Family Planning project was designed specifically to support integration of family planning and public health services by providing the Ministry with (1) an improved institutional capacity to train the large numbers of paramedical employees required to staff the 500 rural health centers, and (2) contraceptive supplies required by the family planning element of the program.

As originally developed, the 1976-1981 Integrated Rural Health/Family Planning project was to be a \$6.918 million project with A.I.D. providing \$1.434 million in bilateral funds and \$1.593 million in central A.I.D. contraceptive funds for a total A.I.D. contribution of \$3.027 million. The Government was to provide an additional \$3.171 million in counterpart funding. The Pan American Health organization was to provide \$20,000 and IPPF \$500,000.

The project goal was "reduced population pressure on development strategies and programs in and for Honduras." The project purpose was "to increase the Honduran institutional capacity to provide effective means of fertility control and maternal/child and other basic health services, especially in rural areas." The Project Paper presented family planning as a major component of the basic health services package that the Ministry intended to make available. The number of women of fertile age practicing family planning was expected to increase from approximately 8 percent in 1975 (given as the rate attained under the prior vertical 1965-1976 Maternal and Child Health/Family Planning project) to 23 percent by 1980. To do this, the Ministry would need the institutional capacity to serve a total of 134,000 women. By 1980 there were to be 136,000 births averted along with decreased infant and maternal mortality. The project's logical framework included multiple, objectively verifiable indicators related to family planning: 500 CESARs providing services, 150 acceptors per CESAR, 1.6 million home visits for family planning, and so on.

Reportedly A.I.D. was forced by end-of-fiscal-year obligation pressures to push this project quickly through A.I.D. and Ministry of Health review and approval processes. After the project was approved, the Ministry refused to implement the family planning components. This refusal is generally attributed to resentment carried over from the previous vertical project. As actually implemented, the Integrated Rural Health/Family Planning project created three permanent training sites and supported the general training of auxiliary nurses,

midwives, and *guardians*. This training capability, which still exists and is still functioning, has probably been one of A.I.D.'s most successful health sector undertakings in Honduras. However, the 10-month training course for auxiliary nurses that was developed spends only 4 of its 1,600 hours of instruction on family planning.

### **Health Sector I Project (522-0153), 1981-1988**

As seen above, A.I.D.'s influence in the health sector and, in particular, in the family planning area had been reduced by the problems of the 1970s. In the late 1970s, A.I.D. again began to play a larger role in designing programs for the health sector. A \$475,000 Health Sector Planning grant (522-0148) was used in part to fund some special studies and a detailed Sector Assessment. A.I.D. used this Sector Assessment process to involve Honduran health officials in a structured examination of their own institutions and programs and to delineate and develop priority areas of mutual interest. Reportedly, after years of tension and communication difficulties between the Ministry of Health and A.I.D., a renewed atmosphere of cooperation and mutual respect was created and serious policy dialog began. The Government commitment to extending service coverage to rural and marginal urban areas was renewed. Seventeen areas of need, an amalgam of discrete programs and system support functions, were identified and later used as the subcomponents of the 1981-1988 Health Sector I project (522-0153). Overall, it was agreed that the principal focus of the project would be improvement of the management, planning, and logistical systems needed to operate a primary health care program.

A number of decisions were considered at the time to be particularly noteworthy. Foremost was the Ministry's decision to suspend further hospital construction in order to dedicate more resources to primary health care. Second was the decision of the Minister that family planning services should be strengthened as a health measure to protect maternal and child health and that support for family planning should be included in the Health Sector I project.

As originally developed, the Health Sector I project was to be a 4-year \$32.452 million project with A.I.D. providing \$15.391 million (\$4.426 million grant funding and \$10.965 loan) and with the Government of Honduras providing a counterpart contribution equivalent to \$17.061 million. The project had 17 different components, mainly child survival activities and support for Ministry institutional strengthening. The Project Paper generally skirted the subject of family planning. It did state that the complications of pregnancy were a major cause of mortality and morbidity and it acknowledged that Honduras was believed to have an extraordinarily high population growth rate (3.59 percent) and total

fertility rates (7.0 overall; 8.7 rural, 5.3 urban). It also noted that births in Honduras tended to be closely spaced, with both mothers and children suffering as a result. The words "family planning" were almost always in parentheses and the one subcomponent dealing with family planning is called, "Maternal child care (family planning)."

In discussing the maternal child care (family planning) subcomponent, the Health Sector I Project Paper indicated that the Ministry's integrated maternal and child health services had deemphasized family planning and referred to lack of support within the Government and among nongovernmental leaders. It is noted that "the request of the MOH for A.I.D. assistance in this area represents an opportunity to strengthen the MCH program and inject some vigor into the family planning aspects of the program." This was to be done through training, leadership support, mass media technical assistance, and the provision of equipment.

Of the 17 subcomponents, maternal child care (family planning) was to receive \$1.367 million, about 9 percent of A.I.D.'s total contribution to the project. The counterpart contribution to this component was to be the equivalent of \$301,500, about 2 percent of the total Government counterpart contribution. Approximately \$600,000 of the A.I.D. contribution appears to have been for contraceptives. Family planning was also mentioned as a topic for the health education messages to be developed under Subcomponent 13: "Mass media for village health workers."

The Project Agreement was signed on July 31, 1980. For multiple reasons, there was nearly a 2 year delay before the implementation of Health Sector I began. The day after the Ministry Signed Health Sector I, a new Minister of Health took office and all top level management changed within 6 months. Within 2 months, the A.I.D. team involved in project development had all been transferred. The major factor in the delay, however, was A.I.D.'s time-consuming procurements of a major technical assistance institutional contract.

More than 3 years later, in September 1983, the first external evaluation of project activities found there had been virtually no activity during the first 3 years of the Health Sector I project on the Maternal child care (family planning) subcomponent. However, there was reason for some new optimism at that time about the future of the subcomponent, because it was undergoing a reprogramming with active support from the Ministry's Director General to incorporate a new reproductive risk approach to family planning, which the

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Ministry found politically and programmatically appealing. The new focus justifies the use of family planning methods only to reduce high-risk births, not to reduce population growth. This rationale is attractive for countries like Honduras where family planning is a highly politicized and culturally sensitive issue.

During this period, there was some progress on the policy front. The 1981 Contraceptive Prevalence Survey had revealed a sizeable unmet demand for services. In November 1983, Ministerial Resolution Number 202-83 was published, calling for a national family planning program integrated into the Maternal/Child Health Division of the Ministry of Health. Family planning and breastfeeding norms were developed and published in 1984.

In 1985, the Health Sector I project was amended, modifying a number of components, but not changing the overall approach. Project support under the amendment for the Ministry's strategy of expanding family planning service delivery using a reproductive risk focus included the following:

- Technical assistance (continuation of the long term advisor, operations research)
- Training for 80 physicians in voluntary female sterilization, 34 nurses in IUD insertion, an additional 320 physicians and nurses in temporary methods, 500 auxiliary nurses in barrier methods and pills, 10,000 midwives in the identification and referral of high-risk women, plus 55 others in family planning program administration
- Equipment (laparoscopes, laparotomy kits, cytology supplies, contraceptives)
- Personnel (family planning program director and two staff in Health Education Division to work on mass media campaigns promoting family planning in the context of responsible parenthood and high risk).

Additionally, the project worked to improve contraceptive supply problems through its logistics subcomponent, and a management information component began to address problems of statistics and administrative information in support of Ministry reproductive risk services.

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With time extensions and the obligation of additional grant and loan funding, Health Sector I ultimately became an 8½ year project with A.I.D. providing \$34.75 million (\$19.098 million grant and \$15.652 million loan). The Health Sector I Project Close Out Report noted that the total fertility rate had dropped from 7.5 in 1972 to 5.6 in 1988 and that the population growth rate had been reduced to under 3 percent per year. It also noted a decrease in the infant mortality rate from an estimated 117/1,000 in 1978 to an estimated 60/1,000 in 1988, a reduction far in excess of the targeted 75/1,000 in 1990 called for in the original Project Paper.

Specifically in the area of family planning and maternal and child health, the following accomplishments were identified:

- Increase in contraceptive use from 27 percent to 35 percent of women in the reproductive age group
- Official approval of a Government of Honduras population program
- Significant improvement in training of personnel in the use of family planning methods and in making family planning commodities available at the health centers (in 1988, 95 percent of the centers had oral contraceptives available and 75 percent had condoms)
- Legalization of voluntary surgical sterilization norms
- Training of over 5,000 *parteras* in improved birthing techniques and in the rudiments of family planning
- Increased use of mass media to support family planning activities
- Creation of a new family planning unit in the Maternal and Child Health Division
- Creation of a new breastfeeding program with personnel at central and regional level.

Project accomplishments in management and planning were the successful completion of two maternal and child health/family planning national surveys. Of the 360 months of technical assistance provided, only 6 months appeared to have been devoted to family planning. The final project evaluation noted that the lack of contraceptives at the CESAR level seriously affected the achievement of the family planning objectives. As late as 1986, oral contraceptives were unavailable in 60 percent of CESARs and CESAMOs.

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The Health Sector I Project Paper Amendment had called for the number of active Ministry of Health family planning users to increase from 23,000 to 60,000 by 1987. However, at the time of the final evaluation, the number of users was estimated at only 18,000. The evaluation comments, "this goal will not be achieved because starting levels were much lower than originally thought and targets too high."

Other planned family planning outputs were assessed in the close-out report. The objective of defining, approving, and officializing program norms by the Government was fully accomplished. The objective of training 90 percent of auxiliary nurses in program norms was nearly reached—80 percent of nurses were trained. It had been planned that 80 percent of CESARs should report no contraceptive stockouts in the previous 3 months; in fact, 46 percent reported no stockouts. The objective that 90 percent of women of fertile age would know one method of family planning was exceeded by 3 percent. The objective of training 70 percent of midwives in family planning was not achieved; no midwives were trained under the project.

### **Health Sector II Project (522-0216), 1988-1995**

In designing a project to follow Health Sector I, it was decided to combine, for the first time, public sector child survival activities, public sector water and sanitation activities, and private voluntary organization (PVO) activities into a single project aimed at reducing infant mortality.

Consistent with the Government's preference for a reproductive risk emphasis, family planning is presented as a health, not demographic, intervention. Planned life-of-project funding is \$83.27 million over a 7-year period, with A.I.D. contributing \$57.253 million in grant funds and the Government of Honduras providing the equivalent of \$26.016 million in counterpart funds. A significant portion of the A.I.D. contribution is for technical assistance. Whereas Health Sector I focused on management improvements at the central level, Health Sector II is designed to focus on the sustainable implementation of system improvements at the regional and subregional levels. The Health Sector II project was also designed to be fully consistent with the current Government of Honduras health sector policy. In March 1986, the Government issued a new national health policy, which gave top priority to extending primary health care services to the rural population and to those groups at highest health risk.

The birth-spacing subcomponent is designed to support an integrated program of maternal care, including the prenatal and postnatal periods. Attention is to be focused on women at high reproductive risk (women under 18, or over

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35, or with children under 18 months, or with four or more children). Contraceptives are to be provided and the logistic system improved. Considerable delivery room equipment and cytology lab supplies. The A.I.D. Project Paper includes the following objectively verifiable indicators for the birth-spacing subcomponent of the project:

- Decrease in the percentage of births with intervals less than 2 years from 30 percent to 15 percent
- Increase in contraceptive use prevalence nationwide from 35 percent 1984 to 45 percent in 1990 and to 50 percent in 1993
- Ninety percent of pregnant women detected in the high risk group are attended to by the health system (40 percent in 1986)
- Ninety percent of CESARS will be distributing temporary contraceptive methods (40 percent in 1986)
- Sixty percent of the voluntary personnel (midwives and *guardians*) will be distributing oral contraceptives and condoms (none presently)
- Fifty percent of women of fertile age are aware of the health risks of short intervals (under two years) between pregnancies

The A.I.D. contribution to the project's birth-spacing subcomponent is \$3. million, about 5 percent of A.I.D.'s total contribution to the Health Sector II project. The equivalent of \$25,000, or 0.001 percent of the total, is the planned Government counterpart contribution. Approximately \$1.35 million, or 45 percent of the A.I.D. contribution to the birth-spacing subcomponent is for contraceptives, and \$960,000, or 32 percent of A.I.D.'s contribution to the birth-spacing subcomponent, is for technical assistance.

The Health Sector II agreement with the Ministry of Health was signed in June 1988. Meanwhile, A.I.D. had commissioned a five-person team to conduct a 35 day evaluation of the Ministry's Women's Health Care Program with special emphasis on its family planning component. The team was in country in May, June, and July of 1988. The report found almost nothing positive to say about Ministry of Health family planning and reproductive health services. The problems were described as follows:

- **Structural.** Problems including a lack of institutionalization of the program; scarcity of human resources at the central and regional levels of the program, confused and contradictory goals and objectives, nearly inflexible regulations governing family planning services and methods (surgical, IUD, pills), no manual describing the functions and responsibilities of each level of the system, deficiencies in the management and operation of the program, little internal and external program coordination, and very low motivation among hospital personnel.
- **Services.** Hospitals do not provide reversible methods of contraception and do not adequately meet the demand for surgical contraception. Men are excluded from the program. There is low supply and demand for family planning at all levels
- **Supervision.** Deficient supervision existed at all levels of the program
- **Training.** There were deficiencies in personnel training at all levels of the program
- **(IE&C).** Deficiencies existed in educational materials and there was; no community outreach
- **Logistics.** The entire logistics system contained deficiencies
- **Programming and evaluation.** There were poor programming procedures and deficiencies in the collection and use of data.

The evaluation made a long list of recommendations to strengthen the program and also recommended technical assistance on a continuing and timely basis.

The findings and recommendations of this A.I.D. evaluation were angrily rejected by the Ministry. The recommendation that a Department of Family Planning be created was viewed as an attempt by A.I.D. to once again create (and possibly control) a vertical family planning program.

Three years into the Health Sector II project, in 1991, a mid-term evaluation of the project was conducted. This evaluation concluded that the priorities and strategies of Health Sector II were still valid and appropriate. The team found many of the subcomponents keeping pace with or surpassing planned targets. However, it was noted that only 17 percent of the allocated funds for women's health care had been expended through June 1991 and many discrete

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activities were considerably behind schedule. On the positive side, a recently published study of reproductive and maternal mortality appeared to be providing strong incentives for action, causing a renewed commitment to the reproductive risk approach. A health education and communications plan was being developed. The norms were to be revised and updated. A plan to incorporate the hospitals more effectively into the delivery of family planning services had been formulated. The commodities and logistics system had been considerably strengthened.

Nonetheless, the availability of services continued to be quite limited. Condoms and vaginal tablets were available from some guardians and midwives. These methods, as well as pill refills, were generally available at the CESARs. IUD services at the CESAMO level were extremely limited. Male and female voluntary sterilization services were essentially not available directly from the Ministry of Health. Considerable regional variation was noted.

In June 1992, a possible breakthrough for the slow-moving Ministry program was the design, approval, and initiation of a public information and advertising strategy. After 2 years of delays and indifference, the Ministry finally accepted a detailed technical plan developed by A.I.D.'s technical assistance advisors for a national mass media campaign designed to promote the use of family planning services to reduce high risk pregnancies. The campaign will include radio spots with music and brief dramatic exchanges about risk factors, posters, a photonovel, and training materials for nurses. Since this activity has been delayed repeatedly, a large reservoir of unspent grant funds are available to finance it. It is planned that this campaign will begin in mid-1992 and will be considerably more intensive than anything that the Government has done in the past.

## **THE HONDURAN SOCIAL SECURITY INSTITUTE (IHSS)**

The Honduran Social Security Institute (IHSS) is the other major public sector institution working in the health sector in Honduras. IHSS activities in the family planning/reproductive risk area were not evaluated directly by the CDIE assessment team because they operate on a small scale and receive minimal A.I.D. support. Nevertheless, they will be summarized briefly here because they add another dimension—family planning services delivered through the workplace—and because they demonstrate the feasibility of more aggressive and effective public sector services.

The IHSS reproductive risk/family planning program began in 1982 with some small operations research activities done by AVSC, supported by central A.I.D. population funds. IHSS began with a Pan American Health Organization case management protocol for perinatal attention for women who are not pregnant. The IHSS innovation at that time was to add educational videos and pamphlets for women to the Pan American Health Organization system.

Beginning in 1987, the IHSS hospital in San Pedro Sula was the site of additional innovative activities. The Preventive Medicine Department there operates an experimental outreach service which works directly in plant with 80 different companies in the San Pedro Sula area. With the help of the plant owner or manager, IHSS medical staff people get the employees together for educational sessions, then provide contraceptives and related reproductive health services.

Initially, it was difficult getting this program into motion. Many IHSS physicians were opposed, as were some plant managers. Now, after 5 years of experimentation and refinement, the program is catching on. Most of the IHSS doctors have gotten over their ideological worries and institutional turf concerns because they see that a functioning reproductive risk program reduces the number of birth complications they have to deal with. IHSS reports that an internal study has shown that a normal birth costs IHSS about \$78, while a birth with complications costs an average of \$192. With family planning and reproductive risk services, IHSS has estimated that birth complications can be cut in half.

Nationally, IHSS is training all its staff in reproductive risk interventions and providing A.I.D.-supplied contraceptives. However the IHSS is on the verge of bankruptcy and collapse, and the demonstration of theoretical savings to IHSS management has not translated into sufficient resources to run a national reproductive risk program for its membership through its health facilities nationwide. Frustrated staff talk of trying to shift the program to a PVO, providing an IHSS subsidy.

IHSS covers only about 6 percent of the Honduran population, 26 percent of the population in San Pedro Sula. It will have to expand its membership if it is ever to be financially viable. There is presently a bill before the National Congress that would essentially privatize the IHSS. In the reproductive risk area, it finds itself in competition for extremely scarce resources and for clients with ASHONPLAFA and the Ministry of Health.

For the reproductive risk activity in IHSS, AID is providing all the contraceptives and some training, including observation trips to Mexico for IHSS officials to see the successful Mexican Social Security program.

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## APPENDIX C

### FAMILY PLANNING SERVICE QUALITY: STRATEGY AND ORGANIZATION

Section 8 examined family planning quality in Honduras using the six elements of quality of care identified by Judith Bruce of the Population Council. Although quality was not perfect in ASHONPLAFA, it was considerably better in ASHONPLAFA than it was in the Ministry of Health. This appendix attempts to identify some of the institutional basis for the differences that were observed in quality. The analytical tool for the institutional analysis comes from the Service Quality literature, a branch of total quality management. The analysis focuses on institutional elements—systems, culture, structure, employees, management, service design and physical environment.<sup>1</sup> Policy, service delivery and quality for the client result from these institutional elements. Over the years, through Mission and central funds, A.I.D. has provided support to all of these elements in both the Ministry and ASHONPLAFA.

Service quality management, as other branches of Total Quality Management, is built upon several premises:

- Quality is the result of institutional commitment to quality: quality in management and quality for its customers.
- Organizations have customers at three levels, and quality is essential at all three levels:
  - Internal customers are the employees. In this analysis, they are the employees of the MOH and ASHONPLAFA.
  - Intermediate customers are collaborators, suppliers and distributors. In this analysis, the most important intermediate customers for the MOH and ASHONPLAFA are A.I.D. and A.I.D. contractors.
  - End customers are the final recipients of service- family planning clients.

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<sup>1</sup>Alan Dale and Stuart Wooler, "Strategy and Organization for Service" in *Service Quality, Multidisciplinary and Multinational Perspectives*, editors Brown, Gummesson, Edvardsson and Gustavsson, Lexington Books, Lexington MA, 1991.

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- An institution is a system composed of inter-related and inter-dependent parts. All are vitally important—systems, culture, structure, employees, management, service design and physical environment.

## **Defining the Institutional Elements of Service Quality**

### *Technology/Systems*

These are the procedures, forms, hardware and software of the organization. They are analyzed in terms of being service enhancing and "customer friendly" to employees (internal customers), donors (intermediate customers) and clients (end customers). Two systems uniquely important in family planning, logistics and service statistics, are chosen for analysis.

### *Culture*

These are the collective values, beliefs, norms, symbols, etc., that apply to all staff. They include symbols, ethos (shared values and beliefs), codes and standards, both written and unwritten. Culture particularly influences interpersonal relations with clients and the organizational commitment to giving full information to clients.

### *Structure*

This is the organizational structure and the extent to which it promotes quality. It includes:

- *Corporate responsibility*: that service quality is accepted as a corporate (institutional) responsibility by the top management.
- *Authority and responsibility*: Staff have the authority to give good service and are held accountable for it.
- *Numbers employed*: Must be sufficient for good service.
- *Rewards*: There are appropriate incentives for and reinforcement of high quality service.
- *Employees*: Staff involved in giving service. Indicators include:
  - *Involvement*: Staff motivation and commitment to high-quality family planning service.

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- **Characteristics:** Staff have the individual characteristics which are appropriate for service giving. This factor is particularly important for interpersonal relations and for positive communication and information giving.
- **Skilled:** Technical competence.
- **Management:** Those who lead, plan, organize, and evaluate institutional performance. Indicators of quality are:
  - **Leadership:** Managers envision, initiate, direct and emphasize service.
  - **Change strategy:** Management's strategy for bringing about a service orientation and improved quality.
  - **Top involved:** Chief executive is involved and outspoken about service.
- **Aligned purposes:** The mission, values, strategies, plans and actions are all in line and focused on service.
- **Service design:** This is the way family planning services are delivered and adjusted to meet client need. Service design includes choice of methods, mechanisms for continuity and the constellation of services.
- **Customer oriented:** The design is focused on meeting client needs.
- **Performance feedback:** There are mechanisms for getting feedback on service from clients and staff.
- **Adaptability:** The organization responds to such feedback by taking appropriate action.
- **Physical environment:** The infrastructure, layout, physical conditions that have an effect on quality. Indicators are:
  - **Customer friendly:** The physical environment is convenient and welcoming to the client.
  - **Employee effectiveness:** The physical environment, including equipment, helps and enables staff to give good service.

- *Customer image:* The physical environment communicates a service image to the family planning client.

## **Analysis of ASHONPLAFA: Strategy and Organization for Service Quality**

### *Technology/Systems*

ASHONPLAFA is an IPPF affiliate and has steadily improved its systems over the years with IPPF/WHR assistance and technology. The logistic system functions effectively for staff, donors, and clients. Contraceptives are where they need to be, when they need to be, and in good condition.<sup>2</sup>

Service statistics are based upon standard family planning indicators. Staff understand and agree upon the indicators; forms and formats are used correctly. A.I.D. can use the statistics to compare performance across time and with other regions. Clients benefit from the mechanisms for follow-up built into careful patient records and service statistics.

### *Culture*

The culture of ASHONPLAFA has at least three roots. The first and perhaps most important is IPPF/WHR affiliation. IPPF/WHR is family planning - with a history and a network of relationships throughout Latin America in particular, and more loosely, around the world. The values and beliefs proclaim that family planning is important to individual and family well-being, to national development, and to sustainable global development. ASHONPLAFA values, technical standards and protocols are derived from IPPF roots.

Secondly, ASHONPLAFA is a Honduran organization. It is political and nonconfrontational. In the hostile social environment surrounding family planning, it steadily provided family planning services as broadly as possible and tried to minimize hostile feedback; its IE&C has been weak and not aggressive. Honduran

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<sup>2</sup>The logistic system was not always so effective. A 1984 audit report was critical of ASHONPLAFA's not addressing known stock-out problems in a timely ways and for unknowingly distributing contraceptives whose shelf life had expired.

planning methods, side affects, and counter-indications.<sup>3</sup> The culture of ASHONPLAFA is also centralized and authoritarian—led by its original physician founder for the last 25 years. Change has not come easily.

### *Structure*

Until recently ASHONPLAFA was a centralized structure with financial, program, and personnel authority all residing in the Executive Director. Change is in process; limited authority has been delegated to the six regional centers; more delegation is planned. ASHONPLAFA is well staffed, perhaps even overstaffed. It grew from 67 employees in 1978 to nearly 150 employees in 1992. The Executive Director speaks of downsizing the organization to make it more cost effective.

### *Employees*

Employees appear motivated and technically competent. The 1992 Private Sector Population Project Evaluation concluded that with the exception of some areas of the organization where training was needed (MIS particularly), the staff were trained and competent.

### *Management*

The Executive Director stands for family planning service. In response to a public attack on him by the Catholic Church and threats of excommunication and hell for his family planning work, he stated to the newspaper that his conscience was clear. The purposes of ASHONPLAFA have been aligned—the mission was to provide quality family planning services to as many persons as possible. Over the years ASHONPLAFA's mission expanded from serving the easily served middle class in two cities to national coverage including the harder-to-reach rural poor. The base was A.I.D. funding. However, in the last several years, ASHONPLAFA has been less institutionally sure. It finds itself in conflict between service expansion and sustainability. Pushed by A.I.D. to increase its level of self-financing (currently 26 percent of funds are locally generated), it is attempting both cost control and cost recovery. As a cost control measure, it unwisely curtailed several activities, including staff training programs, which would have improved organizational functioning. It has instituted fees for services to at least partially recover costs; rural and very poor clients may find these fees

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<sup>3</sup>See Box 9 in text.

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too high<sup>4</sup>. Both measures impact upon quality. ASHONPLAFA states that it is unsure how to resolve the service expansion and sustainability dilemma. Certainly, sustainability is essential and ASHONPLAFA would be very unwise to rely on A.I.D. and IPPF funding indefinitely. However, self-financing is only one part of the sustainability which A.I.D. seeks. Also important is continued ability to fulfill institutional mission. ASHONPLAFA, A.I.D., and IPPF must jointly search for balance so that ASHONPLAFA sustains its mission while growing increasingly financially self-reliant.

### *Service Design*

ASHONPLAFA provides services through clinic, CBD, and social marketing programs to meet the family planning needs of men and women at different stages of their reproductive life, in urban and rural locations. The choice of methods includes orals, condoms, IUDs, and male and female VSC. Mechanisms for continuity and follow-up are built into the design. But to some extent, the program is rigid and employee rather than client directed. Clinic services are scheduled in the morning for the convenience of physicians, most of whom work at ASHONPLAFA in the morning and attend their private clinics in the afternoon. There are no evening or Saturday appointments except for the Male VSC clinics in two centers which are open for that service only, on Saturday mornings. ASHONPLAFA evaluations have noted its resistance to change and reluctance to decentralize authority.

### *Physical Environment*

The infrastructure, layout and equipment of ASHONPLAFA are good, pleasant and support quality service delivery. The location of clinics—and of CBD distributors—is convenient, well publicized, and client friendly. The physical environment also supports employee effectiveness—clinics are well and appropriately equipped. In contrast to MOH facilities where physicians insert IUDs by the light of a flashlight held under their armpit, ASHONPLAFA clinics are fully and modernly equipped.

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<sup>4</sup>ASHONPLAFA fees are 3-4 times higher than the MOH's for oral contraceptives and fifteen times higher for VSC. In turn, service quality is higher.

## **Analysis of Ministry of Health: Strategy and Organization for Service Quality**

### *Technology/Systems*

Family planning services are one component of the MOH Reproductive Risk Approach aimed at reducing maternal mortality. The Approach, in turn, is one component of the integrated, large, and complex Health Sector II Project whose stated goal is "to contribute to the improvement of the health of Honduran people, particularly under the age of five years and pregnant and lactating women." The stated process is to "support, strengthen and continue the process of extension of coverage of efficient, sustainable and effective primary health care services and rural water and sanitation services with an emphasis on child survival services." The Health Sector II Project has had responsibility for developing the technology and systems for everything from ORS to vector control to family planning; in the last year it has also had to face prevention and treatment of cholera. In the project design, family planning was a minor project component of Health Sector II; accordingly, the design of systems, procedures, forms and formats to support it has not been a priority. There has, however, been slow progress since the highly critical evaluation of MOH family planning in 1988.

The logistic system is working effectively: it is relatively user friendly and service enhancing. Contraceptive supplies are now included in the MOH's reporting and requisition forms. Staff know how to use the system; staff interviewed by the team appeared comfortable with it and their capacity to manage it. The system is delivering contraceptives to the field; commodities are continuously in stock 95 percent of the time in CESARs and CESAMOs. In even small villages, orals and condoms are available at free or token cost. The implementation of a good service statistics system continues to be problematic; the system is not, as yet, either user friendly or service enhancing for staff, donors, or clients. New forms with data on number of visits, methods and services (new or control) pass information from the village level to Tegucigalpa. Staff understanding and use of the forms is inconsistent; staff in large urban CESAMOs appear to use them correctly; staff in some rural CESAMOs did not understand the forms; some did not appear to be using them. Donors, including the CDIE team, found the service statistics difficult to understand because the MOH is not using standard family planning indicators. The benefit to clients is unclear; to date, the statistics are not being used as internal mechanisms for control or follow-up.

### *Culture*

Unlike ASHONPLAFA where there is a homogeneous corporate culture on family planning, there has been profound disagreement on the value of family planning in the MOH. While consensus on family planning is building, there are reportedly three views on family planning within the MOH, ranging from firm support to opposition. One counter-family planning culture holds that family planning is an imperialistic anti-Honduran tool. Technical standards and protocols, which would be both a symbol and a support to quality service delivery, have needed revision for a number of years. Such revision, recommended by the 1988 evaluation, is planned but not begun. An IE&C program, which would be a public expression of MOH support for family planning, was under design for several years and was finally approved in May 1992, four years after Health Sector II began. The result of high level MOH policy disagreement and decentralization of authority for program planning is inconsistent quality in the field; individual MOH managers provide family planning services according to their personal convictions rather than on the basis of institutional values and norms. Some MOH facilities, directed by medical staff in favor of family planning, do the best they can to enable positive communication with clients, the provision of full information and quality procedures - even to the point of buying equipment for their clinics out of their own pockets. Other MOH facilities are passive or decline to offer services at all. This internal disagreement characterizes the MOH program in Honduras but not public sector programs in general. The family planning program in Mexico, a Latin American success model, has been led by the Mexican Social Security Institute; it has had the firm support of the Presidents of Mexico and the MOH. An Asian model is the program in Indonesia; the culture in the public sector supports family planning from the capital to the village leader.

Organizational culture is one of the most important indicators of quality and one of the slowest and hardest areas in which to affect change. Change agents, whether a new Minister of Health or A.I.D. itself, can quite rapidly train staff, buy equipment, and develop formats. Changing the organizational culture, however, takes commitment and effort over years. Although such change has been slow in Honduras, it appears that the process is underway. The current Minister of Health is a strong supporter of family planning and has indicated that he believes it is time for the MOH to be less timid.

### *Structure*

Two characteristics of the MOH structure, combined with policy disagreement, are important for family planning: integration and decentralization. In themselves integration and decentralization are neutral or even positive

characteristics. Other primary health services, such as child survival, which have unanimous MOH support, have succeeded beautifully under the structure. However, in a decentralized structure, integrated services for which there is not institutional consensus, as there has not been for family planning in Honduras, may not fare well. Services can plateau, get buried, and/or lost. They have done so in Honduras and MOH staff have not been held accountable for family planning performance as they have for child survival because there has not been firm policy support for those services.

### *Employees*

The involvement, commitment, and technical competence of MOH staff varies but is becoming consistently of a higher caliber. In 1990-1991 81 physicians and nurses were trained in IUD procedures and management. Many staff interviewed by the CDIE team in rural and urban MOH facilities expressed and demonstrated their commitment to providing the best services possible. They do so against considerable odds. CESARs and CESAMOs are understaffed to give high quality family planning services. Providing full information on a variety of methods, client counseling, and a medical exam take time—more time than the average MOH 10 minute patient visit. In rural sites a single professional staff member may assume all functions while 50 women and children wait their turn.

### *Management*

The Minister of Health is acknowledged as a family planning supporter; so much so, reportedly, that his appointment to the position was challenged by the Catholic Church until an agreement was reached that he would not aggressively push family planning during his term in office. The Minister told the CDIE team that the family planning program to date had not been successful and that he was resolved to be more aggressive in moving it forward. The challenge for the Minister is twofold; the first is to mobilize support for family planning so that service provision is routine and institutionalized and secondly, to promote improved quality for those services.

### *Service Design*

Family planning services are designed to meet client needs within a comprehensive network of primary health care services and referrals.

- Voluntary health workers (VHW) and midwives are the first level, providing counseling, condoms, and referrals. They are able to provide pill resupplies to clients who previously have seen a physician. VHWs and midwives provide services in even the tiniest communities.

- **CESARs, staffed by a nurse, provide counseling, condoms, resupply of pills and, in some CESARs where the nurse has been trained, IUDs.**
- **CESAMOs, staffed with physicians and nurses, provide all methods except VSC for which they provide referrals to either a MOH hospital or to ASHONPLAFA.**
- **MOH Hospitals provide a complete range of methods, often in collaboration with ASHONPLAFA. Postpartum counseling includes a segment on family planning.**

The MOH service design includes locating MOH facilities at the clients' convenience - small villages, the inner city, and out in marginal settlements. One excellent urban CESAMO the CDIE team visited was in the midst of a barrio high on the hillside outside Tegucigalpa. It was perfectly accessible to the barrio community; MOH staff rode buses and walked considerable distances to reach it each day. The medical director and most of his staff had worked there over five years; they were committed to the community and quality service delivery. In focus groups which the CDIE team conducted in Honduras, both MOH and ASHONPLAFA clients stated they liked the MOH constellation of services - and they like it better than the vertical programs of ASHONPLAFA. As one woman explained, "You know, pregnancy, birth and family planning are all part of the same process in a woman's life."

#### *Physical Environment*

While services have been designed to serve clients, the physical environment in which they are offered is poor for both clients and staff. The principal problem for clients is the long wait in crowded rooms with insufficient benches for even a majority of the waiting people. Clients state they must arrive at the Center by 6 a.m. to be sure of getting service that day and that they wait 2-5 hours for attention. The environment is also a handicap for staff attempting to give high quality services. Supplies and equipment are in short supply; sterilization capacity inadequate and even water in limited supply. In the CESAMOs the team visited, many physicians trained for IUD services were providing services in rooms with wooden platforms, torn mattresses, and no stirrups for examining tables, with flashlights instead of standing lamps. Proper and sufficient equipment would greatly assist these CESAMOs to provide quality services.

## APPENDIX D

### NATIONAL PROGRAM EFFORT: THE LAPHAM-MAULDIN SCALE

The CDIE evaluation team utilized the 30-item Lapham-Mauldin Family Planning Program Effort Scale (L-M Scale) to arrive at conclusions on program effort, defined as "the sum of the policies adopted and implemented; the activities carried out to provide family planning knowledge, supplies and services; the availability and accessibility of fertility regulation methods and the monitoring and evaluation of all of these."<sup>1</sup> The L-M scale has four components: (1) policy and stage-setting activities; (2) service and service-related activities; (3) record keeping and evaluation; and (4) accessibility and availability of methods and services. The score range on each of the 30 items is zero to four with four indicating a strong policy, effort, or performance. The maximum total score which is possible is 120. Country scores are divided by 120 to give a percentage score which is then classified as follows.

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Program Effort Classification	Percentage Score
Strong	67 and higher
Moderate	46-66
Weak	21-45
Very weak or none at all	0-20

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The principle lying behind the L-M scale is that for a family planning program to be judged making strong efforts, it need not have a high score on every item. A strong program is one which scores well across the four components.

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<sup>1</sup>Accessibility and availability are defined in terms of ready and easy access, meaning that clients spend no more than an average of two hours per month to obtain contraceptive supplies and services and that the cost is not burdensome.

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## The 1982 and 1989 Application of the Scale In Honduras

Program effort in Honduras doubled from 1982 to 1989 according to the L-M scores of 1982 and 1989. As Table 1 illustrates, the scores more than doubled overall and rose significantly in each category. The Table figures in parentheses are the maximum scores possible for that component. The most dramatic increase in effort was in *Record Keeping and Evaluation*.

Given that the total possible L-M score is 120, the 1982 Honduras score of 30.30 was 25 percent; the 1989 Honduras score of 75.42 was 63 percent. According to these scores, Honduras rose from a weak country effort in 1982 to the high end of a moderately strong country effort 7 years later. As will be noted below, the 1992 CDIE team did not believe the 1992 effort was that strong.

**Table 1. L-M Program Effort by Component, 1982, 1989 and 1992**

Program Effort Component	1982	1989	1992
Policy and stage-setting activities (32)	7.70	14.67	13.40
Service and service-related activities (52)	10.20	33.70	28.78
Record keeping and evaluation (12)	1.80	9.80	8.00
Availability and accessibility of fertility-control supplies and services (24)	10.60	17.25	14.30
<b>TOTAL SCORE</b>	<b>30.30</b>	<b>75.42</b>	<b>64.48</b>
Program Effort level (total score divided by 120)	25	63	54

There was major effort and progress from 1982 to 1989 in *policy and stage-setting activities*. In November 1983 Ministerial Resolution No. 202-83 was published calling for a national family planning program integrated in the Maternal and Child Health Division of the MOH. In 1984 family planning Standards and Regulations were drawn up including Resolution No. 141-84 which laid out regulations for Voluntary Surgical Contraception (VSC). The National Development Plan for 1987-1990 called for decreasing the rate of population growth by the provision of educational measures at the primary and secondary levels, by support to family planning programs of the Ministry of Health and the

Social Security Institute and by coordination with private sector organizations. The L-M Scores of 1982 and 1989 reflect the real increase in effort: 7.70 in 1982 and 14.67 in 1989. The CDIE team, however, believed the 1992 score was higher than warranted; see below for discussion.

From 1982 to 1989 there was also great effort, principally on the part of ASHONPLAFA, in *Service and Service Related Activities*; the score rose from 10.20 to 33.70 during this period. In 1983 ASHONPLAFA began its social marketing program; the oral contraceptives Perla and Norminest were introduced into the market the following year. The low-dose Norminest was introduced in 1987. The A.I.D. centrally funded project Social Marketing for Change (SOMARC) provided technical assistance. There was an expansion of the Community Based Distribution Program (ASHONPLAFA calls it Community Services Program). A 1987 evaluation judged the program to be one of the more efficient programs in the hemisphere in terms of family planning users per distributor and supervisor and in terms of cost per couple-years-of-protection. The number of distributors had increased to 1,478 by 1989.

The 1982 and 1989 scores indicate major increased effort in the administrative structure, training program, personnel carrying out assigned tasks, and logistics and transport. The scores must have been based on ASHONPLAFA's effort and the proposed effort of the MOH. During this period, although there was some MOH effort, the family planning program in the MOH essentially disappeared.

The L-M Scores show the greatest increase in effort from 1982 to 1989 in *Record Keeping and Evaluation*. They rose from 1.8 out of a potential score of 12 to 9.80 in 1989. During this period there were three national health and demographic surveys which built upon a 1981 Contraceptive Prevalence Survey. In 1983 a National Demographic Survey was conducted. In 1984 a Maternal and Child Health/Family Planning Survey was carried out by the MOH and ASHONPLAFA. In 1987 an Epidemiology and Family Health Survey, modeled after the 1984 Survey, was conducted.

These surveys were conducted with good technical assistance and in collaboration with a number of national and international demographic and health institutions, including the Honduras General Directorate for Statistics and Census, the Latin American Center for Demography (CELADE), Family Health International, Management Sciences for Health, the MOH and ASHONPLAFA. The surveys were designed in part so their results could be used to evaluate and restructure the maternal child health and family planning programs carried out by the MOH, IHSS and ASHONPLAFA as well as to aid in the design of new projects.

## 1992 Use of the L-M Scale by the CDIE Team

After three weeks of field study in Honduras, the five member CDIE team ranked the Honduras family planning program effort using the L-M scale. CDIE's use of the L-M Scale was based only on a reading of L-M literature and lacked the rigor of other published L-M results. Therefore, the CDIE scores reported below are presented only for discussion purposes, and are not necessarily comparable to the two earlier published L-M ratings of the Honduras program. CDIE's initial application of the L-M scale was on the national effort as a whole. Having noted a major difference between the effort of the MOH and ASHONPLAFA, the team then decided to rank the two efforts separately. In this second application, equal scores were given both to both of the institutions for L-M items 1-10 and item 30 which represent truly national characteristics that encompass both the MOH and ASHONPLAFA. The two institutions were given separate, different ratings on items 11-29.

Overall conclusions concerning the four major components of the scale are the following:

*Policy and stage setting activities:* The 1992 judgement was that Honduras' effort in policy was, in L-M terminology, weak. The CDIE team gave the country a 2.40 on policy on fertility reduction and family planning, noting that within the MOH there is disagreement on family planning policy and that last year an attempt to pass a Population Law failed in the face of Catholic Church attacks and the unwillingness of MOH family planning supporters to come forward in its support. The team noted that although legally contraceptive advertising is allowed, there are social restrictions and prohibitions which effectively limit such advertising.

*Service and service-related activities:* The CDIE team gave this area a total score of 28.78 versus 33.70 in the 1989 application. Here, most particularly, the weak effort of the MOH pulled the national score down. Individual scores were 15.14 for the MOH and 37.13 for ASHONPLAFA. The two are therefore discussed separately.

The MOH has a weak CBD program, no social marketing, and has had no family planning IE&C. The administrative structure has been in transition from centralized authority to decentralized. As yet the structure does not work satisfactorily to assure family planning resources, supervision, and support that are available at the different MOH levels of service delivery.

On the other hand, the ASHONPLAFA program is strong. Although it is not perfect, ASHONPLAFA has good CBD and social marketing programs; the administrative structure functions to support ASHONPLAFA's policies and strategies, to get personnel and resources where they are needed; and staff are trained and carry out their jobs.

*Record keeping and evaluation:* In this component, as in service and service-related activities, it was the weak effort and performance of the MOH which led the CDIE team to score national effort as 8.00 out of a potential 12.00; the ASHONPLAFA effort was strong. The 1989 score was 9.80, presumably based upon the ASHONPLAFA effort in record keeping and evaluation.

Although the MOH has established a new services statistics system, the CDIE team felt the data produced by it was neither reliable or valid. Service indicators were not standard family planning indicators. MOH facilities were interpreting the formats differently and erratically. Logistics supply and usage data could not be reconciled with the service statistics; sometimes a pharmacy within a CESAMO or CESAR reported distributing more contraceptives than users and other times considerably less.

*Availability and accessibility of fertility-control services and supplies:* In 1989 Honduras had a score of 17.25 out of a possible 24 or 75 percent. At that time Lapham and Ross gave Honduras the top scores on points 26-28: female sterilization, pills and injectables and condoms, spermicide and diaphragms indicating that there was ready and easy access to these services. The CDIE team did not believe that there truly was ready and easy access. A principal barrier to female sterilization is cost and distance for rural women. Sterilization is available in six ASHONPLAFA clinics and in MOH hospitals, however, data indicates that rural women find it hard to reach those facilities; the costs of transportation and time are the impediments.

Ready and easy access to pills and condoms other than through CBD and social marketing programs is through the six ASHONPLAFA and the many MOH facilities. Cost is a factor in the ASHONPLAFA services where fees are two to three times those of the MOH. In the MOH facilities, time (2-6 hour waits for service) is an impediment.

**LAPHAM AND MAULDIN PROGRAM EFFORT:  
1982, 1989 AND 1992**

<b>Program Effort Measures</b>	<b>1982 score</b>	<b>1989 score</b>	<b>1992 score</b>	<b>MOH score</b>	<b>ASHON score</b>
<b>Program effort score</b>	30.30	75.42	64.48	44.32	76.49
<i>policy and stage setting activities (32)</i>	7.70	14.67	13.40	13.4	13.40
1. policy on fertility reduction and family planning	2.00	4.00	2.40	2.40	2.40
2. statements by leaders	2.00	.00	.80	.80	.80
3. level of program leadership	.00	.67	.80	.80	.80
4. policy at age of marriage	.00	.00	1.20	1.20	1.20
5. import laws and legal regulations	1.00	4.00	3.40	3.40	3.40
6. advertising of contraceptives allowed	2.00	4.00	2.80	2.80	2.80
7. involvement of other ministries and public agencies	.70	2.00	2.00	2.00	2.00
8. % of in-country funding of family planning budget	.00	.00	0	0	0
<i>Service and service-related activities (52)</i>	10.20	33.70	28.78	15.14	37.13
9. involvement of private-sector agencies and groups	2.00	3.00	3.50	3.50	3.50

10. civil bureaucracy involved	.00	.00	.80	.80	.80
11. community based distribution	3.20	4.00	3.50	1.20	3.50
12. social marketing	.00	4.00	3.20	0	3.50
13. postpartum program	.50	.62	1.50	1.40	1.84
14. home-visiting workers	.00	.50	1.30	1.06	2.20
15. administrative structure	.00	3.00	1.80	.84	3.40
16. training program	.50	4.00	2.60	1.74	3.30
17. personnel carry out assigned tasks	1.00	4.00	2.70	1.60	4.00
18. logistics and transport	.50	2.83	2.30	1.50	3.38
19. supervision system	.50	4.00	2.70	.90	3.78
20. mass media for IEC	1.00	3.75	2.38	.60	3.10
21. incentives and disincentives	1.00	.00	.50	0	.63
<i>Record keeping and evaluation (12)</i>	1.80	9.80	8.00	3.90	8.26
22. record keeping	1.00	3.50	2.70	1.50	3.70
23. evaluation	.80	3.80	3.00	1.20	3.70
24. management's use of evaluation findings	.00	2.50	2.30	1.20	2.40
<i>Availability and accessibility of fertility-control supplies and services (24)</i>	10.60	17.25	14.30	11.88	16.16
25. male sterilization	1.00	1.50	1.50	.20	1.80

26. female sterilization	1.10	4.00	2.80	1.80	3.40
27. pills and injectables	3.00	4.00	3.40	2.80	3.70
28. condoms, spermicide, foam and diaphragms	3.00	4.00	3.40	2.78	3.50
29. IUDs	1.80	2.75	2.60	2.20	3.16
30. abortion	.70	1.00	.60	.60	.60

## POLICY AND STAGE SETTING ACTIVITIES

### 1. POLICY ON FERTILITY REDUCTION AND FAMILY PLANNING

Honduras has no population law or policy on fertility reduction and family planning. Nor is there any explicit resolution on the right of couples to choose the timing and size of their families. However, there have been several documents which recognize its importance and several Ministerial resolutions which provide official support for family planning on the operational level. In November 1983, Ministerial Resolution No. 202-83 was published calling for a national family planning program integrated in the Maternal and Child Health Division of the MOH. In 1984, family planning Standards and Regulations were drawn up including Resolution No. 141-84 which laid out regulations for Voluntary Surgical Contraception (VSC). The National Development Plan for 1987-1990 called for decreasing the rate of population growth by the provision of educational measures at the primary and secondary levels, by support to family planning programs of the Ministry of Health and the Social Security Institute, and by coordination with private sector organizations.

Since that time, the MOH policy has been that family planning is to be dealt with in the context of child spacing for maternal health. The emphasis is on maternal health rather than personal choice or demographic concerns. Child spacing (family planning) is one component within the Reproductive Risk Approach and one component in the large Health Sector II Project. The budget for the birth spacing component is U.S. \$3.0 million from A.I.D. (5 percent of A.I.D.'s contribution) and U.S. \$25,000 from the GOH (.001 percent of the GOH contribution).

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## **2. STATEMENTS BY LEADERS**

Whatever their personal opinions, high officials do not speak publicly and favorably about family planning for fear of the church and for fear of being identified with foreign-imposed population control. Although in the last 6 months there have been no attacks, the Catholic Church regularly and loudly attacks family planning and the institutions that support it. Newspaper articles present those attacks on the front page with headlines such as "Deputies fear burning in Hell and do not approve projected Population Law." Other leaders' statements against family planning are also printed: "Foreigners are sterilizing by injection more than 3,000 women, says Director of the Honduran Workers Federation." Although privately the current Minister of Health supports family planning and expresses disappointment with the MOH performance, he does not openly advocate or support family planning in the MOH or with the public. On this L-M component there has been little progress in the last 10 years.

## **3. LEVEL OF PROGRAM LEADERSHIP**

Within the MOH there is no formal national family planning program or national leadership on family planning; family planning services are one component of the maternal/child health program and offered within the Reproductive Risk strategy. That strategy has been implemented very slowly. In the fall of 1991 at mid-term of the Health Sector II Project, only 17 percent of the women's health care budget had been expended. In May 1992 the design of the IE&C program was finally approved. The Minister of Health confided to the CDIE team that he felt the MOH's program is too small and cautious; he described the program as "fearful" and "timid" and believes the time is right for a more aggressive program.

## **4. POLICY AT AGE OF MARRIAGE**

The official policy is that girls must be 18-years old to marry with their parents' permission and 21 years without it. However, two factors weaken the effect such a policy might have upon fertility. First, reportedly a large percentage of pregnancies and births occur outside marriage or formal unions. Secondly, in rural areas girls are in union at 15-16 years regardless of the official policy.

## **5. IMPORT LAWS AND LEGAL RESTRICTIONS**

There are no restraints on the importation or sale of contraceptives by pharmaceutical companies. There are regulations on sterilizations: women must be at least 24-years old and have three children. Although these restrictions on age and parity are unfortunate, they are an improvement over the previous

restrictions which limited sterilization to women over 30 years. Abortions are illegal but there is no indication of legal sanctions being pursued against women who have them or those who perform them.

#### **6. ADVERTISING OF CONTRACEPTIVES ALLOWED**

There are no legal restrictions against advertising contraceptives; however, the social climate and fear of the Catholic Church makes both the private and public sectors cautious about such advertising.

- There is no advertising on TV.
- Radio is used extensively to promote family planning and ASHONPLAFA.
- Several billboards in Tegucigalpa promote condoms. The billboards are discrete and present the word "Guardian" and a picture of a couple in the moonlight. The billboard would be meaningless to a viewer who did not know that "guardian" is a brand of condoms.

#### **7. INVOLVEMENT OF OTHER MINISTRIES AND PUBLIC AGENCIES**

The Honduran Institute of Social Security (IHSS) has a Reproductive Risk Program which contributes to the national program in two important ways. First, the IHSS program is important for the services it delivers. The 1987 EFHS attributed 10 percent of VSC to the IHSS. Furthermore, the program is innovative; in San Pedro Sula, where the program is the largest, an employment-based program offers family planning counseling and services in 80 different companies in the San Pedro Sula area. Quality is acknowledged to be relatively good. Several family planning users commented in focus groups that counseling on all methods, including natural methods, was very good. The IHSS was the only institution described in focus groups as providing full information on all methods, including natural methods. As an example of public sector commitment to family planning. The IHSS family planning program is recognized by clients and professionals as being more advanced than the MOH's. Services are more comprehensive and quality is better. The program demonstrates that the public sector can do more and better work in reproductive risk if there is strong advocacy. But the program does have it problems. IHSS is nearly bankrupt and is facing an administrative and funding crisis which could result in a radical restructuring in the future.

**8. PERCENTAGE OF IN-COUNTRY FUNDING OF FAMILY PLANNING BUDGET**

A.I.D. continues, after 25 years, to support most of the family planning services in Honduras. Lapham and Mauldin gives a top score if in-country sources provide 85 percent or more of the national family planning budget; no score is given if these sources provide less than 50 percent.

In Honduras in-country support is as follows:

- MOH: The GOH provides 1 percent of the MOH's child spacing budget.
- ASHONPLAFA: 26 percent from in-country sources
- IHSS: A.I.D. provides all contraceptives and some training.

Honduras receives a zero on this item since the total family planning budget available from in-country sources continues to be less than 50 percent.

**SERVICE AND SERVICE RELATED ACTIVITIES**

There is a division of labor between the public and private sectors that will be efficient when public sector services become more effective. The 1991 survey data showed that roughly one-third of users obtain their services from each of the available providers: the Ministry of Health, ASHONPLAFA, and commercial sources.

**9. INVOLVEMENT OF PRIVATE-SECTOR AGENCIES AND GROUPS**

The private sector is the source of supply for the two most common methods: orals which accounted for 13.4 percent of contraceptive prevalence in 1987 and voluntary female sterilization which accounted for 12.6 in the 1987 study. The 1987 EFHS attributed 78.9 percent of oral contraceptives to the private sector: to ASHONPLAFA, 52.5 percent and to pharmacies, health shops, private MDs, and hospitals another 26.4 percent. In 1987 ASHONPLAFA, either directly in its own clinics or in collaboration with the MOH or private MDs and clinics, provided 71.4 percent of the female voluntary sterilizations. Private practitioners performed an additional 15.2 percent of the sterilizations, independently of ASHONPLAFA. In 1987 the MOH and IHSS accounted for only 10.9 percent, independently of ASHONPLAFA. ASHONPLAFA has been the lead actor in family planning in Honduras for the last 25 years. ASHONPLAFA

leads in the delivery of family planning services, training, family planning education, and communication and as a catalyst for other institutional involvement in family planning. A.I.D. has actively supported private sector involvement. In addition to support of ASHONPLAFA, A.I.D. has supported the development of family planning services in PVOS through both direct grants and through a buy-in to the Population Council to promote family planning in PVOs serving rural communities.

A.I.D. has a grant with PLAN Tegucigalpa and supports PLAN programs in San Pedro Sula and PLAN Santa Rosa through the Population Council. Together these PLAN programs directly assist 24,000 families. Also, through the Population Council, A.I.D. supports family planning IE&C in Save the Children which works with 6,000 families in marginal barrios of Tegucigalpa and in two rural areas of the country. Technical assistance is provided through the Population Council to AHLACMA (Honduran Association for Maternal Lactation), to La Leche League and a project is being developed with CARE. The rationale for support to a group of institutions with a potentially relatively small impact on the CPR lies in the belief they can provide support to the national policy framework. They have prestige and credibility in rural areas and serve as a good endorsement for family planning.

Support to PVOs has not been without its problems. Original goals with PLAN were for direct delivery of services and for financial assistance and transport of rural women to ASHONPLAFA for voluntary sterilizations. However, after the project agreement was signed, PLAN's Regional Office vetoed the direct service delivery component; PLAN's principal role at this time is IE&C and referral.

#### **10. CIVIL BUREAUCRACY INVOLVED**

Because family planning is a minor component among 15 components of the large and complex Health Sector II Project and is, moreover, only one component of the Reproductive Risk Program, MOH staff and bureaucracy are not, understandably, focused upon family planning. However, even given that family planning is a minor activity for the MOH, there are highly polarized opinions about the commitment of the government at different levels to this activity. Some factions indicate there is commitment to family planning at the highest and regional levels; that the bottleneck lies in middle management at the Ministry. Other factions indicate this Ministry is committed and doing the best it can under the circumstances and hostile social environment. Whatever the causes, it is apparent that implementation of the Reproductive Risk Approach has progressed slowly and that the overall commitment to the success of the program has not been sufficient to ensure timely design or implementation.

### 11. *COMMUNITY BASED DISTRIBUTION*

ASHONPLAFA has an excellent Community Based Service Program with nationwide coverage. Services are available in over 2,200 locations in all 18 departments and in all but 26 of 263 counties in Honduras. The program of the MOH is weaker. Services continue to be limited. Condoms and vaginal tablets are available from some *guardianes* and *parteras*, at some times. On the basis of the ASHONPLAFA program, Honduras would receive a top L-M score of four.

### 12. *SOCIAL MARKETING*

There are four classical components in marketing: product, price, place, and promotion. ASHONPLAFA has instituted a social marketing program which is strong in three of the four: product, price, and place. Promotion is weak. Pills are available at subsidized prices in 17 cities through an ASHONPLAFA contract with MANDOFER, the leading pharmaceutical company in Honduras. However, "only a limited amount of promotion and advertising has been accomplished."<sup>2</sup> Obviously although subsidized prices and wide distribution are important, promotion and advertising are essential to increased contraceptive usage. The failure to do so significantly weakens the program. A CDIE team visit to six pharmacies in Tegucigalpa revealed that three of the six carried subsidized oral contraceptives. In each of the three pharmacies there were significant weaknesses. For example, although the packaging of the pills themselves was well and attractively done, there was no advertising for these contraceptives in the store. Another problem is that staff who sold the contraceptives gave inadequate or incorrect information about their usage. "All oral contraceptives reduce the amount of milk a lactating mother will produce." "None of the four brands in the pharmacy, including Perla, Norminest, Ovrал and Denoval, would affect a mother's milk production." "Age is not a factor in usage—any woman regardless of age can safely take them." "All pills are equal." "All pills cause facial spotting." There is no MOH program. Less than a L-M score of four seems appropriate.

### 13. *POSTPARTUM PROGRAM*

The 1987 EFHS reported that 60 percent of the births occurred at home, roughly the same percentage as 1984. Home births accounted for 11 percent of all deliveries in Tegucigalpa and San Pedro Sula; 36.1 percent in other urban areas and 79.3 percent in rural areas. Traditional Birth Attendants (TBAs) attended 48.3 percent of all deliveries, two thirds of all rural births and four fifths

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<sup>2</sup>1992 Evaluation Honduras Private Sector Population II Project, page 12.

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of all home births. Approximately 10 percent of all births were not attended by a health worker. Good hospital-based post-partum programs are difficult to run in Honduras due to the short maternity hospital stay. Due to overcrowding, hospital stay is very short. For example, the Hospital Escuela, the main maternity hospital in Tegucigalpa, reports that last year there were approximately 19,000 births in a facility built to accommodate 5,000 births a year. The result is that women must leave as soon as possible after giving birth: 5-8 hours for normal deliveries, 48 hours for Caesarean Sections. Despite the short "window of opportunity" for counseling and the very crowded conditions for holding an effective information and education service, the Hospital does offer two talks daily for post-partum women. The talk covers care of a newborn, breastfeeding and family planning. A low L-M score seems appropriate despite the efforts of hospital staff to provide such a program.

#### 14. HOME-VISITING WORKERS

Both the MOH and ASHONPLAFA have home visiting programs in urban areas. ASHONPLAFA has a home visiting program, focused exclusively on family planning, out of each of its six regional centers. The MOH has Volunteer Health Workers (VHW) in Tegucigalpa and other cities. The VHW's responsibilities include child health, communicable diseases, vector control and family planning. Home-visiting programs are weaker in rural programs and focus on health in general. The population that is covered by such programs is the population affiliated with one of the international NGOs. PLAN en Honduras has an excellent community volunteer program in many rural communities throughout the country. Save The Children, La Leche League, and others have similar but smaller programs.

#### 15. ADMINISTRATIVE STRUCTURE

The administrative structure of ASHONPLAFA is currently adequate in the Lapham-Mauldin terminology; it is, moreover, in the process of regionalization, the goal being to delegate authority and responsibility to the six ASHONPLAFA regional offices for regional program planning and operations. When that process is completed ASHONPLAFA will more effectively and efficiently administer local programs.

The administrative structure of the MOH is in transition. Health Sector II is transferring decision making and resources to the regional level. "Sub-regional areas and health centers, however, in most regions, still lack an adequate and dependable flow of resources to enable them to service delivery needs in a timely manner. In effect, resources and authority have now become centralized at the regional level... The Ministry currently has no internal regulation which defines

its organizational structure (chain of command) or the functions and responsibilities of its many normative and operational units... nor do there exist clear and efficient mechanisms to insure coordination of policies and actions either internally or with other agencies. This lack of definition and consensus seriously impedes progress of HSII goals and strategies."<sup>3</sup> The structure does not provide sufficient support and supervision to CESAMOs and CESARs. CESAMOs are understaffed and underfunded to provide quality accessible and available family planning services. Patients wait 2-6 hours, in waiting rooms without sufficient benches for most people to sit down, for a ten minute visit with a physician or nurse. Clinic staff have insufficient equipment and supplies: examining tables, lamps, chairs, IUD instruments, sterile supplies, etc. They state that they appeal to the MOH for more equipment and supplies to no avail. The MOH staff stated that the MOH answer is that there are no funds; yet the maternal care component of the Health Sector II Project is underspent. By June 30, 1991, after 3 years of HSII, only 17 percent of the funds for equipment and supplies for maternal health had been spent.

#### **16. TRAINING PROGRAM**

The design of the current Private Sector Population Project placed a large emphasis on training. U.S. \$800,000 was budgeted over 5 years for training staff within ASHONPLAFA and other institutions. The goals for 1989-1991 have been substantially achieved; shortfalls were noted in training for MIS, management training, pharmacists, and male VSC. The 1991 training budget was significantly underspent.<sup>4</sup> The 1992 Private Sector Population Project Evaluation recommended a reorganization of training, which is currently managed by the Evaluation and IEC Departments, through the development of an ASHONPLAFA Training Department. "At present training is a secondary activity at the Evaluation Department and only a limited time can be devoted to training." The development of a unified Training Department would increase the capacity and efficiency of ASHONPLAFA training; additionally, renewed emphasis should be given to training as a matter of policy. Reportedly one reason for underspending the training budget was attempted "cost control" to increase levels of ASHONPLAFA self-financing. The MOH has devoted considerable effort to training physicians and professional nurses in IUD management. Every CESAMO the CDIE team visited had at least one staff member trained in family planning

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<sup>3</sup>Report of the Health Sector II Project External Mid-Term Evaluation, Presented to U.S. Agency for International Development, Tegucigalpa, Honduras, March 1992.

<sup>4</sup>782,710 Lempiras budgeted; 431,636 spent.

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and IUD management. However, as the Health Sector II Evaluation noted, there is a continuing need for training MOH staff at all levels and particularly at the community and CESAR level.

#### **17. PERSONNEL CARRY OUT ASSIGNED TASKS**

ASHONPLAFA staff receive high scores on this point. The performance of the MOH, however, is variable and inconsistent. Within the Ministry there is disagreement on the importance of family planning and implementation of the Reproductive Risk Approach has been slow. Staff within the Ministry give the impression of prolonging the design phase of the Reproductive Risk Approach interminably. For example, the design of a national IE&C program was not approved until May 1992, 4 years after Health Sector II began. The process of revising and updating Department standards, identified as a necessity in the 1988 evaluation, is reportedly planned but not yet begun. At the service delivery level there is apparently a greater commitment to implementing services. In underequipped CESAMOs, the CDIE team observed that staff had brought equipment from home, including stethoscopes, lamps, tables and chairs so that they could carry out their job. Also, lack of a clear family planning policy and decentralized authority leaves regional managers free to establish local family planning policies. Some MOH facilities offer no family planning services. The MOH Hospital in Chaluteca offers no services; neither do several CESARs and CESAMOs including one in Tegucigalpa. The issue appears to be a lack of a policy requiring all MOH facilities to provide family planning services rather than one of supervision.

#### **18. LOGISTICS AND TRANSPORT**

The 1988 evaluation of the MOH Family Planning Program was highly critical of the MOH logistics system. It noted at that time that logistics and supply were a constant problem and that in 1986 contraceptives were unavailable in 60 percent of the CESARs and CESAMOs. The MOH system has been significantly improved since that time. Considerable attention has been given, both directly and indirectly, in the Health Sector II Project to management of family planning commodities and to improving the contraceptive logistic system. Contraceptives are now included in the Ministry's standard medication list (previously it was necessary to secure special permission from the DSMI to authorize contraceptive shipments). Reportedly all contraceptive supplies, including the newly introduced progestin-only mini pill, and those that are not pharmaceutical, are now included in the MOH reporting and requisition forms. Data on contraceptive availability at a randomly selected sample of CESARs and CESAMOs is collected by the MOH/MSH teams. A recent sample indicated that orals and condoms had been

continuously available for the previous three months.<sup>5</sup> Orals were available in all the CESARs and CESAMOs the C.D.I.E. team visited. The Health Sector II Mid-term Evaluation Team noted in November 1991 that the Central Warehouse was out of low-dose oral contraceptives. It noted that regional stocks were adequate but expressed concern that supply gaps might occur later. The Private Sector Project Evaluation Team gave ASHONPLAFA high marks on its logistics system. It noted that the "logistics system is reliable with clean and cool warehousing of medical commodities, careful stock records, FIFO use system and input of the data into the MIS." Since 1987 when Honduras logistics was ranked 2.83 on the L-M effort scale, there has been significant improvement nationwide.

#### **19. SUPERVISION SYSTEM**

The supervision system of ASHONPLAFA is adequate by L-M criteria. As noted under the Administrative Structure, the MOH has decentralized decision-making and resources to the regional levels. Local programming, including family planning, is to be done on a decentralized basis. The MOH now needs to officially define its organizational structure and the functions and responsibilities of its various units to support decentralization and promote accountability. Supervisory systems have been developed, but to date not institutionalized. Implementation of the system is currently dependent on directors and nurse supervisors. Job descriptions based on required behaviors and assigned tasks are needed before the new system can be successfully implemented.

#### **20. MASS MEDIA FOR IE&C**

ASHONPLAFA has an IE&C program targeting most of the country on a regular basis. ASHONPLAFA reports that 117,011 (1990) and 120,711 (1991) radio messages were broadcast in most of the country by 55 radio stations. The only exceptions to this coverage were Islas de la Bahia and Gracias a Dios, two of the less developed areas in the country. ASHONPLAFA has used the radio for broadcasting spots, talk shows, and messages about family planning.<sup>6</sup> Additionally, ASHONPLAFA provides talks and courses. Fifty billboards have been put up around the country. Although ASHONPLAFA carries out numerous activities to reach new family planning users, particularly in the rural areas, the MOH has made no use of the mass media for family planning IE&C. In May 1992 the design of a MOH IE&C program was finally approved.

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<sup>5</sup>ANNEX J, "Women's Health Care, Report of the Health Sector II Project Mid-Term Evaluation, March 1992, page 7.

<sup>6</sup>Reported in the 1992 Private Sector Population Project Evaluation.

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## 21. INCENTIVES AND DISINCENTIVES

Currently there is one important incentive program: ASHONPLAFA CBD distributors keep a percentage of the revenues from sales of pills and condoms. Previously there had been an additional incentive program for community-based distributors, promoters, and supervisors. This program has been discontinued and is currently under review by ASHONPLAFA. The results of the second incentive program had been inconclusive. The Private Sector Population Project Evaluation team concluded that their qualitative evaluation data suggested "some lack of knowledge about the plan, enthusiasm of those who had received an incentive and a little resentment on the part of those who thought the system unfair." They noted it might be perceived more favorably if it were managed regionally. Formerly, ASHONPLAFA provided a payment to MOH physicians for sterilizations; this practice has been discontinued.

## RECORD KEEPING AND EVALUATION

### 22. RECORD KEEPING

The 1992 Private Sector Population Project Evaluation reviewed ASHONPLAFA's record keeping. The Report noted that record keeping is reliable; ASHONPLAFA uses standard indicators and a follow-up system to check data. It noted however, that processing of data is slow. The MOH has developed an improved service statistics system but its implementation has been inconsistent and doubt and confusion exist at the CESAR and CESAMO level about the use of new formats. Some facilities the CDIE team visited understood and appropriately used the new MOH service statistics forms. Others did not; two rural CESAMOS apparently were not using them. Even among MOH facilities using the system. Data are erratic and unreliable; logistic supply and usage data cannot be reconciled with services statistics; some pharmacies report distributing more contraceptives than users while other underreport.

### 23. EVALUATION

In Honduras this point can be viewed at three levels: national health and demographic studies; within the MOH; and within ASHONPLAFA. At the national level Honduras ranks high on the L-M scale. The country has carried out national demographic and health studies in 1971-72, 1981, 1983, 1984, 1987 and has just completed the analysis of the latest study, conducted in 1991. The MOH has been stronger in implementing special studies than it has been in institutionalizing family planning evaluation within the MOH. The strongest recent MOH activity was the 1990 national study of mortality in reproductive age

women generally and maternal mortality specifically. This study reportedly provided Honduras with its first scientifically derived estimate of maternal mortality and was cited as a basis for generating increased MOH support for family planning. Currently an operations research project is being developed on "Lost Opportunities in Family Planning." However, on other L-M indicators of evaluation program effort the MOH does not fare as well. There is no evaluation unit seriously examining family planning data. ASHONPLAFA has an evaluation unit which produces quarterly and annual family planning service statistics reports and conducts small in-house sample survey studies on program aspects. The unit collaborates with other institutions and was a lead collaborator in the national demographic studies.

#### **24. MANAGEMENT'S USE OF EVALUATION FINDINGS**

It is difficult to judge the MOH's use of research and evaluation findings to improve the family planning program when in fact there have been no clear family planning objectives against which to measure performance and no evaluation unit routinely undertaking such assessment. The 1992 Private Sector Population Project Evaluation of ASHONPLAFA questioned management's use of evaluation findings. Speaking of the quarterly and annual data the evaluation unit produced, the Evaluation Report noted "Much of the data is published without analysis or discussion of management implications."

### **AVAILABILITY AND ACCESSIBILITY OF FERTILITY-CONTROL SUPPLIES AND SERVICES**

#### **25. MALE STERILIZATION**

Male voluntary sterilization accounted for .2 percent of contraceptive prevalence in the 1984 MCH/FP study and in the 1987 EFHS. Male voluntary sterilization is available on Saturday mornings in ASHONPLAFA clinics in Tegucigalpa and San Pedro Sula. Vasectomies represented 1.7 percent of ASHONPLAFA's sterilizations in 1991.

#### **26. FEMALE STERILIZATION**

High quality female voluntary surgical contraception (VSC), sterilization, is legally and openly available to women 24-years old who have had three children through: (1) ASHONPLAFA's six regional centers in Tegucigalpa, San Pedro Sula, La Ceiba, Choluteca, Santa Rosa de Copan and Juticalpa; (2) private physicians, in collaboration with ASHONPLAFA and upon their referral, in seven cities where ASHONPLAFA does not have sterilization services; or (3) in most

MOH hospitals (the CDIE team found the MOH hospital in Choluteca does not offer any family planning services). The principal barrier to ready and easy access in rural areas is the monetary and time cost of transportation to the nearest clinic. A.I.D. has tried to reduce excessive transportation cost and time requirements for users in the Private Sector Population Project. One component of this project was to provide funding to the PVO PLAN International in Honduras to subsidize transport or provide special transportation direct to clinics. Although such an arrangement seemed initially promising, it was vetoed at the PLAN International Headquarters level. As a result, solutions to the problem of rural access are still being sought.

### **27. PILLS AND INJECTIBLES**

Pill refills are available, theoretically, in all CESARs, CESAMOs and hospitals after an initial consultation with a physician at a CESAMO or hospital. MSH/MOH data reported that a recent random survey of CESAMOs and CESARs indicated that in 95 percent of those sampled, low dose orals had been continuously available for the last three months. The CDIE team confirmed this availability. Limiting access, however, are two factors: (1) the long wait at CESARs and CESAMOs, and (2) authority of local administrators to decide the nature of their family planning program. Although in fact it does appear that most MOH facilities do at least stock contraceptives, in a few exceptions no services are offered, including one in Tegucigalpa due to the opposition of the local priest.

### **28. CONDOMS, SPERMICIDES, FOAM AND DIAPHRAGMS**

Condoms are available theoretically in all MOH health facilities. MSH/MOH data reported that a recent random survey of CESAMOs and CESARs indicated that in 95 percent of those sampled, condoms had been continuously available for the last three months.

### **29. IUDs**

The prevalence of the IUD has been low in Honduras: 2.9 percent in 1987. One reason has been access. Until recently IUDs have been available only at ASHONPLAFA clinics and at MOH hospitals. In 1990-1991, however, ASHONPLAFA trained 81 MOH physicians and professional nurses in IUD management; those staff are positioned in CESAMOs and hospitals throughout the country. Access to this service has been greatly improved. Resources must now

be invested in sufficient equipment and supplies so that staff can perform the service. The CDIE team encountered several CESAMOs with trained staff but insufficient clinic equipment (tables with stirrups and lamps) and insufficient IUD instruments and supplies.

**30. ABORTION**

Abortions are illegal; however, the 1987 EFHS found that 24 percent of women reported having had at least one abortion. The Hospital Escuela in Tegucigalpa, the largest maternity in the city, reported that approximately 33 percent of its maternity beds were occupied with abortion patients, including both spontaneous and induced abortion.

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