

March 20, 1989

MEMORANDUM

TO: Anita Siegel, USAID/Honduras

FROM: J.J. Pansini, Consultant/URC

SUBJECT: Project Social Analysis

PROJECT TITLE: PRIVATE SECTOR POPULATION: PROGRAM IIEXECUTIVE SUMMARY

The social analysis focuses on the major program components of the Project identified in the PID: these are the Community Service Program (CSP -- known in the present Project as CBD, Community Based Distribution); the Contraceptive Social Marketing program (CSM); the Servicios Medicos (SM) clinical services program; the Information, Education and Communication, and Education of Leaders program (IE/C) under which mass media will be used in different formats; an Employee Based Family Planning program and a PVO program. Other Project components are related to management and administrative needs; they include Program Statistics, Evaluation and Operations Research, and Administration.

The Project design is in fundamental compliance with the major features of Honduran culture and tradition. After a quarter of a century of family planning under the leadership of ASHONPLAFA, the Project appears to be regarded as a genuine Honduran institution. The Project is, moreover, in strict conformity with the stated formal policy of the GOH. However a number of socio-cultural and policy problems do exist and need to be critically examined and addressed. A major problem is that GOH family planning implementation has not kept pace with its policy. The analysis assesses the socio-cultural implications of constituent programs in light of assumptions and constraints stated or implied in the PID.

Major assumptions are that: 1) family planning has a positive effect on economic development; 2) and the Nation's overall health status; 3) there is a strong desire for smaller families; 4) the GOH will not reverse its supportive family planning policy; 5) the

bulk of family planning services will continue to be delivered by the private sector -- primarily ASHONPLAFA;
6) the greatest potential impact for reduced fertility will come from the increased use of contraceptives in rural areas.

Discussions on constraints include: 1) the extent to which family planning success is dependent on development and 2) on education; 3) the extent to which family planning is impeded by poverty; 4) by rural isolation; 5) by illiteracy; 6) by "vergüenza" (shame); 7) by the lack of confidentiality, and 8) by the lack of male involvement.

The analysis found that the degree of acceptability of Project components has varied in the past with the socio-economic condition of targeted populations and will, most likely, continue to be so in the future, i.e., those most and best served by the Project are urban dwellers; and among rural beneficiaries by those with the most years of formal education.

Component acceptability was found to range from easily acceptable for the better educated and more economically advantaged urban residents; acceptable-with-difficulty and not-acceptable for less- and non-formally educated rural poor. According to ASHONPLAFA staff (and according to medical anthropological literature on illness and curing) a major reason for this relatively low level of acceptability is the difficulty of the Project to provide confidentiality. "Vergüenza" (shame, shyness) is a feature of all animal behavior which is overcome by confidence. Its importance will be described in some depth. Moreover, SECPLAN data will suggest that ASHONPLAFA pricing schedules for rural families are beyond the financial means of rural women, many of whom receive only in-kind support from their spouses but not cash.

Potential conflict areas are identified in the area of management, in part due to different cultural viewpoints. Other factors appear to be political and interpersonal. Finally the criticism of the religious groups towards family planning and ASHONPLAFA is examined and found to be less significant as an obstacle to family planning than generally believed by major donors.

I PROJECT DESCRIPTION

Population Project. Follow-on to Private Sector Population Program I ending June 1989.

PROJECT RATIONALE

The rationale for this project is derived from the Mission's

Population Strategy. It aims to satisfy the unmet need for family planning services. That such a need does exist was confirmed in the 1987 family health survey which was utilized in its two versions, one in Spanish without commentary: Encuesta Nacional de Epidemiologia y Salud Familiar (borrador) by the MOH/S&T epidemiological studies unit; and a more final version in English: National Epidemiology and Family Health Survey by Family Health International (FHI). An earlier 1984 study by the MOH and ASHONPLAFA, with the assistance of FHI and Management Sciences for Health (MHS), was used for comparative purposes.

TARGET GROUP OF BENEFICIARIES

Although women in the 20 to 29 years age group are experiencing the highest fertility rates, younger women (aged 15 to 19) and women over 35 years of age experience greater risks to their health during childbirth as do their children. Therefore the target group identified for the Project includes all women in union between the ages of 15 to 44 years.

STATEMENT OF THE PROBLEM

According to the direct method of estimating infant mortality rates (IMR) the Honduras IMR has declined substantially in the past 15 years: from 117 per 1000 live births in 1971-72, to 47 per 1000 in 1985-86, a reduction of about 60 per cent. However, if the indirect method of estimating IMR's is used, then the reduction is about 52 per cent over a roughly one generational span -- since 1967-68. By whatever measurement used to estimate IMRs, the reduced rate is significant. What makes the accomplishment striking is that the decline occurred under economic conditions that are not at all favorable. At US\$ 740 dollars, Honduras has the lowest per capita rate in Central America. According to the indirect rate, the Central American IMRs appear as follows:

COUNTRY	IMR/000
Costa Rica	18/000
Panama	23 "
Honduras	61 "
El Salvador	61 "
Guatemala	61 "
Nicaragua	64 "

Indirect IMR estimates for 1986
Source: Estado Mundial de la Infancia

At 61/1000 Honduras (with its closest neighbors) has one of the highest infant mortality rates (IMR) in Latin American. It

nevertheless has one of the highest total fertility rates (TFR) at 5.5 children per woman. This combination of a very high IMR and TFR gives Honduras a 3.1 percent annual growth rate, one which will cause the Honduran population -- like its neighbors -- to double its 1988 population of 4.8 million in approximately 22 years (7 million by the year 2000). It is important to note that by this date more than half of the population will be under 16 years of age.

The significance of this exceedingly rapid pace of population growth in Honduras can be better understood by comparing its 22 year population doubling time with Belgium's over one-thousand years (1034), Italy's well over three thousand years (3,465); and Denmark's, Austria's, West and East Germany's, and Hungary's decreasing populations (assuming that present rates remain constant in those countries.)

Such a rapid population growth has its most adverse effects on women and their children, the vast majority of whom are poor by any standard. Uncontrolled population growth greatly increases infant and child mortality -- especially during childbearing years -- and it dramatically decreases life expectancy for mothers and children.

With respect to marriage, high birth rates force countless young teenagers into very early marriages and child-bearing unions where very low contraceptive prevalence is the rule. In such contexts a low educational level is generally the rule for parents (countless of them single parents) and their children, many of whom never get beyond the first primary grades.

The employment situation of Honduras is very bleak, but especially so for the Country's poorest women. Unable to earn adequate income or locate credit to assist the micro entrepreneurial endeavors in which countless of their numbers attempt to eke out a living, women are forced into the most menial of employment situations, in which contexts they are regularly pressured to give up children -- frequently permanently -- to the care of others: or to let them suffer the consequences of a street life leading to illiteracy, malnutrition, chronic unemployment, discontent, openness to political extremism and delinquency.

One of the attendant problems which rapid population growth suffers is the poor access which the poorest women have to birth control information and assistance. It is well known that the vast majority of contracepting families are the best formally educated and those with significant incomes relative to their poorest neighbors -- whether in urban or rural contexts, but most notably in the latter. ASHONPLAFA data regarding the educational levels of contraception acceptors indicate that those least involved in ASHONPLAFA family planning and birth-spacing activities are those without any formal education.

Distribution of Total Number of Acceptors by Type of Program
According to Educational Level Attained

	<u>Medical</u>	<u>Surgical</u>	<u>CBD</u>
No Formal Schooling	2.6%	17.4%	9.8%
Primary (incomplete)	16.2%	54.3%	40.0%
Primary (graduated)	24.6%	21.3%	29.8%
Secondary (incomplete)	16.2%	2.4%	12.3%
Secondary (graduated)	33.1%	4.4%	6.8%
Superior School	<u>7.3%</u>	<u>0.2%</u>	<u>0.4%</u>
	100.0	100.0	100.0

Given the generalized lack of opportunity for formal education and of jobs that pay enough to feed, clothe and house a family, the Project has little choice but to reach out to those that it can with family planning information and services, who are most disposed by their education and socio-economic status: in the hopes that in time a critical mass of women of child-bearing ages (ages 15 to 44) will become family planning acceptors, and in so doing play an influencing role on those socio-economically below them which the Project is unable to reach in significant numbers at the present time.

PROJECT GOALS AND STRATEGIES

The project goal is to reduce the current Total Fertility Rate (TFR) from 3.9 urban and 6.8 rural, to 3.0 urban and 5.8 rural. Behind this goal is the assumption that neither the GOH, nor the U.S. Government will change its policies in support of family planning. The Project Purpose is to increase contraceptive prevalence (the percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50.4% in 1993. In order to achieve this level of prevalence, 362,500 Honduran women nationwide will need to be practicing contraception with their partners during 1993, up from the 1987 number for all of Honduras of 231,250 -- a difference of 131,250. The Project's contribution to the National Contraceptive Prevalence Rate, therefore, will be more than 50%.

USAID's population strategy is to support Honduras in implementing its policy of reducing the crude birth rate, calculated at 39/1000

for 1988, by assisting in the strengthening and expansion of family planning services in both the private and public sectors.

The Mission's Project strategy is to increase self-sufficiency, increase cost-recovery, improve efficiency and reduce costs for those programs, like the Medical Clinical, which will require deficit financing. Regionalization of operations will continue as regional staff plan and budget their own programs and identify volunteers to support local family planning programs.

ONE PROJECT/TWO CONTEXTS: ASHONPLAFA AND THE OTHER PVOs

To more effectively reach the market of women aged 15 to 44 so that contraceptive prevalence may be increased to 50% by the end of this five year project, the Project calls for the continued support of ASHONPLAFA and for the expansion of its Community Service Program (CSP.) This program includes promoting and selling contraceptives commercially through a Contraceptive Social Marketing (CSM) program; as well as providing voluntary surgical contraception through ASHONPLAFA's Medical Clinical (M/C) program in five regional centers.

USAID's strategy for this new project includes a much smaller second context within which additional targeted women may be reached, namely the provision of support to other PVOs which are already supplying primary health services to their beneficiaries (Foster Parents, Save-The-Children, Meals for Millions and Horizontes de Amistad.) Another organization is a common cause and advocacy group associated with the Christian Democratic Party called the Union Nacional de Campesinos (UNC) which has no experience with the provision of health services but which has expressed an interest in collaborating with ASHONPLAFA in the provision of family planning services.

TIME SPAN OF THE PROJECT

A five year project is planned for two reasons. First because the project strategy emphasizes greater cost-recovery and steps toward self-sufficiency for all the ASHONPLAFA components. Five years is a reasonable period of time to enable the Mission to measure changes brought about by this strategy. Second, because Honduras will require assistance in family planning until the year 2000 if it is to reach 60 percent contraceptive coverage. This project can be viewed as the second phase of the Mission's support to both public and private sector population programs.

USAID has supported family planning programs in the public sector through its Health Sector I and Health Sector II projects. Under Health Sector I, funding was provided for family planning training, commodities, information & communications campaigns through mass

media and technical assistance to the MOH. Under Health Services II, funds are available for supervision of family planning services at regional and local levels, training, technical assistance and for the purchase of contraceptives.

Although the Honduran public sector has the greatest potential, in the long run, for providing family planning services because of its extensive network for health centers, survey results show that the private sector continues to be the principal provider of family planning services.

I I. U. S. A. I. D. / H O N D U R A S S U P P O S I T I O N S

o Family planning (FP) will have a positive effect on the Nation's overall health status;

o Family planning will have a positive effect on economic development;

o There is a strong desire for smaller families by Honduran couples;

o There is an unmet demand for family planning. This demand can be met by increasing the availability of family planning information and services;

o Neither the public nor private sectors have the means to adequately finance the needed expansion of family planning services without external resources;

o The GOH will not reverse its supportive family planning policy;

o The bulk of family planning information and service will continue to be delivered by the private sector -- primarily by ASHONPLAFA;

o The greatest potential impact for reduced fertility will come from increased use of contraceptives in rural areas.

C O M M E N T S O N S U P P O S I T I O N S

1. Positive Effect of FP on Health: Every authority on public health supports the contention that women are especially prone to health problems during periods of pre- and post-natal pregnancy -- as are the children in their care. Not even the most pro-natalist advocates would deny the fact that child-spacing will significantly diminish the dangers to a mother's health and well-being.

2. On Economic Development

It is difficult for those of us convinced of the need for reduced fertility to argue against the theoretical basis that both micro and macro economic situations will improve to the extent that fewer persons share available resources for individuals, families and institutions. In this theoretical sense, family planning and child-spacing cannot but help to improve the poverty situation of poor nations. What is problematic is the extent to which one is dependent on the other, or that one is the cause of the other.

Nevertheless some do argue against the wisdom of reduced fertility when it comes packaged under certain labels (Family Planning, Yes! Birth control, No!) and this on grounds based on economic and market theories. One such argument maintains that in some countries, including Honduras (as Bolivia), the development of the economy needs increased, not decreased, population growth.

As described by M. Bacardit in Poblacion y Religion this argument suggests that birth control programs (but not family planning) are fundamentally expatriate in origin and have, as an essential part of the program's motivation, the de facto well-being of developed countries through the maintenance of some world areas as reserves for raw materials. This topic is one of several being widely discussed in the field of Ethics.

Another argument against (even) family planning for the poor in Third World countries (obviously, not authored by the same ideology) maintains that a constant and on-demand cheap labor supply of campesinos is the mainstay of agriculturally based for-export economies, and must not be jeopardized by significantly reduced populations. Such a situation, if it is strongly maintained, endangers the supply of, especially, seasonal workers for the agricultural exploitations upon which everyone depends --both rich and poor. Such topics are among the ethical issues being widely debated under fertility reduction policies and poverty.

Another popular argument is that in sparsely populated countries, such as Bolivia with a less than 1 person/kilometer population density, countries need an increased population in order to provide a domestic market for manufactured goods, so that economic development can proceed. In these situations development problems will not be solved by reducing the birth rate. In such contexts solutions require serious redistribution of wealth schemes, new jobs paying a living wage, more capital and credit at all levels, and an overhauling of public administrative systems.

FERTILITY AND DEVELOPMENT

The populations of European nations are highly educated and their economies highly developed. It is also clear that most have very

low fertility rates. The both Germanys, Denmark, Austria and Hungary have negative population growth rates: their populations are diminishing; they will never double. At Italy's current fertility rate its population will double in 3,460 years, while Belgium's will take well over a thousand. In contrast, the Honduran -- and other Central American countries -- will double in approximately one single generation. Comparisons closer to the socio-cultural situation of Honduras are more difficult to make, but at least two Caribbean populations with large populations (Cuba and Puerto Rico with 10.4 and 3.4 millions) have reduced fertility rates during the past decades. The population doubling time for Puerto Rico is 56 years while for Cuba it is 69 years. The differences in doubling time between North and South Korea is also supportive of that belief that development is the best of all contraceptives: 28 years in the North; 52 years in the now highly industrialized South.

It is worthy of note that in many developed countries of the West, there have never been family planning efforts for its populations in proportion to the efforts which have taken place in developing countries like Honduras and Guatemala.

The literature on declining fertility is very complex, but some elements stand out, namely that in developed countries reduced fertility has come about as a consequence of two overarching phenomena: economic/educational development and a intellectual climate of opinion -- a vogue -- among a critical mass of people, which enabled/facilitated the masses to make appropriate contraceptive decisions. Contraceptive information and accessibility to services were sine qua nons for assisting the process of reducing fertility. But they appear not to have been the fundamental cause of reduced fertility.

3. THE DESIRE FOR SMALLER FAMILIES BY HONDURAN COUPLES

It is widely held that the desire for smaller families rises to the taking of appropriate contraceptive actions in direct proportion to educational and socio-economic levels attained. It is at that point where the availability of resources facilitating contraception is utilized at a more efficient level.

IDEAL FAMILY SIZE

Data from the 1981 Contraceptive Prevalence Study indicate that women aged 15 to 44 held that 2.5 and 3.5 represented the ideal number of children in urban and rural areas respectively. In the 1984 study the same question regarding ideal family size elicited almost identical responses for younger women, but climbed to ideal numbers of 4.0 and 4.9 for ages 40 to 44, against actual numbers for that age group of 4.5 and 6.2 children for urban and rural women respectively. The 1987 study shows a mean ideal family size of 3.2 children per family. The actual number has been calculated

at 5.5 children.

All contraceptive prevalence studies indicate that the ideal number of a family becomes smaller or larger accordingly as the respondent to the question is urban or rural based; and to the extent that the respondent is formally educated. The 1987 study indicates the percentage of women who did not want their actual or last pregnancy (39.8 per cent), and those that wanted it, but wanted it later (60.2 per cent). The study also shows the immediate fertility expectation of mothers surveyed: 52.4 per cent wanted another child, as opposed to 39.9 per cent who did not.

4. THERE IS AN UNMET DEMAND FOR FAMILY PLANNING. THIS DEMAND CAN BE MET BY INCREASING THE AVAILABILITY OF FAMILY PLANNING INFORMATION AND SERVICES

It is well known, that many people hesitate to obtain what they need, and want, from easily available sources. There are many reasons for this. They range from the pressures of tradition and culture not to do some thing, which have not been dulled by education and socio-economic status (feelings of fear and shame are, frequently, linked to such restrictions): to idiosyncratic psychological fears proper to specific personalities rather than to specific cultures. With respect to contracepting, especially culturally based fears are more conducive for inaction in rural contexts than urban ones. The major reason appears to be the difficulty of widely known programs like ASHONPLAFA to provide the overriding need for privacy and confidentiality which many rural campesino peoples have.

This issue of privacy and confidentiality is why the inclusion of support for healthcare-providing PVOs in the Project Paper design is exceptionally significant and needs to be closely monitored in order that valuable lessons may be learned for appropriate policy determinations.

Many rural primary healthcare clinics, even those operated by religious organizations and churches (for example many of the 163 parish clinics assisted by CRS) succeed in assisting many women with information and services about family planning and child spacing -- but this is done in a context that does not single out one's in any aspect of human reproduction. Given the tightness of social networks in rural areas and the rapidity of communication between points in those networks, many rural poor people around the globe have hang-ups about airing anything related to their personal sexuality in what they interpret to be a public situation.

5. NEITHER THE PUBLIC NOR PRIVATE SECTORS HAVE THE MEANS TO ADEQUATELY FINANCE THE NEEDED EXPANSION OF FAMILY PLANNING SERVICES WITHOUT EXTERNAL RESOURCES

Like all country private sectors, the Honduran private sector is a multi-faceted phenomenon and should not be lumped together with respect to its inability to finance some significant part of the expansion of family planning services. It might be worthwhile to undertake a rapid assessment study to determine the financial ability/inability of different sub-sectors of the for-profit private sector to provide integrated healthcare for its employees, in the context of which family planning services could be offered. The PID indicates that a discussions have already taken place regarding this issue by its mention of ASHONPLAFA's exploration of the use of employee health programs. Given the interest expressed in the PID about employment related programs for expanding family planning opportunities, the following comments are offered about the utilization of the private sector. PLANTATIONS

One very large sub-sector which employs huge numbers of the Country's poorest rural campesino families, are the Country's plantations: large numbers of which are located in most difficult to reach, almost inaccessible, rural areas. This rural isolation represents a major constraint for the CSP(CBD) Program. Farmworkers, both permanent and seasonal, constitute a significant part of the Honduran rural work force, which work force often includes women and children of the household -- especially during harvest periods.

Given the relatively few latifundia-type coffee and cardamon plantations in Honduras, which utilize large numbers of resident workers (so common to other countries of the Region) it will be difficult to market many fee-for-service primary care programs (with family planning as an integral component) for the poorest rural families, as many seasonal/migrant farmworkers are known to be. But the theoretical possibility of reaching a significant number of these poorest of rural poor through plantations is not a pie-in-the-sky idea. It should be one of the options considered in the planned intensive review of the use of PVOs to reach greater numbers of rural peoples.

The 1979 Census of the Instituto Hondureno Del Cafe lists a total of 40,000 fincas, the vast majority of them under 20 manzanas in size. But there are almost one thousand between 20 and 50 manzanas; 178 between 50 and 100 manzanas; and 78 plantations which are listed as being over 100 manzanas in size.

Another plantation related study, the 1982 Country Environmental Profile done for the USAID/Honduras Mission by JRB Associates states that 5.9 per cent of all the farms in Honduras are commercial/private farms -- many of them owned by transnationals. The smallest of these 667 largest farms are properties of 340 hectares (acres) or larger, many of which employ large numbers of resident and seasonal workers. These cultivate 57.2 per cent of all the farm land; while 93.6 per cent of the farms, largely

subsistence farms, cultivate 36.8 per cent of the land. An important point of the discussion is that in spite of the relatively small number of plantations with resident populations, relative to other Central American countries, there are, nevertheless, a significant number of large plantations/farms employing large numbers of workers.

It is important to point out that plantations employing more than a minimum number of workers are required by Honduran law to provide minimum healthcare for its workers. Given the practical impossibility of monitoring observance, however, how this requirement of the law is observed by the planter depends on a wide range of factors, but uppermost is the personal concern -- great or little -- of the planter for his/her workers. The area of fincas and farmworkers in one in which one or several PVOs can be of significant service. One such program in Guatemala, named AGROSALUD, was established by planters in 1977 on a fee-for-service basis with no expatriate financial assistance, except for the aid received from APROFAM (the Guatemalan counterpart of ASHONPLAFA - - Asociacion Pro-Familia.) Albeit at a reduced level due to several factors, including a civil war which has ravaged the countryside, the AGROSALUD program is still functioning.

6. THE GOH WILL NOT REVERSE ITS SUPPORTIVE FAMILY PLANNING POLICIES

On paper the policy of the GOH in support of family planning is difficult to fault. In the past several years the Government has increased its commitment to formulating and implementing explicit population policies as a means of attaining development objectives. The GOH's most recent effort in this regard is the formulation of the Population Law, which is presently in congressional committee for discussion prior to promulgation. The Population Law follows a Government decree of 1983 which made family planning a priority area within the national primary health care program.

However, while the government's de jure policy record is an impressive one, its de facto commitment to implementing its policies is weak. One reason for the Government's apparent reluctance to put its money where its political mouth is has been attributed to the very sharp criticism leveled against the Government by the most influential elements within the Catholic Church, notably the Archbishop and other senior prelates, and the largely social elite Opus Dei group, some of whom are known to be close to senior government officials and capable of influency policy decisions.

Two indications of the Government's reluctance to have as strong a de facto policy position as it has a de jure one, are found in the relative little use being made of its over 500 primary health

CESAMO and CESAR clinics for the provision of family planning information and service; and in the reduced number of contraceptive surgical procedures being performed in the eleven hospitals of the Ministry of Health over the past three years: from 2,501 procedures in 1986 to 1,414 in 1988.

At worst (and said to be the most probable) the Government will continue to permit family planning activities to exist without any significant support for the growth of those services within the CESAMO/CESAR system. The best possible scenario regarding the role of the MOH, would be the provision of family planning information/education and service within that system, by personnel trained/sensitized to make appropriate inquiries of patients who have not directly requested family planning assistance as an integral part of its primary healthcare program.

7. THE BULK OF FAMILY PLANNING INFORMATION AND SERVICE WILL CONTINUE TO BE DELIVERED BY THE PRIVATE SECTOR -- ESPECIALLY BY ASHONPLAFA

The USAID/Honduras decision to develop closer working relations with established PVO organizations and the UNC is an extremely important one, as in many areas of the developing world such clinics provide a full range of family planning information and services as an integral part of their primary health efforts: and in a manner which provides a pretty good guarantee of confidentiality being maintained. The importance of providing confidentiality to potential beneficiaries cannot be overstated, as in many instances women request advice on preventing another pregnancy in the face of a husband's direct order not to do so.

Given ASHONPLAFA's quarter-century of experience and its preeminence and dominance in the field, it is appropriate that it continue to deliver the lion's share of USAID/Honduras family planning funds. If the use of PVOs proves successful for the enhancement of the program, then the PVO aspect of the program could develop into a highly desirable competitive situation in which performance, measured by predetermined criteria, would determine what part of the Mission's family planning budget each subsector is granted.

Of course, the possibility of such a development is years away. In fact, the Mission does not have another choice at the present time: and that is not an ideal situation for creativity, program development and quality enhancement.

Given that situation, the family planning activities of PVO clinics involved in the Project need to be closely monitored in a holistic primary healthcare context. Lessons need to be learned about how to best expand collaboration with these other PVO clinics, in order that they may more successfully compete among themselves and ASHONPLAFA in the very best sense of the word.

8. THE GREATEST POTENTIAL IMPACT FOR REDUCED FERTILITY WILL COME FROM THE INCREASED USE OF CONTRACEPTIVES IN RURAL AREAS

The supposition is sound given the actual rural situation of Honduras, i.e., given the extremely difficult-to-overcome constraint of lacking and/or poor educational facilities and employment opportunities. These latter appear to offer more certain solutions for reduced fertility. See the discussion on the relation between fertility and development in Assumption Number 2.

III CONSTRAINTS

Constraints are distinguished into various categories. The most difficult to overcome are usually policy related, followed by resource availability. With respect to Honduras (as anywhere) policy constraints need to be distinguished into formal (de jure) and informal (de facto) categories -- the former frequently having the force of law when implementing authorities so wish it.

In Honduras there are no major de jure policy constraints by the Government with respect to family planning. On the contrary, the GOH has a very supportive family planning policy -- to the point that at the present time a Population Law has been written and proposed to the Congress for promulgation. In spite of supportive formal policy, however, there appear to be strong de facto constraints at play within the Government which is preventing that policy's implementation within the widespread clinical resources of the Country's CESAMO and CESAR facilities.

There are eight categories of socio-cultural constraints which have in depth and complex social and cultural ramifications for this Family Planning Project. They relate to the following:

- o education
- o rural poverty
- o rural isolation
- o gender
- o shame ("verguenza")
- o administration and management
- o financial
- o opposition

1. EDUCATION

There is general shortage of educational facilities and

opportunities throughout Honduras, especially for its poorest populations: a situation which is significantly aggravated by the urban-rural distinction. It is well known and widely accepted that this shortage has a very negative impact for reducing fertility rates, as it appears incontrovertible that there is a direct relationship between educational levels attained by females and their individual fertility. Moreover, in spite of the success which ASHONPLAFA has had in informing large sectors of the Honduran population about family planning and child-spacing options, there is still an admitted lack of knowledge about family planning among large sectors of the population, and a lack of opportunity to obtain it in many rural areas of the Country -- and this especially by its poorest people. However data from the 1987 National Epidemiology and Family Health Survey illustrate that knowledge of contraception among Honduran women has increased since the 1984 survey. As indicated in the PID, the need for additional information will be addressed, in some measure, by the planned mass media communication efforts within the IE/C component of ASHONPLAFA. The following table from the MOH/FHI National Epidemiology and Family Health Survey of 1987 (Table III, D4) illustrates the distribution of women by education and urban/rural residence:

Education	Teg/SPS	Other Urban	Rural
None	4.7%	9.9%	23.6%
Primary 1 to 3rd Grades	12.3%	18.6%	34.6%
Primary 4 to 6th "	31.0%	31.4%	33.8%
More than 7 years	<u>52.0%</u>	<u>40.2%</u>	<u>8.0%</u>
	100.0	100.0	100.0
Total No. of Women	(2724)	(1546)	(5869)

2. GENDER

The ASHONPLAFA experience spanning a quarter of a century indicates that contraception is a woman's world. One of the problems about the male factor in family planning is the great amount of belief about what it is. It is widely believed, for example, that there is a general lack of male involvement in family planning, especially in passive roles. In support of this belief, the fact is quoted that there is little demand for voluntary vasectomies by men. It is also believed by many that, in general, Honduran (and many other Latin American) men are not involved with their spouses

in coming to decisions about contraception. However, one report and a study do exist and these give another view of the issue.

A brief ASHONPLAFA report on a focal group discussion of seven men who had undergone vasectomies is significant for the detail of the personal experiences they portray. They are also important for pointing the way to additional research topics.

A more in depth study in which ASHONPLAFA participated with Tulane University was seen in draft version. It is an unpublished 1987 survey of 959 men, randomly selected in three Honduran communities, between the ages of 30 and 50. The study was commissioned in order to obtain information about how to increase the demand for vasectomies. The study maintains that 67 per cent of the respondents were actually practicing some form of contraception with their spouses; and that 36% of their spouses had been surgically sterilized. These are remarkable findings which the authors noted as such. They are especially remarkable given the 35 per cent national contraceptive prevalence rate existing during the time of the study, and the fact that while 8,255 female AOV procedures were performed in 1987, men underwent only 34 AOVs. None of the men surveyed had submitted to a vasectomy.

Another indication of positively affecting Honduran male thinking about the need for contraception is found in the well known and widespread "comunidades de base" and "concientizacion" education programs, now frequently associated, in some quarters, with liberation theology and leftist political movements. One of the fundamental modules of many such programs, as practiced in many church contexts, is responsible fatherhood which includes the responsibility of the man not to endanger his spouse's, and his children's health by frequent and successive pregnancies of his wife. The positive implications for the growth in the number of family planning acceptors is obvious.

3. RURAL POVERTY

The PID describes as a principal objective, the expansion of the CSP(CBD) program to 310 additional distribution points over the 1400 expected to be in place by the end of the current Project. It points out that this expansion will focus on undeserved rural areas in Lempira, Gracias a Dios, Copan, Ocotepeque, Islas de la Bahia, Intibuca and La Paz. Most of these areas have been reported to be some of the poorest in the Country.

Based on per capita calculations, Honduras is the poorest country in Central America, with US\$740. However it is well known that per capita rates say little about specific population sectors or geographical areas. Per capita calculations are valid primarily as an indication of how a national economy is performing vis a vis other national economies, with respect to total salaries paid to

the work force. Per capita income says nothing about personal incomes in any sector or geographical area. Obviously the per capita income of Honduras at US\$ 740 dollars is significantly less than the legally established minimum wage of roughly US\$ 1,300 dollars annually (L.200/month for 13 months.) That a large part of the workforce earns less than minimum wage is incontrovertible. It is also incontrovertible that many earn significantly less than the per capita amount.

One reported INA study (reported by ASHONPLAFA staff) of per capita income for specific rural areas of the Country comes up with an estimate of an annual per capita income of less than one hundred lempira in some isolated rural areas. The possibility of such a low annual income figure being the case for anywhere in Honduras was denied by several persons consulted. As the title of the study was not known, a search in numerous INA offices proved futile in locating the study. However inquiries in SECPLAN turned up a recent (1988) study entitled Encuesta Permanente de Hogares de Propositos Multiples in which are presented a wide range of data by region and in recapitulated form for the entire rural area of the Country. Among its data are five tables (appended as Appendix I) which relate to income levels in rural areas for men and women.

Table 23 (Poblacion Ocupada. Por Grupo de la Ocupacion Principal. Segun Niveles de Ingreso Mensual y Sexo), lists a total rural work force of 769,991, 621,088 (81%) of whom are men. A total of 169,311 are shown in the data as being "without income". Most of these (87%) are also men. The table gives a monthly income breakdown of both men and women listed. Those figures follow:

INCOME OF RURAL MEN AND WOMEN

MEN	Number
Total Number	621,088
Without any income	149,872 (24%)
Only in-kind income	2,332 (0.3%)
Less than 60 Lps./month	155,770 (25%)
From 61 to 100 Lps./month	79,658 (13%)
" 101 " 200 " "	129,543 (21%)
" 201 " 300 " "	40,200
" 301 " 400 " "	20,651
" 401 " 600 " "	24,680
" 601 " 800 " "	5,706
" 801 " 1200 " "	4,790
" 1201 " 1600 " "	2,504
" 1601 " 2000 " "	1,046
" 2001 Lps. and up "	4,336

=====

WOMEN	Number
Total Number	148,903
Without any income	19,439 (13%)
Only in-kind income	1,364 (9%)
Less than 60 Lps./month	64,996 (44%)
From 61 to 100 Lps./month	17,812 (12%)
" 101 " 200 " "	19,269 (13%)
" 201 " 300 " "	8,228
" 301 " 400 " "	4,540
" 401 " 600 " "	6,972
" 601 " 800 " "	2,287
" 801 " 1200 " "	1,783
" 1201 " 1600 " "	596
" 1601 " 2000 " "	171
" 2001 Lps. and up "	1,446

While the above data give some indication of the cash income of rural populations in Honduras, there are cultural/traditional problems which exacerbate the implications of the data, as they impact directly on the amount of cash available for purchases of contraceptives. Especially at issue is the male tradition of giving the women of the house as much as he can in terms of the basic necessities of life such as foodstuffs and firewood, but usually no, or very little, cash -- as cash is regarded to be for the personal needs of the husband, which often includes support for one or more other families he has sired. Cash is also needed for the males' social obligations during which significant alcoholic beverages are consumed.

This practice is widespread in many Central American campesino communities, but primarily among non-Indian cultured populations -- such as those called "Ladino" in Guatemala. The Honduras version of this "little-cash tradition for woman" is described in an Oscar Lewis type book, published by the Institute for Food and Policy Studies (San Francisco) by Mejia Benjamin entitled "Don't Be Afraid Gringo", in which taped interviews with an Honduras activist woman closely associated with the UNC (Union Nacional de Campesinos), Elvia Alvarado, are transcribed. The book describes what it's like to be a peasant woman in Honduras.

The poverty of rural families is an issue for the Project, given the importance being given in the PID to the ability of programs to pay their own way by the end of the five year period. If rural poverty is as severe as suggested in the SECPLAN data and described by informants, it will be difficult for families to afford the one to two per cent of minimum wage cost which participation in the program requires. All persons with whom the ability of rural families to pay the planned amount was discussed, denied that most could.

4. RURAL ISOLATION

Rural isolation is a major reason why access to the lower-lower socio-economic sector of the population is so difficult to access. According to informants, many of the additional rural areas targeted by the PID are among the most remote and inaccessible in the Country by public transportation. Much of it is accessible only on foot and horseback -- even in dry periods. This rural isolation of an undetermined number of the Country's rural population (put at 61% of the total Honduran population) is a major concern for ASHONPLAFA senior staff with whom this analysis was discussed. By all estimates the number of these isolated families is large. Parelleling their isolation is the lack of educational and health facilities and the Country's worst poverty, youngest marriages and unions, and the largest families.

In such regions of the Honduras (and the globe) many children are regarded as an inexpensive and valuable labor and support resource which can be depended upon. Evidence which can be analyzed in terms of such an attitude can be seen in the SECPLAN data. Cuadro 2 (page 22 of the Total Rural volume -- appended) shows a total rural household population of 2, 629,396. This figure is broken down into 449,345 household heads; 349,374 wives or companero; 1,446,081 children; 54,390 other family members; and 331,206 others without any family members in the household ("otros no parientes".) Many of these "otros" are children who have been either placed in the care of, abandoned or as close to literally given to the household as one can imagine. The custom is known in many peasant societies. This category of numbers supports such an analysis. The point here, is that smaller families make sense for such people only when there are other support systems to take their place. Clearly the problem is a difficult one to unravel, but a beginning can be made in the context of the Project's planned Mass Media Communication effort to bring about behavior modifications.

5. "VERGUENZA"

Another indication of the Project's clash with culture and tradition is the high level of verguenza (shame) experienced by many women and men entering the program for the first time. The phenomenon of shame is universal to all societies. Levels of shame, however, are relative to specific contexts within a culture, and these vary greatly from one culture to another. The verguenza at issue in this specific context of human sexuality in Honduras diminishes significantly with familiarity and the growth of confidence in the program and its personnel. To what extent this phenomenon is responsible for keeping the number of contraceptive acceptors lower than they could be can never be known, but the best guess, and some evidence regarding religious belief, is that verguenza keeps away many more potential beneficiaries than does either poverty or religious belief. "Verquenza" is discussed in greater length below, under No. 4 of the Scope-of-Work (page 29.)

6. ADMINISTRATION AND MANAGEMENT

One management problem with significant social implications for the increased use of family planning was noted in the course of meetings with ASHONPLAFA which merits mention here, as it is the opinion of this analyst that, given the present polarization, it is a problem which can be addressed and resolved, but in a de facto rather than formal way. The problem has to do with the conflict between the Catholic Church hierarchy and ASHONPLAFA senior officials. This will be covered in detail under the subsequent section on "Opposition". Suffice for the moment to point out that while there have been a multitude of attacks by the Catholic hierarchy against ASHONPLAFA in the public media for years (but with especial vigour during the past seven months) ASHONPLAFA unintentionally, but effectively (and understandably) rejected a recent initiative by a CARITAS senior staff person to explore the possibility of collaboration with ASHONPLAFA on the family planning effort.

7. OPPOSITION

The literature review for this analysis included a perusal of five years of local newspaper clippings maintained by ASHONPLAFA relating to the public statements made, primarily, by the hierarchy of the Roman Catholic Church against ASHONPLAFA. Especially during the last six or seven months of late 1988, the polemic of the Catholic hierarchy against ASHONPLAFA became extreme.

One article in *la Prensa* of July, 11, 1988 quotes the Archbishop of Tegucigalpa's accusation of ASHONPLAFA as an organization which has been "assassinating children for 25 years before they are conceived." The statement is a contradiction in terms even in the context of the most conservative pro-life Catholic theologians. But just about one year earlier, on May 18, 1987 in *La Tribuna*, the same Archbishop made a statement in which he could have been speaking as an ASHONPLAFA spokesman: a statement which presupposes the need for Catholic couples to practice family planning, when he declared that "The Church does not ask spouses that they have as many children as they can possibly have; only that they have as many as they can raise and educate."

Criticism against contraception is not a strictly Catholic phenomenon. A strong criticism of the practice of contraception by unmarried youngsters was voiced by the Evangelical, Brother Pablo, in *Tiempo* on July 16, 1988. He uses the example of the development of the pill as the cause of a disastrous climate of opinion which allows for total incontinence in sexual behavior among youth -- something he views as destructive of human nobility.

What is misleading about the criticisms and opinions of church spokespersons is that their thinking is, frequently, taken as being representative of the entire membership of those churches. This is a fallacy. In the Catholic churches of Honduras, (as in different churches, temples and mosques everywhere) there is a very wide range of thinking about what is, and what is not, ethical behavior according to those traditions. Informants consulted during the course of this analysis confirmed this analyst's many years of personal experience with primary healthcare clinics belonging to religious organizations. They indicated that family planning and child spacing is an integral part of most church related programs in Honduras, but that this information and service is not publicly heralded, but is provided in the strictest confidence, and within the primary healthcare context of their clinics.

Several ASHONPLAFA staff pointed out that ASHONPLAFA's inability to provide confidential treatment was a serious problem they had no way of overcoming by themselves. ASHONPLAFA's confidentiality problem was believed aggravated by the Government's de facto policy of not significantly implementing family planning services within the over 600 CESAMO and CESAR health centers. Verquerenza is believed by many to be, very frequently, a difficult obstacle to overcome for many women (and men). If they can't keep their interest in contraception private, they won't go anywhere.

According to an ASHONPLAFA informant, an opportunity for a collaborative family planning and child-spacing effort between ASHONPLAFA and the Catholic Church of Honduras was frustrated when a senior level staff person of CARITAS, the social service arm of the Honduran Catholic bishops, took the initiative to visit ASHONPLAFA, in order to express his interest in family planning collaboration between the two organizations. ASHONPLAFA was in agreement with the idea, but requested that the CARITAS executive send him a letter formally requesting ASHONPLAFA's assistance. Of course, the former could not comply with a letter, as he knew that such a letter could be used by ASHONPLAFA against the bishops, whose criticism was sure to continue. As a result the letter was never received: the possibility was no longer discussed. In the end Hondurans who need the services came out losers -- not ASHONPLAFA; not the bishops.

A similar case is FOPRIDEH, a USAID/Honduras Mission supported funding organization/consortium of about 32 Honduran PVOs which between them include approximately 45 primary health clinics among the other services they are able to provide. The possibility of including the organization as part of the Project's PVO component was questioned in an early version of the PID because of the organization's presumed anticontraception position. In fact on June 22, 1987, Tiempo carried a story on FOPRIDEH indicating that the consortium went on record against birth control and in support of the position of the Catholic Church. However it needs to be

pointed out that the FOPRIDEH statement was made in 1987 when much ado was being made about the distinction between "family planning" (OK) and "birth control" (not OK) -- a distinction which ASHONPLAFA also likes to make. This was also the time when the Archbishop of Tegucigalpa was sounding like a strong supporter of family planning and was quoted as such in the press -- as indicated above.

The FOPRIDEH executive director was interviewed during the course of this analysis. He indicated that the press statement was made in the context of the aforementioned distinction in order to avoid what was viewed by the organization's board of directors as a politically sensitive situation. The statement made to the press also included a statement that FOPRIDEH would not become involved in refugee programs for the same reason -- it was too hot, politically, to do so. It was also pointed out that as regards family planning, all consortium clinics run their own programs in their own ways. The clinics provide as many services as they can or wish to provide, including family planning.

I V S C O P E O F W O R K

1. GENERAL DESCRIPTION OF SOCIO-ECONOMIC & DEMOGRAPHIC CONTEXT OF PROJECT

According to per capita calculations, Honduras -- with \$740 dollars -- is the poorest country in Central America. One reported INA study of per capita income of rural Honduras comes up with an estimate of an annual per capita income of less than one hundred lempira. Significantly less than the national per capita or minimum wage amounts is well known to be the case for rural Honduras, and this because large parts of the Country are made up of sparsely populated rugged mountain ranges, a factor which according to a 1985 UN analysis (Population Policy Compendium) has made communications difficult and has slowed the process of national and social integration as well as the movement of currency. According to the 1988 Censo Nacional de Poblacion y Vivienda (CNPV) Honduras has a population density of 39.05 persons per square kilometer, one of the less densely populated countries of Central America.

CENSUS DATA

Honduras has held thirteen national censuses since 1844, the most recent of which was conducted in 1988 (the data of which has yet to be analyzed and made available to any extent.) Previous to this most recent census the Country's data base was considered to be seriously deficient. Between the censuses of 1910 and 1940, Honduras grew at an average rate of more than 1.5 per cent per annum. The rate of population growth reached 2 per cent after 1940 and 3 per cent after about 1955. By 1970-75 the rate of natural

increase was estimated to be about 3.5 per cent per annum, due to the net effect of a crude birth rate of 49/1000 and a crude death rate of about 14/1000 during those years. It is currently calculated at 3.1 per cent.

POPULATION SIZE

According to a demographic profile for Honduras, done by Palacio Garcia in 1983, the population of Honduras was at four million in mid 1982. At that time the population was growing at a 3.5% rate, the fastest in Central America. The latest provisional estimates by the aforementioned recent Censo Nacional de Poblacion y de Vivienda (CNPV) of 1988 indicates a population of approximately 4.4 million (4,376,839), a figure which is significantly lower than the 4.8 million shown in the 1988 World Population Data Sheet of the Population Reference Bureau (PRB).

CRUDE BIRTH AND DEATH RATES

In comparison to a crude birthrate of 47/1000 in 1982, the 1984 crude birthrate was 37/1000 according to the MCH/FP census; and the current 1988 total crude birthrate, according to the 1987 ENESF census data, is 38/1000. In spite of this accomplishment, the 38/1000 figure represents, according to the data of the UN's Population and Vital Statistics Report, the fifth highest crude birthrate in the entire LA/C region: behind Nicaragua (43/1000), Haiti and Guatemala (41/1000) and Bolivia (40/1000). Those data also show that the crude death rate has also decreased since 1982 -- from 12/1000 reported in the Garcia data, to 8/1000.

RURAL-TO-URBAN MIGRATION STREAMS

In 1982 only 36 percent of the population was estimated to be urban, 61 percent of whom were employed in the agricultural sector -- up from a total of 23 per cent urban residents in 1961. In 1988 the urban based population of Honduras was estimated by the Censo Nacional de Poblacion y Vivienda (CNPV) to have grown to 42 percent, with a corresponding lessening of employment dependency on agriculture. As is occurring everywhere in the world, rural-to-urban migration streams are flooding the globe's largest cities. In Honduras migrant streams are flowing into the Country's two major cities, Tegucigalpa and San Pedro Sula. The current annual growth rates of these two cities are estimated at 4.2% and 5.2% respectively, significantly faster than other urban areas. The total population of Tegucigalpa and San Pedro Sula represent 13.7 and 6.4 percent of the total 1988 Honduran population. Projections put the population of Tegucigalpa at about one million by the year 2000, i.e., about 14.3 per cent of the Country's projected seven

million population by that year.

The migrations to urban areas is due more to economic expulsion than from an attraction for the cities. In 1974 almost two-thirds of all migrants were less than 24 years old. In urban areas these represented 65.2 per cent. Most migrants to the cities face a difficult time once they arrive, and in many cases the reality of city life proves to be as difficult as the situation left behind. Men arrive basically ill-adapted to perform any work other than manual labor, and as a result are absorbed with great difficulty into the work force, given the already great supply of manual laborers.

Women leave rural areas for the same reasons as men, but arrive with a different set of handicaps. While the stereotype for all Honduran women, rural or urban, is to care for the home and children, in rural areas women make a real contribution to many of the agricultural, animal husbandry, and myriad other tasks needed to sustain a rural family. In contrast, in the cities women find it difficult obtaining employment other than in marginal activities. The squatter settlements of the Country's (and the globe's) cities give testimony to the very low quality of life's amenities sustained by countless migrants from rural areas.

One of the major concerns of the GOH is the rapid growth of its cities, the service levels of which are believed to be extremely low. This was said, by one informant, to have been another major reason for the GOH's expulsion of Salvadorans from its territory in 1969, as many were succeeding in resettling to urban areas. At the present time refugee movements of about 33,000 Salvadorans, Miskito and Guatemalan Indians constitute the country's major immigration flows. Most of these are cared for by the UN High Commission on Refugees. Repatriation is a major objective of the UN program.

TOTAL FERTILITY AND CRUDE DEATH RATES

The total fertility rate of Honduras has decreased from 7.5 children per family around 1972 (5.3 and 8.7 along the urban-rural split; 5.8, 7.9 and 8.1 with respect to middle, low and lower class distinction) to 5.5 in 1988.

The crude death rate is currently calculated at 8/1000. This contrasts sharply with past crude death rate data. For 1950-1955 it was calculated by CELADE at 28.5/1000; and at 14.2/1000 for 1970-71 by the Honduran Demographic Survey. That latter figure represented a reduction of approximately 50 percent in a twenty year period. Mortality varies significantly according to region, place of residence, education and socio-economic status.

INFANT MORTALITY RATES

The 1987 National Epidemiology and Family Health Survey (NE/FHS) shows the decreasing IMR figures since 1967-68. The FHI version of the Study's Table IV C1, is reproduced below to illustrate those figures. IMR data, calculated according to the indirect method, suggest that in spite of the outstanding achievement of lowering the IMR in the face of the lowest per capita income rate in Central America (i.e., statistically the poorest country in Central America), the Honduran infant mortality rate is still high -- along with its adjoining Central American neighbors. But the fundamental achievement is indisputable: significantly less than the 127/1000 figure reported by EDENH I Survey of one generation ago, and less than the 85/1000 quoted by the EDENH II Survey of 1978.

IMR Estimates From Various Sources

(Source: FHI Version of 1987 NE/FHS)

<u>Source</u>	<u>Estimate</u>	<u>Time</u>	<u>IMR</u>
EDENH I	Indirect	'67-'68	127
1974 Census	Indirect	'68-'70	112
EDENH I	Direct	'71-'72	117
ENPA (1981)	Indirect	'76-'78	90
EDENH II	Indirect	'78-'80	85
MCH/FP (1984)	Indirect	1981	71
EFSH (1987)	Indirect	1985	61
NE/FHS	Direct	'85-'86	47

POPULATION UNDER 15 YEARS OLD

According to the MOH/S&T draft of the tables of the NE/FHS (Cuadro II-1) 47.6 per cent of the population of Honduras is under 15 years old. This is virtually identical to the figure estimated by the UN Statistical Office, and the 46.9 per cent estimated by Garcia for 1975. In contrast, 44.6 per cent of the population was under

15 in 1950. According to Garcia, Honduras contained about 620,000 children under 15 years old in 1950, in contrast to over 1.6 million in 1980. He projected a figure of about three million under the age of 15 by the year 2000. This projection was pretty much on target, given the most recent finding of the 1988 Census which places the medium age of the population at 16.1 years.

DEPENDENCY RATIO

The increase in the under 15 year old age group has had a direct effect on the dependency ratio. In the quarter-century between 1950 and 1975 the dependency ratio has increased from 89.7 to 98.8. According to the 1974 census, the dependency ration was 89.8 in urban areas and 113.4 in the rural countryside.

THE GOVERNMENT OF HONDURAS' VIEW OF POPULATION POLICY

The formal (de jure) population policy of the GOH is committed to formulating and implementing explicit population policies as a means of attaining overall development objectives. During the 1970s, the Government's development plans contained mainly implicit population policies. Following the establishment of a technical planning unit for population studies within CONSUPLANE, a five-year population strategy was formulated in 1982 termed the Plan Nacional de Poblacion.

In 1983 the Government issued a decree which made family planning a priority area within the national primary health care program, a development which was apparently applauded as an outstanding initiative, as it is widely held that it is within the context of primary healthcare that the most significant family planning/child-spacing and other contraceptive information and service can be imparted with optimum confidentiality -- a feature which increases in importance in proportion to the socio-economic and sophistication level of targeted beneficiaries. Although confidentiality is an delicate issue at any socio-economic level, it is especially so for traditional rural poor population.

The Government's most recent reaffirmation of strong support for a national family planning policy can be seen in the development of a new population law, the wording of which has already been developed. The proposed law is now being discussed by the Congress prior to expected promulgation.

DE FACTO POLICY

However, the de facto policy of the GOH is significantly less enthusiastic in support of family planning than its de jure policy formulations. The reasons for this are unclear. Predictably, the

Government was strongly criticized for the development of its population policies by pro-life groups, and by some very influential groups within the Catholic Church, e.g., most leaders of the hierarchy and the Opus Dei group whose members are said to include at least one cabinet member (the Minister of Health) and numerous lesser officials -- but with major positions capable of influencing policy formulation and implementation. Some evidence suggests that precisely this has happened, i.e., sound family planning policy has been formulated but not implemented.

Given the formulation of the proposed Population Law, it is doubtful that the Government will reverse itself on family planning. At worst (and said to be the most probable) the GOH will continue to permit FP activities to exist without any significant increase in support for the growth of government provided services. In fact, data for female voluntary contraceptive surgical procedures in the eleven hospitals of the Country indicate that fewer women are being surgically attended than previously. Since 1985 the number of such procedures have decreased by about 46 per cent.

YEAR	NUMBER OF PROCEDURES
=====	
1985	2485
1986	2501
1987	2213
1988	1414

An ideal scenario would be for the GOH/MOH to agree on the provision of the full range of family planning information and services within its primary healthcare network of CESAMO and CESAR clinics -- over 600 in all. The utilization of such clinics is suggested in the wording of the population law currently being discussed by the Congress. This would be an ideal development in the cause of family planning and child spacing in Honduras, given the generalized low rate of education and socio-economic status of those targeted beneficiaries most in need of family planning assistance, i.e., the poorest of rural campesino women. This is probably unrealistic, however: not for de facto policy reasons but for resources. According to the CRS office in Tegucigalpa, about 10 per cent of its annual allocation of medicines (over one-half million dollars worth) for the 165 Catholic parish-associated clinics, is donated to mostly CESAR, but also CESAMO, health centers of the MOH in those rural areas closest to the parish clinics -- and this because MOH clinics are frequently without basic medicines.

2. DIRECT AND INDIRECT BENEFICIARIES

The stated target group indentified by the draft PP are all women in union between the ages of 15 to 44 years of age. Men also are direct beneficiaries as users of condoms and acceptors of AOV surgical procedures. The most important indirect beneficiaries are the children of mothers, whose fewer pregnancies through child-spacing will, indisputably, result in her improved physical health.

This is an especially vital concern in poor urban slums where single female-headed households are frequently the rule rather than the exception, and where dangers to childrens' health are many, great and frequently fatal.

One reason for high infant mortality rates this is the widespread lack of sanitary conditions in the homes of the poor. Poor water and sanitation facilities is known to increase the transmission and ingestion of pathogens which are the principal cause of diarrhea long the number one debilitator and killer of children under five.

Mothers in such housing conditions spend a great amount of time caring for sick children; and the death of a mother in poverty spells disaster for surviving children. A mother's chance of death from childbirth is normally high among the poor. A worldwide calculation in a 1984 study by Rinehart, Kols and Moore, estimates the likelihood of death through childbirth to be 60 deaths per 100,000 women, for women under age 35. The possibility ascends to 160/100,000 for women over 35.

It is important to point out that the above quoted mothers-chance of-death (MCoD) figures are analagous to per capita income figures, in that while it is true that Honduras has a per capita income of US\$ 740, it is well known that poor Hondurans earn much less, as the aforementioned SECPLAN data illustrate to be the case for the poorest rural poor. In other words, 60 or 160 childbirth deaths per 100,000 women are national-level figures for those respective age groups. Those MCoD rates, then, need to be understood in higher terms for the poor, and it is even much higher in those many cases of poor rural women who have a rapid succession of childbirths.

The Project has other direct and indirect beneficiaries proper to other Project components listed in the PID. Other than CSP(CBD), CSM, Clinical Services and management and administrative changes, the Project includes Information, Education and Communication (IE&C) for a wide range of persons, including community leaders and students. The employees of Employee-based Family Planning programs facilitated through employers are also potential direct beneficiaraies: as are all of those who could be reached through PVOs and other collaborating resources suggested in one of the PID drafts by "unemployed physician" type of program model.

3. HOW HAVE THE PERCEIVED NEEDS OF WOMEN AND MEN FOR FAMILY PLANNING BEEN DETERMINED. BY WHOM WERE THEY DETERMINED?

Several surveys, studies and reports demonstrate the needs of women and men for family planning services. In the FHI 1987 National Epidemiology and Family Health Survey data illustrate that nearly half of surveyed women in over 11,000 households desired no additional children. Some responses for not using contraception are also indicative of need. These include reasons of fear, opposition of husbands, lack of knowledge and distrust.

A large number of women not contracepting expressed an intention to use family planning methods in the future. The two principal methods mentioned were pills (23.5 percent) and AOV surgical procedures. The most likely provider of family planning services was believed to be the Ministry of Health.

In the 1987 MOH/S&T study of 11,732 households nationwide it was found that 40.2 per cent of 7,343 women surveyed did not choose to conceive their last child or their current pregnancy. That study also found that 50.2 per cent of 2,953 women interviewed did not desire their last or current pregnancy. (Cf. cuadros III, number 6 and 7 of the MOH/S&T draft of the 1987 NE/FHS study. .

With respect to men, one focal group discussion of seven men who had undergone a vasectomy described some of the difficulties involved in doing so. One of the most salient problems mentioned which, probably, deters significant numbers of men is the insults and jokes of friends and neighbors when learning of the decision.

An applied research project based on a survey and a series of focal group discussions involving 959 men in three peri-urban communities by ASHONPLAFA and AVSC, in search of data which would yield lessons regarding how to more effectively market vastectomies. One quite remarkable finding (so remarkable that it is questionable, but very worthwhile replicating) was that while the participants are said to have been randomly selected, it was found that 67 per cent were actually using a family planning method, and that fully 36 per cent of their spouses had undergone AOV surgery. The findings included an indication that a significant number of the men were agreeable to undergo AOV surgery when they finish building their families.

The sessions also yielded information about ideal family size (between 2 and 4 children), beliefs about the effects of vasectomies and female sterilization and about the attitudes of persons who have undergone contraceptive surgery and of spouses, friends and neighbors of these. The data also indicates opinions about condoms and their appropriate use (primarily for use outside of marriage as they are used to prevent disease; they are not used with spouses because they endanger the health of spouses.) One important suggestion which emerged from the discussions was the

need to protect confidentiality.

4. DESCRIBE PROJECT RESOURCES AND ACTIVITIES, AND THEIR APPARENT FIT OR CLASH WITH HONDURAN TRADITION AND CULTURE

The PID describes five programs (one other * is possible), one management and one administrative components as follows:

Program

- o Community Service Program (CSP/CBD)
- o Contraceptive Social Marketing (CSM)
- o Clinical Services
- o Information, Education & Communication, and Education of Leaders (Mass Media -- IE/C)
- o Employee Based Family Planning
- * PVOs (for further intensive review)

Management

- o Statistics, Evaluation & Operations Research

Administration

- o Computerization of financial management system.
- o Inventory management

Clearly, one the most voiced concerns of ASHONPLAFA staff is the difficulty of reaching the poorest households in rural Honduras where roughly 61 per cent of the population live, as well as the poorest of the urban poor. According to the illustrated socio-economic class categories, the beneficiaries of ASHONPLAFA were estimated based on ASHONPLAFA data on education levels attained by beneficiaries, and by the differences of urban/rural situations as reported in numerous studies and reports. ASHONPLAFA staff were asked to comment and revize estimates according to their best impressions.

SOC.ECO CLASS	RURAL	PERI-URBAN	URBAN
upper-upper	n/a	none	none
upper-middle	n/a	none	none
upper-lower	none	none	none
middle-upper	5%	5%	5%
middle-middle	15%	15%	15%
middle-lower	25%	25%	25%
lower-upper	32%	35%	30%
lower-middle	20%	17%	20%
lower-lower	3%	3%	5%

As has been discussed above (No. 5) rural isolation is a major

reason why access to the lower-lower sector of the population is so difficult. Coupled to the almost total absence of formal educational opportunities, the task of enabling the rural poor to exercise their right to undertake effective family planning is, indeed, a challenge. The PID calls for the employment of eight additional CSP(CBD) promoters each attending to an average of 65 distribution points. The possibility of the use of motorcycles is discussed. This would certainly facilitate the reaching and training of many more volunteers during the dry seasons, if the proper maintenance of motorcycles can be assured. Other motorized transportation is being considered, and would be appropriate for the winter/rainy seasons.

But in spite of the serious problem of rural isolation, there are other reasons at play for why there is not a greater number of the rural poor involved in ASHONPLAFA family planning programs. As has already been mentioned, the rural poor are also those who have the least opportunity for a formal education, and this is clearly related to higher individual fertility rates. In great part, of course, the lack of educational opportunities frequently is a consequence of living in remote regions where the only means of transportation in or out of an aldea hamlet is by foot or on horseback.

Another reason is the cost of contraceptives. An early PP draft points out that the ASHONPLAFA pricing structure for all CSM products is based on the "generally accepted social marketing price parameter of one to two per cent of minimum wage for contraceptive protection." Given that the minimum wage in Honduras is L.200.00 per month (US\$100), it then follows that the cost of one month's worth of contraceptive protection is L.3.36 for condoms; L.2.00 for Nominest and L.1.50 for Perla. Of course it is well known that very few rural workers earn the minimum wage. But if the aforementioned SECPLAN data about rural monthly income is anywhere near correct then ASHONPLAFA products are priced beyond the reach of those rural poor which that figure represents. Analogous reasons may keep the involvement of the poorest urban dwellers low.

Still another reason for the low number of poor involved in the ASHONPLAFA program is verguenza (shame). For many people around the globe -- but especially rural women with little formal education -- human sexuality is not a topic of normal discussion -- especially with strangers. The usual contexts in which the traditions of many societies maintain that sexuality may be discussed by women relate to jokes, domestic disputes, the birth process; and this among close kin and friends. The anthropological literature is filled with descriptions of sexual taboos and the extreme sensitivity that many peoples have about discussing the subject.

Discussions about sex are accepted as normal occurrences among men, but not among women -- an attitude which includes the almost

universal belief that casual and extra-martial sex is an acceptable weakness for men, but worthy of scorn for women, at best: at worst she is to be killed. None other than our Judeo-Christian scriptures call for a women's death by stoning when caught in adultery. In one Tegucigalpa taxi a colorful sticker reads "Yo soy soltero; es mi esposa que es casada." (I'm single. It's my wife that's married.) Such attitudes are widespread, even among so-called "sophisticated people" and stems from very ancient traditions -- in the West, anyway.

The point about the above discussion is that such sensitivities are alive and well in Honduran society, and most probably plays a part in why so few poor Honduran rural women, relative to their total number, avail themselves to existing opportunities to use family planning methods. But some rural poor women are family planning acceptors. So while the challenge to market the service to them is extremely difficult, it is not impossible. Given the impossibility of providing even a few years of a primary school education to the many rural Honduran communities without schools (that would be a most significant "contraceptive" program) the following suggestions may be helpful.

It is crucially important that the CSP(CBD) promoters be trained in cultural sensitivity so that they understand and can articulate its importance to the volunteers they will have a major role in selecting. It is also important that promoters themselves have superb inter-personal skills, and that they are able to recognize those skills in potential volunteers. This qualification is of the greatest importance for relating to traditional rural poor people - - to such a point that it needs to be given greater weight in the promoter and volunteer selection criteria than technical and administrative abilities. It is also advisable to develop formal alliances with the elder women and midwives of rural communities, as these are generally persons of relatively high status and influence in their communities. Needless to say, such persons need to be regularly and publicly recognized for their collaboration and service.

5. DESCRIBE THE DESIRED EFFECTS RESULTING FROM THE INVESTMENT OF THESE RESOURCES AND ACTIVITIES: BY USAID; BY ASHONPLAFA.

The desired effects resulting from the Project are articulated in the PID under the Project Description (II), Sections B (Project Goal and Purpose) and C (Expected Achievements/Accomplishments). The principal desired effect is the reduction of the Country's crude birth rate by assisting in the strengthening and expansion of family planning services in both private and public sectors.

Given that the the GOH's implementation efforts have not kept pace with its policy, a desired effect is to see improvements in this

area. A greatly increased role in family planning for the widespread network of Government CESAMO and CESAR primary health clinics has the potential of increasing the number of women using family planning services by significant numbers, and this because the use of primary care clinics guarantees confidentiality to a much greater extent than can the utilization of services by organizations exclusively dedicated to family planning.

The goal of the Project is to reduce the current Total Fertility Rate (TFR) from 3.9 urban and 6.8 rural, to 3.0 urban and 5.8 rural. Another desired outcome is expressed as the Project Purpose, which is to increase contraceptive prevalence (defined as the "percentage of couples in union of reproductive age using modern family planning methods) from 41% in 1987 to 50.4 % in 1993. The key expected achievement/accomplishment according to the Mission's CDSS, is to increase access to voluntary planning services and contraceptive prevalence from 41% to 50% in 1993.

The primary measurement of achievement will be the level of fertility rates as measured in contraceptive prevalence surveys to be carried out in 1990 and 1993. Measurable results will be the number of acceptors, an increase in the variety and quantity of contraceptive products offered, the expansion of distribution outlets, and the number of surgical procedures preformed.

6. DEVELOP PROFILES FOR PROGRAM BENEFICIARIES

When the ASHONPLAFA program began, the typical beneficiary was over 35, with an average of four children whose basic reason for seeking service is their wish not to have additional children. This is still the general pattern for newly implemented outreach programs, particularly the CSP(CBD) program. The initial phase of ASHONPLAFA's work with these women is education, in the course of which fears are allayed and confidence in the program established. This confidence on the part of the new acceptor is important, as it is the basis upon which younger women of the community are encouraged to come for assistance.

There are three basic demographic characteristics which ASHONPLAFA uses to characterize its beneficiaries. These are age, number of children and years enrolled in formal education, and this with respect to each of the three major programs: Servicios Medicos (SM), Community Service Program CSP(CBD) and Anticoncepcion Quirurgica Voluntaria (AQV).

Servicios Medicos (SM): In the context of the Servicios Medicos program, service is provided to women between the ages of 20 and 29 years of age. This age group represents 71 per cent of the total SM program beneficiaries. This is consistent with the fact that the 20-29 age group represents those women with the highest statistical fertility rate.

Community Service Program (CSP): The age of the typical CSP acceptor gets older in this primarily rural program, i.e., the age group attended is primarily rural and is between the ages of 20 and 34. Of the total 71 per cent, 43 per cent are between the ages of 30 and 34. Given as a major reason for the high percentage of women over 30 in this CSP program, is the fact that the program is carried out in a primarily rural context where there is no other choice.

Anticoncepcion Quirurgica Voluntaria (AQV): Women targeted for this program are between 25 and 39. 66 per cent are between the ages of 30 and 34. The percentage climbs to 83 per cent when the age group from 35 to 39 is added, i.e., for women between 30 and 39. Approximately 17 per cent are between the ages of 25 to 29.

According to the three major variables of age, number of children and years of formal education, ASHONPLAFA data indicate that the typical ASHONPLAFA beneficiary uses the organization's three major programs to the extent indicated in the tables below:

BY AGE	SERVICOS MEDICOS	AQV	CSP/CBD
15 to 19	9.4%	0.4%	5.8%
20 to 24	33.5%	11.1%	21.1%
25 to 29	38.2%	35.1%	29.8%
30 to 34	10.5%	30.9%	20.8%
35 to 39	5.2%	17.8%	13.0%
40 and Over	3.1%	4.7%	9.4%
	100.0%	100.0%	100.0%

BY NUMBER OF CHILDREN

NO CHILDREN	5.2%	0.0%	1.3%
1 CHILD	35.1%	0.8%	36.5%
2 CHILDREN	30.9%	3.3%	38.0%
3 "	15.2%	22.3%	12.1%
4 "	6.3%	30.2%	12.1%
5 OR MORE	7.3%	43.4%	
	100.0%	100.0%	100.0%

BY FORMAL EDUCATION

NONE	2.6%	17.4%	9.8%
PRIMARY/INCOMPLETE	16.2%	54.3%	40.0%
" /GRADUATED	24.6%	21.3%	29.8%
SECONDARY/INCOMP	16.2%	2.4%	12.3%
" /GRADUATED	33.1%	4.4%	6.8%
SUPERIOR SCHOOL	7.3%	0.2%	0.4%
	=====	=====	=====
	100.0%	100.0%	100.0%

In the Servicios Medicos program the principal intention of the participants is reported to be child-spacing. 71.2 per cent of those enrolled in the SM program have two children or less. In comparison, 93% of the AQV program users are those with three or more children. The CSP program provides temporary contraceptive services for women with significant numbers of children: 24.2 per cent of these have five or more children.

Regarding formal educational levels, the great majority (81.2%) of the acceptors have completed at least primary school. Only 2.6% of those in the CSP program have had no formal schooling; 16.2 per cent have had some primary education. In other words, only 18.8 per cent have had little or no education. Yet in that same category of women with little or no formal education, a fully 71.7 per cent underwent surgical sterilization.

7. **ASSESS THE DE JURE AND DE FACTO COMMITMENT OF THE GOH TO FAMILY PLANNING AS DESCRIBED IN THE 5 YEAR SECPLAN, AND THE RECENTLY FORMULATED POPULATION LAW.**

As indicated above under Comments on Suppositions, the formal de jure policy of the Government strongly supports family planning. It cannot be faulted. The GOH's health objectives are largely those established by the Pan American Health Organization for the countries of the Americas for the year 2000. As regards family planning/child-spacing, a principal stated objective of the SECPLAN is,

"to increase contraceptive prevalence to 60 per cent of women in union in the fertile age group."

The GOH's and USAID's benchmarks for monitoring progress in the attainment of this objective are the following:

	<u>1980</u>	<u>1985</u>	<u>1990</u>	<u>1995</u>	<u>2000</u>
Contraceptive Prevalence	25%	35%	45%	53%	60%

The above being the case, this Project is fully consistent with the GOH's National Development Plan for 1987-1990, and the health sector policy statement developed by the current Honduran Administration in March 1986 and published in the document entitled Politica Nacional de Salud. In the context of that plan the Government identifies and describes basic programs and the strategies to be used for implementing them, and stresses the importance of strengthening the basic health system which includes Maternal and Child Care in which family planning is conceived of as an essential/integral part. The strategies for implementing these programs include community participation, inter and intrasectoral coordination aimed at behavior modification, appropriate technology, human resource development, improvement in the logistics system, and making more effective use of external financing and technical assistance.

KEEPING PACE WITH POLICY

As has been noted above, the formal policy of the GOH with respect to family planning is widely believed, primarily by ASHONPLAFA staff, to be far ahead of its de facto achievements. Reference is made to the above discussion on this topic, under Comments on Suppositions, Number 6.

8. REVIEW AND ESTIMATE THE EXTENT TO WHICH BENEFICIARY PARTICIPATION CAN BE ACHIEVED DURING PROJECT DEVELOPMENT.

The writer is assuming here that "beneficiary participation" means participating as a volunteer in the cause of the program. In that sense, "beneficiary participation" is an ideal for many human service programs and has a well developed international literature within the schools of social work and community development.

How difficult or easy it is to attain beneficiary participation depends on a host of factors: many of them cultural, but maybe as many depending on accidentals -- the luck of having the right beneficiaries, at the right time, in the right place; and the luck of having the right staff members. With respect to family planning programs, the participation of beneficiaries is an extension of the creativity of donors, program designers and administrators, consultants, etc. In a recent consultant report to the USAID/H Mission, Ana R. Klenicki suggested numerous creative programming

possibilities which could involve a wide range of beneficiaries on a volunteer basis, in activities which would be informative for them and conducive for the recruitment of other clients, as well as activities which would be fun to do.

One type of indirect beneficiary program, directly related to family planning, has proved successful in relatively small PVO primary health clinics among indigenous peoples in the Guatemalan Indian Highlands. "Indirect beneficiary" is stressed, because the volunteers used to break the constraint of the verguenza of Indian women to enroll in a child-spacing program were elder women, some of them traditional midwives; numerous of them the spouses of the community's formal council of elders called the principales. As such they carried the highest status and prestige in the community.

The purpose of these women (referred to as the "ancianas") was to visit every extended family compound in the town (of over 20,000 population in 1973) to ask if anyone was sick. Illness, rather than health, was stressed, because a semantic feature of the Mayan word for "sick" included the notion of pregnant. In other words a women became "sick" as soon as she became pregnant. Pregnancy was a condition requiring special care and special rituals and prayers of protection: some of them against death, as death in childbirth was not a rare occurrence. So while the birth of a child was a fundamentally joyful event, it was also a dangerous time. The cultural milieu, therefore, was right for such an initiative.

What was also "right" was the well known local PVO nurse who had exceptional interpersonal skills; and who gave and received kindness with ease. The ancianas asked her help. She responded. In time references for family planning assistance became an integral part of the compound visiting program.

Can such an effort be made in the rural areas of Honduras? There is one anthropological monograph on compadrazco in the Oriente region of Guatemala (bordering on Honduras) by Doctor Carl Kendall, of Johns Hopkins University, which suggests that Ladino (non-Indian) campesino elder women also have high status and corresponding influence in their communities. In other words, the cultural basis for making such an effort in rural Honduras is probably existent. Whether the financial and appropriate "right stuff" staff resources are available is another issue which needs to be examined. It cannot be overstated, that success or failure of many such programs depends heavily on the selection of the right volunteers and the right staff people.

1. GENERAL DESCRIPTION: DEMOGRAPHIC PROFILE

According to per capita calculations, Honduras -- with \$740 dollars -- is the poorest country in Central America. One reported INA study of per capita income of rural Honduras comes up with an estimate of an annual per capita income of less than one hundred lempira. Significantly less than the national per capita or minimum wage amounts is well known to be the case for rural Honduras, and this because large parts of the Country are made up of sparsely populated rugged mountain ranges, a factor which according to a 1985 UN analysis (Population Policy Compendium) has made communications difficult and has slowed the process of national and social integration as well as the movement of currency. According to the 1988 Censo Nacional de Poblacion y Vivienda (CNPV) Honduras has a population density of 39.05 persons per square kilometer, one of the less densely populated countries of Central America.

CENSUS DATA

Honduras has held thirteen national censuses since 1844, the most recent of which was conducted in 1988 (the data of which has yet to be analyzed and made available to any extent.) Previous to this most recent census the Country's data base was considered to be seriously deficient. Between the censuses of 1910 and 1940, Honduras grew at an average rate of more than 1.5 per cent per annum. The rate of population growth reached 2 per cent after 1940 and 3 per cent after about 1955. By 1970-75 the rate of natural increase was estimated to be about 3.5 per cent per annum, due to the net effect of a crude birth rate of 49/1000 and a crude death rate of about 14/1000 during those years. It is currently calculated at 3.1 per cent.

POPULATION SIZE

According to a demographic profile for Honduras, done by Palacio Garcia in 1983, the population of Honduras was at four million in mid 1982. At that time the population was growing at a 3.5% rate, the fastest in Central America. The latest provisional estimates by the aforementioned recent Censo Nacional de Poblacion y de Vivienda (CNPV) of 1988 indicates a population of approximately 4.4 million (4,376,839), a figure which is significantly lower than the 4.8 million shown in the 1988 World Population Data Sheet of the Population Reference Bureau (PRB).

CRUDE BIRTH AND DEATH RATES

In comparison to a crude birthrate of 47/1000 in 1982, its current 1988 crude birthrate, according to the 1988 census data, is 38/1000 -- a figure which is comparable to the 39/1000 reported by the PRB. This figure represents the fifth highest crude birthrate in the entire LA/C region: behind Nicaragua (43/1000), Haiti and Guatem-

ala (41/1000) and Bolivia (40/1000). The crude death rate has also decreased since 1982 -- from 12/1000 reported in the Garcia data, to 8/1000 according to current PRB data.

RURAL-TO-URBAN MIGRATION STREAMS

In 1982 only 36 percent of the population was estimated to be urban, 61 percent of whom were employed in the agricultural sector -- up from a total of 23 per cent urban residents in 1961. In 1988 the urban based population of Honduras was estimated by the CNPV to have grown to 42 percent, with a corresponding lessening of employment dependency on agriculture. As is occurring everywhere in the world, rural-to-urban migration streams are flooding the globe's largest cities. In Honduras migrant streams are flowing into the Country's two major cities, Tegucigalpa and San Pedro Sula. The current annual growth rates of these two cities are estimated at 4.2% and 5.2% respectively, significantly faster than other urban areas. The total population of Tegucigalpa and San Pedro Sula represent 13.7 and 6.4 percent of the total 1988 Honduran population. Projections put the population of Tegucigalpa at about one million by the year 2000, i.e., about 14.3 per cent of the Country's projected seven million population by that year.

The migrations to urban areas is due more to economic expulsion than from an attraction for the cities. In 1974 almost two-thirds of all migrants were less than 24 years old. In urban areas these represented 65.2 per cent. Most migrants to the cities face a difficult time once they arrive, and in many cases the reality of city life proves to be as difficult as the situation left behind. Men arrive basically ill-adapted to perform any work other than manual labor, and as a result are absorbed with great difficulty into the work force, given the already great supply of manual laborers.

Women leave rural areas for the same reasons as men, but arrive with a different set of handicaps. While the stereotype for all Honduran women, rural or urban, is to care for the home and children, in rural areas women make a real contribution to many of the agricultural, animal husbandry, and myriad other tasks needed to sustain a rural family. In contrast, in the cities women find it difficult obtaining employment other than in marginal activities. The squatter settlements of the Country's (and the globe's) cities give testimony to the very low quality of life's amenities sustained by countless migrants from rural areas.

One of the major concerns of the GOH is the rapid growth of its cities, the service levels of which are believed to be extremely low. This was said, by one informant, to have been another major reason for the GOH's expulsion of Salvadorans from its territory in 1969, as many were succeeding in resettling to urban areas. At the present time refugee movements of about 33,000 Salvadorans, Miskito and Guatemalan Indians constitute the country's major

immigration flows. Most of these are cared for by the UN High Commission on Refugees. Repatriation is a major objective of the UN program.

TOTAL FERTILITY AND CRUDE DEATH RATES

The total fertility rate of Honduras has decreased from 7.5 children per family around 1972 (5.3/8.7 along the urban-rural split; 5.8, 7.9 and 8.1 with respect to middle, low and lower class distinction) to 5.5 in 1988.

The crude death rate is currently calculated at 8/1000 according to the PRB data sheet. This contrasts sharply with past crude death rate data. For 1950-1955 it was calculated by CELADE at 28.5/1000; and at 14.2/1000 for 1970-71 by the Honduran Demographic Survey. That latter figure represented a reduction of approximately 50 percent in a twenty year period. It is widely accepted that mortality varies significantly according to region, place of residence, education and socio-economic status.

INFANT MORTALITY RATES

PRB data for 1988 shows the Honduran infant mortality rate to be, along with Nicaragua, the highest in Central America at 69/1000 live births -- but significantly less than the 103/1000 figure reported by Garcia for 1981, and less than the 86/1000 quoted by the UN in 1978. While pleased with the improvement, the GOH acknowledges that its IMR is still one of the highest in the Latin American Region, being surpassed only by Haiti (117/1000), Bolivia (110/1000) and Peru (88/1000).

PRB data for 1988 shows the Honduran infant mortality rate to be, along with Nicaragua, the highest in Central America at 69/1000 live births -- but significantly less than the 103/1000 figure reported by Garcia for 1981.

POPULATION UNDER 15 YEARS OLD

Like most Central American countries, a great part of the population of Honduras is under 15 years old. The 47 percent PRB figure for 1988 is almost identical to the percentage quoted by Garcia for 1975 (46.9%). In contrast, 44.6 percent was under 15 in 1950. According to Garcia, Honduras contained about 620,000 children under 15 years old in 1950, in contrast to over 1.6 million in 1980. He projects a figure of about three million under the age of 15 by the year 2000. This projection seems pretty much on target, given the most recent finding of the 1988 Census which places the medium age of the population at 16.1 years.

DEPENDENCY RATIO

The increase in the under 15 year old age group has had a direct effect on the dependency ratio. In the quarter-century between 1950 and 1975 the dependency ratio has increased from 89.7 to 98.8. According to the 1974 census, the dependency ration was 89.8 in urban areas and 113.4 in the rural countryside.

THE GOVERNMENT OF HONDURAS' VIEW OF POPULATION POLICY

The formal (de jure) population policy of the GOH is committed to formulating and implementing explicit population policies as a means of attaining overall development objectives. During the 1970s, the Government's development plans contained mainly implicit population policies. Following the establishment of a technical planning unit for population studies within CONSUPLANE, a five-year population strategy was formulated in 1982 termed the Plan Nacional de Poblacion. In 1983 the Government issued a decree which made family planning a priority area within the national primary health care program -- a development which was apparently applauded as an outstanding initiative, as it is widely held that it is within the context of primary healthcare that the most significant family planning/child-spacing and other contraceptive information and service can be imparted with optimum confidentiality. a feature which increases in importance in proportion to the socio-economic and sophistication level target beneficiaries. Confidentiality is an especially touchy issue for males at any level.

The Government's most recent reaffirmation of strong support for a national family planning policy can be seen in the development of a new population law, the wording of which has already been developed. The proposed law is now being discussed by the Congress prior to expected promulgation.

DE FACTO POLICY

The de facto policy of the GOH appears to be significantly less enthusiastic in support of family planning than its de jure policy formulations. The reasons for this are unclear. Predictably, the Government was strongly criticized for the development of its populaltion policies by pro-life groups, and by some very influential groups within the Catholic Church, e.g., most leaders of the hierarchy and the Opus Dei group whose members are said to include at least one cabinet member and numerous lesser officials - - but with major positions capable of influencing policy formulation and implementation. Some evidence suggests that precisely this has happened, i.e., sound family planning policy has been formulated but not implemented.

Given the formulation of the proposed Population Law, it is doubtful that the Government will reverse itself on family planning. At worst (and said to be the most probable) the GOH will continue to permit FP activities to exist without any significant

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increase in support for the growth of government provided services. In fact, data for female voluntary contraceptive surgical procedures in the eleven hospitals of the Country indicate that fewer women are being surgically attended than previously. Since 1985 the number of such procedures have decreased by about 46 per cent.

YEAR	NUMBER OF PROCEDURES
1985	2485
1986	2501
1987	2213
1988	1414

An ideal scenario would be for the GOH/MOH to agree on the provision of the full range of family planning information and services within its primary healthcare network of CESAMO and CESAR clinics -- over 500 in all. The utilization of such clinics is suggested in the wording of the population law currently being discussed by the Congress. This would be an ideal development in the cause of family planning and child spacing in Honduras, given the generalized low rate of education and socio-economic status of those targeted beneficiaries most in need of family planning assistance, i.e., the poorest of rural campesino women.

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COOPERATIVE AGREEMENT USAID/HONDURAS = ASHONPLAFA

PHASE I I

COMMENTS AND RECOMMENDATIONS

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March, 1989

I INTRODUCTION

This report has been prepared following the order of the draft of the Project Paper for the Cooperative Agreement between the USAID Mission in Honduras and the Asociación Hondureña de Planificación Familiar, ASHONPLAFA. Some additional observations and recommendations on subjects not contemplated in the Project Paper, are inserted in the report or placed at its end.

The author acknowledges the full cooperation offered by the two involved institutions, as well as the kind attentions received from the personnel of both entities.

II PERCEIVED PROBLEMS

FAMILY PLANNING DEMAND

I agree with the seven suppositions adopted in the draft, and find them true, but I have to comment on the statement of the final sentence that "the areas of focus should be on the supply side of the equation", in the sense that nobody can be sure that there is in Honduras a strong demand of family planning services. When visiting different points of delivery of family planning services, urban or rural, clinical or community based, and finding those places almost empty; when all kind of efforts are made to increase the number of acceptors in the current family planning programs; when the prevalence of use of contraceptives is still under one half of the target population, one must conclude that there is not an actual strong demand for the services of FP. It is different to think in terms of an existent need or "felt need" -as it was said back in the 60s- for family planning in the hondurean population, that does not materialize itself in actual demand because of lack of information about the existence of FP, defined as how many children the couple wants to have, and when, provided that there is no impairment in the health of the mother or of the already existing children.

So, the focus will not be only in the supply side of the equation but both in the supply and demand sides, in terms of converting the felt need into actual demand. The fact that 60% of women in fertile age and in union wanted to space future children or limit them (National Epidemiology and Health Survey, Honduras, 1987) does not confirm that there is a "continuing unmet demand" for FP, but shows a "continuing unmet need" that can be converted into actual demand by an

adequate IEC activity, which is something different.

It is important to remember that the continuation rates in contraceptives depends on the amount of information received by the user, not only for VSC but for all methods. I finally quote the words of Dr. Jaquin Nuñez, Medical Director of the FPA: "Bring me the patients to the clinics, and I will take care of them".

#1 Recommendation: Both AID and the Family Planning Association should give due attention to the establishment of a nationwide IEC campaign to promote family planning and create actual demand. As a part of the planning for its activities under the new agreement, the FPA should submit to AID a detailed IEC project for the duration of the cooperative agreement. The report on IEC by Ana R. Klenicki (Dec. 1988) could be a very interesting instrument for the preparation of the proposal.

TABLE 2. CONTRACEPTIVE PREVALENCE

Just a short comment on the difference in the percentage of increase in prevalence from previous surveys: 49% between 1981-1984, and only 30% between 1984-1987, that may be explained by the fact that the lower the prevalence, the easier the recruiting of users for a program, provided there is a good IEC campaign.

PRIVATE DOCTORS

In regard to the physicians who provide VSC services in their private clinics and do not have temporary contraceptives available for women who for some reason do not have VSC, the case has been discussed with the Head of the Clinical Dept. of the FPA.

#2 Recommendation: A closer supervision of the private clinics that perform VSC under contract with the FPA should be made, to ensure that a good provision of temporary contraceptives is available and offered to the users who don't have sterilization.

REFERENCE OF USERS FROM CBD PROGRAMS TO AQV

The anecdotal information about some clients of the community services who, after 35 years of age are not referred to VSC and are kept in the CSP under orals, was discussed as well with the head of the CSP DEPT. The discussion and related recommendation are presented in page recommendation #18.

TABLE 4 - PROJECTION OF COUPLE YEARS OF PROTECTION (CYP) AND VSC PROCEDURES

#3 Minor recommendations:

- a). Please, make clear that the column for 1994 corresponds only to the first half of the year, make the necessary adjustments, fill the blanks in the line for "clinics" and revise the whole table jointly with the FPA;
- b). I don't see the reasons to include the projections for the PVOs and Employee-based family planning in the agreement with ASHONPLAFA, since they are having their own Cooperative Agreement;
- c). When referring to the Community Services Program, use a constant acronym, CSP, in stead of CSD or, in Spanish, PSC;
- d). In the paragraph that follows Table 4, after mentioning "new approaches through PVOs, community doctors, and employee-based FP services, it should be stated that these are not FPA programs but are part of a separate agreement.

LIAISON OFFICER FOR THE PROJECT

"ASHONPLAFA's Executive Director will appoint a Deputy Director..... who will act as a counterpart to the USAID Project Liaison Officer (PLO)".

- a). The Deputy Director has been already appointed and taken office, and her responsibilities are not to be the counterpart of the PLO of USAID, but a support to the Executive Director and a liaison element with AID if the FPA considers it appropriate;
- b). The position of a Liaison Officer of AID within ASHONPLAFA has generated plenty of controversy. USAID considers it necessary to provide the APF with technical assistance, so that complete programs and budget planning is done at central and regional levels. The FPA thinks that under the new Cooperative Agreement a liaison officer will not be necessary. Obviously, it is accepted that USAID has full right to have the necessary personnel for the follow-up of the project, as well as for offering technical assistance whenever requested by the FPA, but this should be an internal officer in AID offices and not a resident AID advisor inside the FPA premises. Once again, ASHONPLAFA accepts that AID has the right to have that position, and that it can be useful for the accomplishment of the agreement, but they argue that if there must be a permanent observer of AID inside the Association, they will never have the opportunity to develop their own managerial and programmatic capabilities, which is one of the main objectives of the present Cooperative Agreement.

#4 Recommendation: To settle the issue of a permanent advisor of AID in the FPA, the two parties should meet and after a friendly discussion, come to an agreement on this point, based on the liberty of AID of having the officer for the project, who will work from his office in AID quarters, and in the usefulness and convenience of an officer for liaison and technical assistance upon request from the FPA.

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III COMMUNITY SERVICES PROGRAM (CSP)

UNITS OF PERFORMANCE

"....ASHONPLAFA proposes to increase the users (CYP)..."

#5 Recommendation: That all along this Cooperative Agreement and in all documents, projections, statistics or any activities related to it, the unit "Couple Years of protection" (CYP) be exclusively used by USAID or ASHONPLAFA, in order to avoid confusion or misunderstandings. It is understood that there are cases in which it will be necessary to refer to VSC or IUD methods by number of procedures rather than by CYPs.

TABLE 5 In the column for 1984, the actual percentage of change is 2.6% and not 14%

TABLE 6

#6 Recommendation: To discuss and agree with the FPA the most real and viable projections of program performance for the years 1989-1994, since the figures have been changed three times in one week.

INCREASE OF CSP

Regarding to the mechanisms to face the projected increase in the performance of CSP, the document considers the establishment of new distribution posts over the already existing ones, assuming a current average of 36 users per post, with the corresponding increase in the number of promoters. However, to increase the number of distribution posts it is not essential to increase the number of promoters in the same proportion: many of the existent promoters can open new posts if the CSP adopts the policy of leaving the old and well established posts work by themselves or, at least, with much less activity of the promoter, so that the latter will have the time to explore new areas and open new posts.

On the other hand, the increase in the number of users can be achieved not only with more distributors and promoters, but by improving the average of the current posts, as well. It is understood that the two mentioned mechanisms can work together in a parallel way and do not exclude each other, as it is the intention of the FPA.

#7 Recommendation: ASHONPLAFA will submit to AID a detailed plan to improve the performance of the distribution posts of the CSP, over the current average of 36 users per post.

TRANSPORTATION OF CSP PERSONNEL

As to the transportation options to provide supervision by promoters, i. e. FPA four wheel drive vehicles, motorcycles and/or contracts with local taxi cooperatives, I have some experience with the first two but, due to the extremely ample variations in each country or in each region of the same country, I do not feel sure to particularly recommend one of them. However, I can inform that in regard to 4 wheel drive vehicles and motorcycles, it proved far better to sell them to the promoters in favorable conditions of price and terms of payment, and contract with them the transportation on a basis of an agreed rate per kilometer according to pre-determined travel schedules. This substantially reduces the costs for maintenance, prolongs the life of the vehicles and eliminates the problem of the control of the use of the vehicles for personal activities or in non-work time. It is important to point out that ASHONPLAFA is in the way of initiating two Operation Researches on this subject.

INCENTIVES

As any institution, the FPA may have a personnel policy that contemplates incentives or any types of performance recognition for its employees. As a matter of fact, the FPA currently has a plan for incentivation of the CSP personnel at all levels, and it is intended to improve their motivation. There is also an incentive plan for the voluntary distributors. In this regard, the CSP must be particularly cautious not to give the idea that the program is "buying" the conscience or the good will of the volunteers. Preferably, the recognition can be made in the form of certificates, distinctions, medals, parties, or modest gifts, rather than in money. Naturally, incentives of any kind should be never considered for users.

VARIETY OF METHODS AND PRODUCTS OFFERED

"...the range of products available at the distribution posts will be increased." This is an already existing plan in the FPA to increase the range of products offered in the CSP, through two different ways: a) distribution and sale of the contraceptives of the Social Marketing Program, and b) addition of new health products of popular use and demand, that will be purchased with the revenues of the current CSP. I think this will be a good innovation in CSP for improving the confidence an interrelationship between the users and the FPA.

#8 Recommendation: That the CSP includes new items for distribution in its posts, provided that if different brands of the same contraceptive are sold, all of them should have the same price to avoid confusion in the public regarding to whether the program is offering "good" and "bad" products or methods.

QUESTIONS FROM THE CONSULTANT'S SCOPE OF WORK

- a). The design of the CSP in ASHONPLAFA is fully consistent with the existing body of knowledge regarding the use of community distribution networks for increasing contraceptive average. Even more, is one of the top CBD programs in Latin America. Obviously, as considered above, improvements can and should be made.
- b). The Operation Research proposed for increasing CVFs and lowering costs are worth the inclusion in the project, as long as they are not taken as a pretext for delaying the initiation of positive changes in the program;
- c). The question about incentives has been answered right above.

IV CONTRACEPTIVE SOCIAL MARKETING (CSM)

PRICES POLICY

I have already recommended for CSP the policy of equal prices for different brands of same contraceptive; in the same order of thinking, I find inconvenient to have different prices for the same article in different points of delivery of the FPA: in other words a given article should have the same price either in a CSP distribution post of ASHONPLAFA or in a clinic of the FPA, whether in urban or rural areas, not to create the idea of internal competition of prices. It is different when the same contraceptive is sold by a pharmacist through the CSM program, since the pharmacy is not owned by the FPA, there is no internal competition, and CSM is a commercial activity oriented to keep contraceptives at low prices and to generate some income for the FPA and, therefore, the prices in CSM are more subject to the alternatives of the market than the internal prices in the FP programs of the FPA.

#9 Recommendation: To establish a policy of equal prices for equal products within the family planning programs of ASHONPLAFA.

COST-EFFECTIVENESS OF CSM

Under the new structure, it is expected and expectable that CSM will cover operating costs in its fifth year of operations. It is different from the case of Drogueria Nobel since the latter was always very far from self-sufficiency for two reasons: a) DN was intended to be a nationwide organization for the distribution of four to six products in competition with other Droguerias that distribute over 600

55'

products each; b) the over-generous amounts of money put in Drogueria Nobel that made self-sufficiency even more remote.

URBAN - RURAL CSM?

Although the paragraph stating that CSM was basically oriented to urban low-class couples that can afford the purchase of CSM contraceptives, was deleted from the Project paper Draft, it is yet important to insist that the character of urban or rural is not an indicator of economic status of people and that there can be poorer people in the cities than in the countryside, hence the need for CSP distributors in urban marginal areas, even in the case that some overlapping of the two programs could eventually occur.

#10 Recommendation: To reword paragraphs 3 to 5 of the section F (Social Marketing) of the draft of the project paper so that they have a more clear meaning.

QUESTIONS FROM THE CONSULTANT'S SCOPE OF WORK

Although I have no expertise in Social Marketing, the experience in the management and observation of FP programs has shown me that the answers to the questions raised in the scope of work about CSM programs of ASHONPLAFA regarding to 1) technical feasibility of a model with commercial and CBD distributors; 2) cost-effectiveness of the model, and 3) experiences in other countries, should be answered in a positive sense. As for question No. 1, the only important observation is that CSP distribution posts should be just additional outlets for CSM, that CSP will not be the administrator of CSM, and that none of the two programs will be a branch or a part of the other. Collaboration but not interdependence.

For more details, please see the SOMARC report of December/88 on the CSM program of ASHONPLAFA, by Santiago Plata and Juan Manuel Urrutia.

V CLINICAL SERVICES

On clinical services, the project draft deals only with Voluntary Surgical Contraception; for better understanding, the projections and targets of the project should be made for all methods delivered by the Medical-Clinical Dept., although no funded by AID.

The first paragraph of the draft is not clear in regard to the time when six clinics of the FPA will be operational. Is

it before the current (first) stage of the project ends (June 1989) or before the end of the second stage (June 1994)? Or when?

TABLE 6, VSC PROJECTIONS

Different opinions were found about the figures in Table 6, and it must be defined whether the projections include private clinics under contract with ASHONPLAFA, Government Hospitals supported by the FPA in their programs of VSC (AID doesn't want to include them in the present project because financial support is being given to the MOH), or not.

#11 Recommendation: To discuss and agree with Dr. Joaquin Nuñez about the projections and goals for the FPA during the validity of the agreement, not only for VSC but for all clinical methods offered by ASHONPLAFA.

CAPACITY OF THE FPA FOR VSC PERFORMANCE

I agree in the feasibility of assigning to surgical contraception three of the four contracted medical hours in the ASHONPLAFA clinics, but I am not sure whether it will be possible and practical to try to reach in three hours an average of eight VSC procedures, since there are many variables different from the time of the surgeons, that influence the output of a surgical unit. Among them, the number and skills of the auxiliary paramedical personnel, a stock of surgical instruments for at least 8 minilap sets, space enough for the recovery of 8 patients (especially in ASHONPLAFA where general anesthesia is a current procedure) and, the most important, enough demand for the method in the respective areas and clinics. Where there is money, it is not difficult to build up a facility for 8 VSCs a day; but even if there is money the development of the demand will take an unpredictable lapse of time, so that it is not realistic to project an average of 8 daily cases during the duration of the agreement. It makes more sense to think that for a given clinic, no more than the traditional 3 cases per day should be projected for the first year after the opening of the services, and then, depending on the demand, add one or two daily cases each year until the goal of eight is gradually reached.

FUNDING PROTOCOL FOR VSC

"For the first year, AID will make up 100% of the difference of cost per procedure, after the amount recovered is deducted. Each subsequent year, the cost per procedure will be reduced." Once again, it doesn't look realistic that the absolute costs of VSC procedures will be reduced each year -10% of the cost of the previous year; it is true that a larger volume of procedures may lower the unitary costs but, on the other hand, devaluation will not permit the reduction

and, in the best of cases, the absolute costs might be kept stable.

The recovery of part of the costs from fees charged to the users is something different. In spite of the unfortunate policy of giving all services for free, that has been followed in Honduras for years, I still think that an effort could be made to initiate a change in this policy and try to recover something from the patients. I accept that it will take time and generate some problems, but it is high time to begin with a new policy of recovering part of the costs, especially in VSC. Most Latin American Countries have succeeded in their efforts to charge some fees in the VSC programs, and the only difference with Honduras is that others have tried and Honduras has not.

#12 Recommendation: The establishment in ASHONPLAFA of a policy of charging fees to the users of the VSC program, on the basis that no patient will be rejected for lack of money.

TRANSPORTATION OF VSC PATIENTS

"FPA will explore the feasibility of arranging transportation for women in remote rural areas as a way to assuring equal access to all services." The APF is already trying some different approaches to the problem in its clinic of Choluteca, with the idea of expanding the solution, if found, to other clinics. My only comment in this regard is that one must be careful in providing this type of services to poor rural communities, because of the risk of creating in the people the custom of receiving everything for free and make not the least contribution (be it transportation) to the solution of their problems. The case of the CBD/VSC program in El Salvador is a good example: CBD provided plenty of first class transportation for VSC patients to the surgical centers; but when this service had to be finished because of the extremely high costs, the rural people were already used to free transportation and didn't come anymore to the clinics unless the vehicles of the VSC program were transporting them again.

QUESTIONS FROM THE CONSULTANT'S SCOPE OF WORK

a).- In my opinion, the proposed medical-clinical program is in full accordance with the accepted medical practice in VSC. The fact that the medical director of ASHONPLAFA is Dr. Joaquin Nuñez, who has been in close contact with AVSC since its initiation, and who was chairman of the International Project of AVSC for a two years period, is a guarantee for the quality of services. Besides that, the Cooperative Agreement states that AVSC will provide periodic supervision of the program.

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b). It is difficult to establish the level of the cost of the VSC services in Honduras, in relation to the costs in other Latin American Countries. Lacking a direct knowledge of the matter, I inquired for figures in the Regional Office of AVSC in Bogota, Colombia, and I was told that the only documented figure they have is a study made in PROFAMILIA, Colombia, in which it was found a cost of US\$35 per procedure; besides that, the Regional Office of AVSC works with an estimated figure of US\$30-35. Comparatively, the costs of ASHONPLAFA estimated at US\$70 per case of VSC, are quite high.

#13 Recommendation: That AID and ASHONPLAFA make a joint study of the actual costs of AVSC in Honduras, in order to be able to make more realistic budgeting and projections.

FINAL REMARK ON CLINICAL PROGRAMS

In the Program Paper Draft there is no mention of the services with reversible methods provided by the clinics of ASHONPLAFA.

#14 Recommendation: In order to have a complete overview of the FPA activities, all the program aspects of the temporary clinical methods should be considered in the agreement, with projections and goals proposed by ASHONPLAFA.

VI "NATURAL FAMILY PLANNING"

It looks like it is a policy of AID to include "natural" methods in the FP projects and that, although this is not considered a reliable way to do family planning, its inclusion into the programs could serve to build up an image of completeness and respect for other ways of thinking.

#15 Recommendation: If it is necessary for political reasons, "Natural FP" should be included in the programs of ASHONPLAFA, starting with the training of personnel and with the establishment of a pilot program that could be eventually extended to other services according to results. "Natural methods" extremely costly in terms of time of the IEC personnel, and ASHONPLAFA is already overloaded with the commitments of the Cooperative agreement to waste time and efforts in "natural family planning".

VII INFORMATION, EDUCATION, COMMUNICATION

"The new project will place heavy emphasis on an integrated mass communication strategy to increase awareness of ASHONPLAFA as an organization as well as to increase (create?) demand for its services." I agree, on the condition that the IEC work of promoters and education personnel of the programs will not be neglected, and that the growth of the mass media communication not be made at the expenses of personal IEC. Mass media should be taken as an important complement, but not a substitute for personal communication in all contraceptive delivery programs: Clinical, CSP, AOV, CSM.

"The IEC Dept. will assume responsibility for product advertising associated with the CSM effort." I do not agree. IEC activity in FP programs is for information and promotion and creation of demand for FP as a social and public health activity. CSM is a strictly commercial program managed by businessmen, and thus requires a strictly commercial type of advertising that cannot be made by IEC communicators but needs the services of professional publicity agencies, in the same way that a professional advertising agency will do not a good job in the promotional activity or in the preparation of IEC material.

#16 Recommendation: The IEC Dept. of the FPA should be strengthened through observational trips and technical assistance to carry out the communication strategy, both personal and mass media, and a professional advertising agency will be hired for the CMS commercial publicity but not for promotion of FP.

17 Recommendation: When possible, the FPA should consider the utilization of the IEC materials developed by other neighboring FPAs, particularly Guatemala, and should purchase, adopt and/or adapt the already existing useful materials, in order to save time and resources trying to create what has already been developed. Same for the training and updating of its IEC personnel.

AOV PROMOTERS OR FP PROMOTERS?

Since the Overall Program Evaluation and Management Audit (OPE/MA) carried out in ASHONPLAFA in November/88, I have been against the idea that a promoter of a FP program should promote one single method, AOV, for the following reasons: a) Promoters should promote FP as a whole and inform the clients about all the methods available in the programs; b) promoters should work for the FPA and not for a particular Dept. or program; c) the reason for a promoter not having

interest in referring clients to other Depts. because he/she has to meet a pre-determined goal, is not valid since the referral can easily be credited to the promoter performance for goals purposes; d) the diversification of promoters means duplication of activities (i.e. costs) in a given area.

#18 Recommendation: All promoters in the FPA should promote all methods and refer the clients to all departments according to the choice of the client or the most suitable method for each case. All promoters must be trained for this purpose, and the referrals will be credited for the accomplishment of goals.

PUBLIC RELATIONS

During the mentioned OPE/MA of 1988 I commented about the isolationism of ASHONPLAFA in regard to other institutions, particularly the Ministry of Health, United Nations Development Program and the big private enterprises for social action or industrial activity. Now, I would like to go a little further:

#19 Recommendation: ASHONPLAFA should have a special office or officer in charge of the public relations of the FPA vis-à-vis other important organizations, to improve the image created by the current attitude of isolationism.

QUESTIONS FROM THE CONSULTANT'S SCOPE OF WORK

They are answered in the text.

CONTACTS WITH JOURNALISTS

This might be an interesting field to explore in Honduras. I don't want to be negative when I comment the rather unhappy experience we had in Colombia when in multiple occasions the FPA tried to have meetings and different ways of motivating journalists to write and make some social publications about FP; almost nothing came out of this effort and the journalists paid more attention to trips, congresses and meetings than to family planning promotion. Nevertheless, I consider it worth trying.

VII MONITORING, EVALUATION AND STATISTICS

"ASHONPLAFA's consultants routinely comment about the absence of data with which to understand the functioning and performance of the various components of the program and its interrelationship to cost data." These opinions are particularly stated in a report by Dr. Gabriel Ojeda (1987) and in the already quoted OPE/MA report of Nov. 1988; in

these documents and regarding to this field, there are plenty of recommendations that have not been implemented yet. I think it isn't worth to repeat what I wrote in the OPE report since the comments and recommendations are still valid. During the present visit, the situation was openly discussed in ASHONPLAFA with the Executive Director and the Assistant Director, the Head of the Department and the Technical Council, and in all instances the FPA admitted the existence of the problem and expressed its will to tackle it. One of the arguments raised as a reason for not having re-structured the Department was the stage of transition of the collection and processing of service statistics data from the manual to the electronic system. Everybody knows the difficulties and problems faced by the FPA with the technical assistance and the establishment of the new and modern Management Information System but, in my opinion, this is not a completely valid reason. If there is a "political will" to tackle the problem of the data in the FPA, the immediate and necessary action should be taken.

20 Recommendation: The reports from Dr. Ojeda and the OPE/MA mission must be carefully reviewed, all the recommendations studied, and a clearly defined plan for reforms and improvement of the Department made. For this purpose, immediate action should be taken by the Executive and Assistant Directors, the Head of the Department and the Technical Council of ASHONPLAFA: the formers to order and direct the implementation of the necessary methods; the second, to insist before the formers on a quick solution, and the latter to ensure that the solutions are convenient and fit with the needs of the Association.

#21 RECOMMENDATION: As soon as possible, the FPA should request from IPPF/WHR the necessary technical assistance for the reorganization of the Department, particularly in the field of service statistics, and adapt it to the new electronic equipment now available in ASHONPLAFA. IPPF/WHR has a well known and recognized capability and experience in these fields and, with their TA, the new information and data system will be compatible with the information of the other federated Associations.

Finally, in regard to the special interest manifested by USAID in the establishment in the FPA of a correct and opportune service statistics, as well as for evaluation and research, the two quoted reports have all the recommendations that I could make in this field.

IX FAMILY PLANNING IN THE PRIVATE SECTOR

Two chapters on FP programs with the private sector are found in the Project Paper Draft: one deals with Technical Information on Population with the Private Sector (TIPPS) and is based on bringing the big industrial enterprises of the North Coast to the conviction of the economic profit they will have if they offer FP to their employees; the other, through Enterprise Project, to include FP as a part of the activities on infant survival in the Private Voluntary Organizations (PVOs). Although it looks like these two projects are not part of the Cooperative Agreement between USAID and ASHONPLAFA, the paper draft makes insistent mention of the participation of the FPA with the delivery of services, while the PVOs will carry out the promotion activities and will refer the users to the health centers of the MOH or to the FPA clinics. Furthermore, the project counts on the FPA to do the training of the personnel of the PVOs.

#23 Recommendation: The part of ASHONPLAFA in these projects will receive ample discussion between the involved institutions to clearly establish how far the Association is willing to distract the time of its personnel in these activities, coexistent with the tremendous pressure generated by the extension of the AID agreement.

#24 Recommendation: USAID and/or its technical agency, Enterprise Project, should pay special attention to the PVOs with which they are going to work in this project, to avoid the experience of other countries where a "demographic explosion" of PVOs has occurred. Quite often the PVOs are not real organizations but individuals with no infrastructure at all for the delivery of counseling and services in FP and primary health care, and that look as if they were more interested in a share of the generous budgets that usually come with this type of projects.

X TECHNICAL ASSISTANCE

"The SOMARC project will give the TA to de Social Marketing Project, and the Population Council will help in the Operation Research. TA will also be needed for the Management Information System, communications, logistics, and National Prevalence Survey." Everybody agrees in the need for technical assistance to enable the FPA to face the responsibilities originated by the new Cooperative Agreement. In this regard, I quote once again the OPE report of 1988

where this need is discussed jointly with the importance of the fact that TA be requested by the FPA, who will determine when and for what the TA is needed and, in some cases, the institutions or persons who will act as advisors or consultants. If AID considers that the FPA needs some assistance not yet requested by the Association, the Liaison Officer will discuss the need with the FPA and obtain a formal request for it.

#25 Recommendation: Before hiring TA, there must be a formal request or approval from ASHONPLAFA, who will determine the specific object of the TA, the dates, the duration, and the institution or person(s) who will provide the TA.

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**ECONOMIC ANALYSIS OF THE
PRIVATE SECTOR POPULATION PROGRAM II
HECTOR CORREA**

Executive Summary

This document has two parts:

- a) An economic evaluation of the Private Sector Population Program II, and
- b) An analysis of the price elasticities of different contraceptives.

The first part could be useful to decide whether Program II should be implemented. Part b) is likely to provide some guidelines for pricing policies. Under ideal conditions, these two components should be integrated because different pricing policies would determine different costs and benefits for the program. However, with the statistical data available it is not possible to do so. In addition, the results of the economic evaluation of the Program showed that it is on sufficiently solid grounds, so that moderate changes in pricing policies are not likely to eliminate its economic soundness.

1.- Economic evaluation of the Private Sector Population Program II. Well known methods of economic evaluation are used in this economic evaluation of the Private Sector Population Program II. These methods include the following steps:

- a) Forecast of the total number of births and persons of different ages avoided. Description of this step is presented in appendix 1.

- b) Forecast of medical expenditures per birth and of other health related expenditures per person in the population. This step is described in appendix 2.

- c) Forecast of consumption expenditures per person in the ages relevant for the program being evaluated. The approach used in this step is presented in appendix 3.

- d) Forecast of the educational expenditures per child. This step is described in appendix 4.

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e) Forecast of the costs of the program. The estimates of these costs prepared by AID are used below. The values in dollars were transformed to lempiras using the official rate of exchange of 2 lempiras per dollar.

The birth, health, consumption and education expenditures per person are multiplied by the estimated number of births and persons avoided with the population program to obtain total expenditures avoided. The results obtained with this procedure are presented in Tables 1-A in dollars and 1-B in lempiras. The transformation is done using the official rate of exchange. These total expenditures avoided are considered the economic benefits of the program.

The economic benefits and the costs are compared in Tables 2-A and 2-B in dollars and lempiras. First, the values of gross benefits, gross costs and net benefits are presented, next discounted present values of the gross figures and of the net benefits are computed, and finally, the internal rate of return is calculated. The results in Table 2 clearly indicate that the Private Sector Population Program II is justified from an economic point of view.

The net present values of costs and benefits of the program discounted at a 12% rate, show that the benefits are about 2.5 times the costs. The internal rate of return indicates that only if the discount rate would reach a value of more than 31%, the program would not be economically justified.

The information presented in Tables 1 and 2 has two important limitations, namely, a) the official exchange rate of 2 lempiras per dollar is used in them to transform dollars to lempiras or vice versa; and, b) there are an infinity number of alternative values for the discount rate that could have been used with as much justification as the 12% employed for the computations. The two points reduce the validity of the results in Tables 1 and 2 despite that it is quite likely that increases in the exchange rate and changes in the discount rate needed to make them a better reflection of the economic realities in Honduras are not likely to be sufficiently large to modify the conclusions presented above, i.e., they are not likely to increase the costs of the project to the point where they would become larger than the benefits.

Trial and error methods are most frequently used to deal with these problems. This means that alternative values are assigned to the discount and exchange rates and the impact of the changes on costs and benefits are analyzed. This is done with both observed and shadow discount and exchange rates. The difference in these two possibilities is that the shadow discount and exchange rates explicitly attempt to take into consideration economic conditions that do not appear in the observed rates as a consequence of say, economic policies of the government, or structural defects in the economy. It should be observed that usually the analyzes of the sensitivity of the results to different values of the discount rate are made independently of similar analyses made of their sensitivity to alternative values of the exchange rate.

No attempt will be made here to use the method described before. Instead, break even values for the exchange rate are presented in Table 3 together with the corresponding discount rates. A break even value of the exchange rate is the value that, for a specific discount rate, makes the net benefits in national currency equal to the net costs in foreign currency. The method to compute them is explained with an example in Appendix 5. This means that any combination of a break even exchange rate and its corresponding discount rate are a boundary for the rates for which the project is economically justifiable. More specifically, one of the rows of Table 3 indicate that to the break even exchange rate of 6.706 corresponds a discount rate of 12%. This means that if the actual exchange and discount rates are below these values, the present value of the benefits of the project will be larger than the costs, or that, the internal rate of return of the project will be larger than 12%.

Taking into consideration that

- a) the current black market exchange rate is between 3 and 3.5 lempiras per dollar, and
 - b) a discount rate of 12% is used in AID/Honduras in their analysis and evaluation of projects and programs;
- it can be concluded that the information in Table 3 supports the observations before that the Private Sector Population Program II is economically sound. The discount rate without inflation would have to be 16% and the exchange rate 5.2 lempiras per dollar for the program not to be acceptable from an economic point of view.

2.- Impact of the changes in prices of contraceptives on their utilization.

The method used for the estimation of the price elasticities of contraceptives for which a minimum of required information is available is described in appendix 6. To a large extent it is simply an adaptation of standard methodologies to a situation in which data are extremely scarce.

The results obtained are presented in Table 4. The interpretation of these results shows that a 10% increment in prices would reduce the utilization of condoms in a 2%, of Ovral in a 20% and of Lofemenal in a 30%. This suggests that using revenues obtained increasing the prices of condoms increases in prices of Ovral or of Lofemenal could be avoided or limited. This policy could be adopted if there is evidence that the contraceptive efficiency of condoms is lower than that of the other two contraceptives.

It is worthwhile to notice that further research in the topic outlined above might lead to substantial improvements in the cost/effectiveness of the population program.

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TABLE 1-A
TOTAL EXPENDITURES AVOIDED
(1988 DOLLARS)

YEAR	CONSUMPTION	HEALTH	EDUCATION	TOTAL
1990.00	0.00	0.00		0.00
1991.00	466162.56	60009.00		526171.56
1992.00	2076720.00	145197.55		2221917.55
1993.00	4149897.36	244630.28		4394527.64
1994.00	6485596.56	355435.60		6841032.16
1995.00	8861364.24	474026.68		9335390.92
1996.00	11822900.77	587035.35		12409936.12
1997.00	16194242.29	663993.09		16858235.38
1998.00	21019252.90	740642.09	2241499.50	24001394.49
1999.00	26137832.00	816754.03	5395088.53	32349674.55
2000.00	28068702.90	915335.60	6226410.96	35210449.46

TABLE 1-B

TOTAL EXPENDITURES AVOIDED
(1988 LEMPIRAS)

YEAR	CONSUMPTION	HEALTH	EDUCATION	TOTAL
1990	0.00	0.00		0.00
1991	932325.12	120018.00		1052343.12
1992	4153440.00	290395.09		4443835.09
1993	8299794.72	489260.56		8789055.28
1994	12971193.12	710871.19		13682064.31
1995	17722728.48	948053.35		18670781.83
1996	23645801.54	1174070.70		24819872.24
1997	32388484.58	1327986.17		33716470.75
1998	42038505.80	1481284.18	4482999.00	48002788.98
1999	52275664.00	1633508.05	10790177.05	64699349.10
2000	56137405.79	1830671.20	12452821.92	70420898.91

TABLE 2-A
(1988 DOLLARS)

COMPARISON OF COSTS AND BENEFITS OF POPULATION PROGRAM

YEAR	TOTAL BENEFITS	TOTAL COSTS	NET BENEFITS
1989	0.00	3469400.00	-3469400.00
1990	0.00	5528903.00	-5528903.00
1991	526171.56	5475968.00	-4949796.44
1992	2221917.55	5743628.00	-3521710.46
1993	4394527.64	6113242.00	-1718714.36
1994	6841032.16	3380464.00	3460568.15
1995	9335390.92		9335390.92
1996	12409936.12		12409936.12
1997	16858235.38		16858235.38
1998	24001394.49		24001394.49
1999	32349674.55		32349674.55
2000	35210449.46		35210449.46
NPV 12%	49125521.04	20234617.44	
INTERNAL RATE OF RETURN			0.31

TABLE 2-B
(1988 LEMPIRAS)

COMPARISON OF COSTS AND BENEFITS OF POPULATION PROGRAM II

YEAR	TOTAL BENEFITS	TOTAL COSTS	NET BENEFITS
1989		6938800.00	-6938800.00
1990	0.00	11057806.00	-11057806.00
1991	1052343.12	10951936.00	-9899592.88
1992	4443835.09	11487256.00	-7043420.91
1993	8789055.28	12226484.00	-3437428.72
1994	13682064.31	6760928.00	6921136.31
1995	18670781.83		18670781.83
1996	24819872.24		24819872.24
1997	33716470.75		33716470.75
1998	48002788.98		48002788.98
1999	64699349.10		64699349.10
2000	70420898.91		70420898.91
NPV 12%	98251042.08	40469234.87	
INTERNAL RATE OF RETURN			0.31

TABLE 3
BREAK EVEN EXCHANGE RATES
AND CORRESPONDING DISCOUNT RATES

ex. rates	dis. rates
8.681984	8%
8.135353	9%
7.625592	10%
7.149876	11%
6.705619	12%
6.290453	13%
5.902207	14%
5.538890	15%
5.198673	16%

Table 4

PRICES AND UTILIZATION OF CONTRACEPTIVES IN HONDURAS

CONTRACEPTIVES	P.ELAST.	IMPACT 10% INCRS.
OVRAL	-1.108	-11.08%
LOFEMENAL	-3.811	-38.11%
CONDOMS	-0.204	-2.04%

APPENDIX 1

FORECASTS OF THE TOTAL NUMBER OF BIRTHS AND OF
PERSONS OF DIFFERENT AGES AVOIDED

The point of departure in the computation of the forecast of the total number of births and of persons of different ages avoided is the estimates of the total fertility rates (TFR) presented as project goals in the PID. These rates were used to estimate the age specific fertility rates to be used to estimate the births avoided. The estimation of these fertility rates was done using the total fertility rates and the age specific fertility rates used in to forecast the population growth in Honduras up to year 1990. (Secretaria Tecnica del Consejo Superior de Planificacion Economica y CELADE "Honduras: Proyecciones de Poblacion, Volumes I and II).

In agreement with the PID, the program is supposed to last up to 1995. To prepare the forecast up to year 2000, it was assumed that the age specific fertility rates achieved with the program will change between 1995 and 2000 in the way they would have changed if the program would not have taken place.

After the computation of the age specific fertility rates to be used to forecast number of births, the actual computations were made using the standard methods available.

The forecasts of births with the project were used to compute population by single years of age between 1990 and 2000 in the ages relevant for the analysis of the program. The estimate number of births and of persons avoided presented in Table 1-1 were obtained subtracting from forecast prepared from data in the official population projections those prepared using the fertility rates computed assuming that the targets of the project will be achieved.

TABLE 1-1
POPULATION AVOIDED WITH PROGRAM II

AGE	1990	1991	1992	1993	1994	1995	1996
0	0	3816	7798	11951	16282	20796	25708
1			9202	12746	16434	20269	15638
2				9304	12193	15188	19546
3					8183	10399	14508
4						5887	9761
5							8458
6							
7							
8							
9							

AGE	1997	1998	1999	2000
0	27135	28626	30185	31814
1	28447	30603	32870	35255
2	14907	27929	30055	32291
3	18821	14175	27407	29503
4	13828	18097	13443	26883
5	11853	15405	19121	13913
6	9566	12553	15672	14519
7		10350	12848	11124
8			10587	8300
9				6019

APPENDIX 2

FORECAST OF MEDICAL AND OTHER HEALTH RELATED
EXPENDITURES

The point of departure for the computation of the expenditures in health were input costs - excluding personnel costs - provided by the MOH. This information is presented in Table 2-1. It was assumed that the costs will increase 2% per year in constant prices.

It should be observed that the estimates of health costs and their rate of growth tend to under estimate the benefits of the births and persons avoided with the population program. This point is important because, as mentioned in the executive summary, the benefits are substantially larger than the costs. The under estimation mentioned here is another reason to believe that the program is economically sound.

TABLE 2-1

EXPENDITURES IN HEALTH SERVICES

EXP. AVOIDED PER BIRTH	
3 PRE NATAL VISITS	17.37
DELIVERY BY TRADITIONAL ATT.	3.08
POST PARTUM CARE	2.61
COMPLETE SCHEDULE OF VACCIN.	3.05
TOTAL	26.11

YEARLY EXP. FOR CHILDREN 0-4	
3 EPISODES RESPIRAT. INF.	1.16
GROWTH AND DEVELOP. VISITS	2.955
TOTAL	4.115

NOTE: PERSONAL SERVICES ARE NOT INCLUDED
SOURCE: VERBAL INFORMATION PROVIDED IN THE MOH

APPENDIX 3

FORECAST OF THE CONSUMPTION EXPENDITURES PER PERSON

The point of departure for the estimation of the consumption expenditures per persons is the data in Table 3-1. This information was elaborated from data in the 78/79 household survey (Secretaria Permanente del Tratado General de Integracion Economica Centroamericana - SIECA - "Patron del Gasto y del Consumo de Alimentos en los Hogares en Honduras", Documento No. 31/82, Octubre 1982). Only the weighted average of the figures corresponding to the 0-100 and the 100-300 income levels also presented in Table 3-1, was used for the estimations utilized here. The reason for this is that the project benefits mainly women in low levels of income. In any case, the worst scenario is that with the procedure used the consumption expenditures under estimated. If this is the case, the observations made with respect to the under estimation of the health costs also apply here. This means that there are additional reasons to believe in the economic soundness of the program.

It can be seen in Table 3-1 that expenditures in health are included among the family expenditures presented there. It is assumed below that these private health expenditures are not included in those considered in the Appendix 2 that deals mainly with public expenditures. In any case, even if there is some duplication, the fact that the proportion of the family expenditures in health is a very small proportion of the total family expenditures shows that the margin of error introduced is not likely to be important.

Special attention was given to the distribution of the total family expenditures between persons of different ages. For this it was assumed that total expenditures were distributed among persons of different ages in the same proportions as the consumption of calories and proteins are distributed. To estimate these proportions, information in Recomendaciones Dieteticas Diarias for Centro America y Panama produced by INCAP (1973) were used.

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It was also assumed that the average family size is 5.16 persons, i.e., the figure given in the 78/79 Household survey and that a family is formed by $\frac{3}{4}$ of a child 0-4, $\frac{3}{4}$ of a child 5-9, $\frac{3}{4}$ of a child 10-14, $\frac{3}{4}$ of a child 15-19, and 2.16 adults.

The results obtained with the assumptions made above and used for the analysis of the benefits of Program II is presented in Table 3-2.

TABLE 3-1

RESULTS OF 78/79 HOUSEHOLD SURVEY

INCOME INTERVAL	N.HOMES	FAM.SIS.	AV.INCM.	TOT.EXP.	PROPORTIONS OF EXPENDITURES		
					SAVINGS	FOOD	DRINKS
0-100	397.000	4.292	73.246	65.630	0.103	0.679	0.102
100-300	1807.000	5.350	188.754	170.920	0.094	0.627	0.080
300-500	1156.000	6.025	384.219	343.589	0.105	0.542	0.065
500-1000	1147.000	6.362	696.599	590.665	0.152	0.433	0.055
1000+	749.000	6.336	2103.382	1400.327	0.335	0.268	0.034
0-300	2204.000	5.160	167.948	151.954	0.096	0.637	0.084

	HOUSING	CLOTHING	HEALTH	ENTERTEIN	TRANSFOR	OTHER
0-100	0.152	0.037	0.019	0.002	0.007	0.001
100-300	0.137	0.072	0.042	0.014	0.017	0.011
300-500	0.171	0.087	0.058	0.025	0.021	0.031
500-1000	0.210	0.095	0.070	0.032	0.036	0.068
1000+	0.264	0.090	0.084	0.037	0.064	0.160
0-300	0.139	0.066	0.038	0.012	0.015	0.009

TABLE 3-2

EXPEN. PER PERSON

AGE	
0-4	244.32
5-9	335.69
10-14	438.51
15-19	491.77
19+	1294.53
TOTAL	2804.82

APPENDIX 4

FORECASTS OF EDUCATIONAL EXPENDITURES PER CHILD

Educational expenditures per child were computed on the basis of the information presented for elementary education in the Anteproyecto del Presupuesto General de Ingresos y Egresos de la Republica para el Ejercicio Fiscal 1988, published by SECPLAN, and information on the number of students in elementary school provided by AID/HRD. The estimates of costs per student at constant 1988 lempiras were forecasted up to year 2000. The results are presented in Table 4-1.

TABLE 4-1

EDUCATIONAL EXPENDITURES PER STUDENT
LEMPIRAS PER YEAR

YEAR	EXPEN
86	221.28
87	227.41
88	238.92
89	251.55
90	265.65
91	281.56
92	299.24
93	318.48
94	339.03
95	360.59
96	383.31
97	407.46
98	433.14
99	460.43
2000	489.44

APPENDIX 5
COMPUTATION OF BREAK EVEN EXCHANGE RATES
AND CORRESPONDING DISCOUNT RATES

The method used to compute break even exchange rates and corresponding discount rates follows from their definition presented in the Executive Summary. The information in Table 5-1 is used in the example below.

The point of departure are the forecasts of benefits and costs in lempiras and dollars for all the life of the project presented in Table 5-1. Their net present values with an assigned discount rate are computed. These values are denoted here as follows:

- BENLEM NPV benefits in lempiras
- BENDOL NPV benefits in dollars
- COSLEM NPV costs in lempiras
- COSDOL NPV costs in dollars
- BREAKEV break even exchange rate.

From the definition given for the break even exchange rate it follows that

$$\text{BENLEM} + \text{BREAKEV} * \text{BENDOL} - \text{COSLEM} - \text{BREAKEV} * \text{COSDOL} = 0 .$$

This means that

$$\text{BREAKEV} = (\text{BENLEM} - \text{COSLEM}) / (\text{COSDOL} - \text{BENDOL}) .$$

This is the formula used in the last row of Table 5-1. More specifically, for the data in Table 5-1

$$\text{BREAKEV} = (98,25 - 15,91) / 12,28 = 6.706 .$$

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TABLE 5-1

COMPUTATION OF A BREAK EVEN EXCHANGE RATE

YEAR	BENLEM	COSLEM	COSDOL
1989	0.00	2260934.00	2338933.00
1990	0.00	3993964.00	3531921.00
1991	1052343.12	4513294.00	3219321.00
1992	4443835.10	4784348.00	3351454.00
1993	8789055.28	5178106.00	3524189.00
1994	13682064.32	2993756.00	1883586.00
1995	18670781.84		
1996	24819872.24		
1997	33716470.76		
1998	48002788.98		
1999	64699349.10		
2000	70420898.92		
NPV 12%	98251042.10	15910594.25	12279320.31
BREAKEY	6.706		

APPENDIX 6

ESTIMATION OF THE PRICE-ELASTICITIES OF CONTRACEPTIVES

The data used for the estimation of the price elasticities Ovral, Lofemenal and Condoms are included in the PID, and are summarized in Table -1. It should be clear that only the basest minimum of data are needed are available, and, as a consequence the results obtained cannot be considered definitive.

No attempt was made to correct the information of the use of contraceptives to consider changes in income and size of the population of potential users. It was considered that income per capita has remained stable, or even decreased in the last few years in Honduras. No information is available on the number of potential users of Ovral and Lofemenal. It was considered that it was more appropriate to simply treat changes of income and size of potential users, together with the efforts made in the last few years to increase the use of contraception, as determinants of a time trend.

The actual estimation of the elasticities was done with a regression equation of the form

$$c = a + b*t + c*x$$

where the notation means

c natural logarithm of contraceptive utilization,

t time index, and

x natural logarithm of prices

The following results were obtained for these regressions:

$$\ln OVRAL = 10.265 + .262*t - 1.108*\ln PRICE$$

$$\ln LOFEMENAL = 2.552 + 1.556*t - 3.811*\ln PRICE$$

$$\ln CONDOMS = 10.924 + .270*t - .204*\ln PRICE$$

In these equations, the coefficients of $\ln PRICE$ are the elasticities of the different contraceptives with respect to their prices.

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TABLE 6-1

USE AND PRICES OF CONTRACEPTIVES IN HONDURAS

YEAR	OVRAL		LOFEMENAL		CONDOMS	
	USE	PRICE	USE	PRICE	USE	PRICE
1983	28198	1.5			110164	.10
1984	32982	1.5			154997	.10
1985	57142	1.5	14148	.50	217874	.10
1986	81631	1.5	166728	.50	257926	.10
1987	110049	1.5	317385	.50	329513	.10
1988	117546	2.0	340374	.80	389380	.20

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