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Office of Health • Bureau for Research and Development • United States Agency for International Development

## ***Country Strategy Plan: Honduras***



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HEALTHCOM, or Communication and Marketing for Child Survival, is a project of the Office of Health, Bureau for Research and Development, of the United States Agency for International Development (A.I.D.) HEALTHCOM is conducted by the Academy for Educational Development (contract no. DPE-5984-Z-00-9018-00) and its subcontractors: the CIHDC of the Annenberg School for Communication at the University of Pennsylvania, Applied Communication Technology, Birch & Davis International, The Futures Group, The Johns Hopkins University, and Porter/Novelli. This document was developed by Patricio Barriga, HEALTHCOM resident advisor, and Julia Rosenbaum, senior project officer. We would like to acknowledge our principal counterparts: Dr. César Castellanos (minister), Dr. Marco Tulio Carranza, Dr. Alirio Cruz, Prof. Luis Canales, Marco Montenegro, Dr. Jorge Meléndez, Dora Rubí, Roberto Pineda, Luis Merlo, Prof. Luis Sarmiento, Víctor Murillo, Santos Cubas, Cécica Martínez, Dr. Alvaro González Mármol, Dra. Daisy Guardiola, Dra. Maria Elena de Rivas, Dra. Mirta de Ponce, Suyapa Barahona, Ana Lanza, Norma Durón, and Karla Lezama. We would also like to acknowledge the HEALTHCOM staff in Honduras: Nalda Chávez, Martha Medina, Lino Roberto González, and Santos Cuba.

# TABLE OF CONTENTS

I.	HEALTHCOM PROJECT BACKGROUND .....	1
	MASS MEDIA AND HEALTH PRACTICES PROJECT .....	1
	HEALTHCOM I .....	1
	HEALTHCOM II .....	2
II.	COUNTRY PROJECT BACKGROUND .....	4
	BRIEF STATISTICAL PROFILE .....	4
	HEALTH SITUATION ANALYSIS .....	4
	SUMMARY OF COMMUNICATION AND SOCIAL MARKETING ACTIVITIES .....	5
	AUTHORIZING MANDATE .....	7
III.	PROJECT GOALS AND RELATIONSHIP TO NATIONAL PROGRAMS .	8
IV.	PROJECT INPUTS .....	19
V.	ACTIVITIES AND GOALS OF PARTICIPATING INSTITUTIONS ....	10
VI.	MAJOR PROGRAM COMPONENTS .....	11
	CONTROL OF ACUTE RESPIRATORY INFECTIONS .....	11
	CONTROL OF DIARRHEAL DISEASE .....	11
	PRIVATE SECTOR ORS .....	11
	REORIENTATION OF IMMUNIZATION STRATEGY .....	11
	EXPANDED USE OF HEALTHCOM METHODOLOGY .....	12

**STRENGTHENING REGIONAL CAPABILITIES . . . . . 12**

**SUPPORT OF NUTRITION COMMUNICATION ACTIVITIES . . . . . 12**

**DEVELOP IN-HOUSE DESKTOP PUBLISHING CAPABILITIES . . . . . 12**

**VII. INSTITUTIONALIZATION PLAN . . . . . 13**

**MANAGEMENT PROCESS . . . . . 13**

**TRAINING . . . . . 13**

**APPENDIX: BUDGET . . . . . 15**

# I. HEALTHCOM Project Background

## **MASS MEDIA AND HEALTH PRACTICES PROJECT**

In 1978 the United States Agency for International Development (A.I.D.) initiated a project (#931-1018) to apply state-of-the-art knowledge about communication and social marketing to selected child survival practices. The Academy for Educational Development was contracted by A.I.D. to implement the project under the name Mass Media and Health Practices (MMHP).

From 1978 to 1985 MMHP developed a methodology for conducting public health education in developing countries to effectively reach large numbers of people and applied it in seven project sites--Honduras, The Gambia, Ecuador, Peru, Swaziland, Lesotho, and Indonesia. The methodology integrates communication (radio, graphic print materials, and interpersonal communication) and social marketing with traditional channels of health education, training, and product distribution. It relies on the systematic development, testing, and monitoring of communication strategies, messages, and products to bring about positive changes in health-related practices. The original country programs all focused on the promotion of oral rehydration therapy (ORT) and other key objectives of national diarrheal disease control efforts.

## **HEALTHCOM I**

In August 1985 A.I.D. extended the project under a new name--Communication for Child Survival (or HEALTHCOM I). The Academy was contracted to administer HEALTHCOM for an additional five-year period, and the project's mandate was broadened to include additional countries (up to 17) and a range of child survival technologies, in addition to ORT. The project continued to be jointly managed by the Office of Health and the Office of Education in A.I.D.'s Bureau for Science and Technology.

HEALTHCOM's primary purpose was to increase our understanding of how best to use modern communication, social marketing, and behavior analysis to modify existing child care practices. HEALTHCOM's experience, as well as that of health communication programs in other countries such as Egypt and Bangladesh, showed clearly that communication strategies can improve child care practices. HEALTHCOM pursued a significant research and development agenda which included a series of country-specific studies. Each HEALTHCOM intervention was designed to provide some significant

insight into one or another of several key issues. Work was divided into three components: Institutional Studies, Health Practices Studies, and Diffusion Activities.

## **HEALTHCOM II**

On August 31, 1989, the Academy was awarded a five-year contract representing the third phase of A.I.D.'s support for health communication and marketing. Fiscal year 1990 constituted an overlap year for the two contracts. The project is managed by the Office of Health in A.I.D.'s Bureau for Research and Development. HEALTHCOM II focuses increasingly on sustainability of behavior changes and institutionalization of the methodology. The project continues efforts to assist public and private sector agencies in developing comprehensive communication strategies. Formative research remains an essential component of the project, providing essential data for the development of communication messages. In addition, the project continues the use of multiple communication channels (face-to-face, print, and broadcast), while strengthening the face-to-face component. HEALTHCOM II will further the development of the communication methodology and seek to refine it to make the approach more sustainable by host country governments and other institutions.

This phase of the HEALTHCOM Project has several components: Technical Assistance, Applied Research Activities, and Dissemination activities including extensive training.

The Technical Assistance component of the project will include:

- **Intensive Long-term Assistance:** to approximately six core countries, consisting of multiple long-term advisors, support staff, and short-term technical specialists. Assistance will allow for additional activities, such as development of a training curriculum. In each intensive site which received assistance under HEALTHCOM I, communication programs will be developed for at least two additional child survival interventions.
- **Less Intensive Long-term Assistance:** to approximately nine countries through one resident advisor, limited support staff, and short-term technical specialists. Assistance will allow for up to three child survival interventions. Research and evaluation will focus mainly on immediate program priorities. Technical assistance will be phased.

- **Short-term Technical Assistance:** up to three months for discrete activities to missions, ministries of health, PVOs, and other organizations. These TA activities should be part of a longer-term plan in the country.

Six subcontractors have agreed to work with the Academy in carrying out the HEALTHCOM II Project. They are: the Annenberg School for Communication, University of Pennsylvania (for applied research); Applied Communication Technology (to continue the longitudinal study in Honduras); Birch and Davis International (to conduct cost studies); The Futures Group (for policy maker and private sector support); The Johns Hopkins University (for curriculum development); and Porter/Novelli (for social marketing).

## **II. Country Project Background**

### **BRIEF STATISTICAL PROFILE**

Honduras, the second largest country in Central America, has almost five million inhabitants. It is one of the poorest countries in the region with an average per capita income equivalent to \$740 (1986). While population growth is still high, infant mortality has decreased significantly in the past five years. In 1979, infant mortality was reported at more than 120 per 1,000 live births. A recent maternal and child health study indicates that infant mortality is now 61 per 1,000. The principal causes of infant mortality are acute respiratory infections, diarrheal disease, and diseases that can be prevented by immunization. It is important to note that diarrheal disease was the principal cause of infant mortality until the early 1980s, when the MOH launched an aggressive national CDD program. Malnutrition is a major problem throughout the country. It is estimated that 70 percent of all children under the age of five suffer from some degree of malnutrition.

Honduras is one of the most rapidly growing countries in Latin America. Between 1975 and 1980, the population growth rate reached 3.5 percent per year, but it is now declining. In 1987, the total fertility rate was estimated to be 5.6 per woman, a decline of almost 2.0 children per woman compared to 7.5 children per woman during the period 1970-1975. The Honduran population is relatively young; approximately 50 percent is under 15 years of age. Forty-five percent of the women in the reproductive age range are 25 years old or younger. A high percentage (61 percent) of women of reproductive age are in union, and the average age of marriage or union is 20 years. The 1987 Contraceptive Prevalence Study indicated that 27 percent of Honduran women use "modern" contraceptive methods.

### **HEALTH SITUATION ANALYSIS**

Honduras has had a permissive attitude toward private family planning programs for nearly two decades. Within the public sector, family planning falls under the mandate of the women's health program of the MOH's Division of Maternal and Child Health (DMCH). Family planning services are available through ministry facilities and availability is spotty. In reality, the MOH is in the process of updating its approach to women's reproductive health services. A maternal mortality study (Ochoa, David, et al., 1990) caused a whirlwind of policy debate and is resulting in the development of a reproductive risk approach to women's health and family planning.

The MOH divides the country into nine health regions, each of which is divided into several areas. Health personnel are assigned to either the national, regional, or area level. It is estimated that 70 percent of the population has some type of access to health services, either public or private. However, a recent maternal and child health study indicates low usage of the public sector service providers.

The Honduras health system is divided into two subsystems, institutional and community. Health institutions are of four types. Beginning with the most basic, they are (1) the rural health center with an auxiliary nurse (CESAR); (2) the health center with a physician (CESAMO), (usually a student conducting his or her year of social service and hence temporary); (3) the area hospital; and (4) regional and national hospitals with greater specialization. The community subsystem relies on local volunteers who collaborate with the various ministry programs. Volunteers include (1) trained midwives who provide maternal-child attention, especially before and during birth; (2) *guardianes* who are trained to provide basic health services and refer patients to CESARs when necessary; (3) health representatives who work in basic sanitation, helping build and maintain latrines and water systems; and (4) volunteer collaborators who carry out vector control activities.

In addition, a nonformal system of health providers is active, particularly in rural areas beyond the effective reach of the official system. These providers include *sobadoras* (masseuses), *comadronas* (herbalists), *curanderos* (curers), and injection givers. Many of them are accorded a great deal of credibility and can be valuable links to the segment of the population that is not using institutional health services.

A well-developed private sector system (not necessarily physicians) also reaches even the most rural areas. For example, recent studies indicate that small stores, or *pulperias*, are the first line of treatment for many childhood illnesses.

## **SUMMARY OF COMMUNICATION AND SOCIAL MARKETING ACTIVITIES**

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In 1980, Honduras was among the American nations with the highest rates of infant mortality. Preventable conditions and diseases accounted for the principal causes of premature death. Improving the situation required focusing not only on the strengthening of health service delivery but also on modifying attitudes and behaviors of health personnel and target audiences.

Honduras was a sentinel country under the Mass Media and Health Practices (MMHP) Project, the predecessor of HEALTHCOM. The MMHP Project had two basic objectives:

(1) to apply a public health communication methodology to change behaviors related to oral rehydration therapy (ORT) and contribute to lowering infant mortality from diarrheal diseases; and (2) to institutionalize that methodology within the Ministry of Health (MOH), specifically within the Division of Health Education (DHE).

The project, called *Proyecto de Comunicaciones Masivas* (PROCOMSI), began to be implemented in one health region in early 1980. The work centered on the widespread distribution and correct use of the locally produced oral rehydration salt (ORS) product Litrosol. Educational materials included radio programs and spots and a series of graphics designed to increase demand and teach correct product use. Health personnel in both the formal and nonformal systems were trained to distribute the product and to teach the correct use of ORS, the importance of feeding during diarrhea episodes, and the appropriate time to refer a child to a more sophisticated treatment level.

Stanford University, and later Applied Communication Technology (ACT), had been contracted by A.I.D. to conduct an independent evaluation of the impact of the public health communication work. Their findings indicated significant changes in knowledge about health-related practices and a decrease in infant mortality. These results helped motivate the MOH to establish a national Control of Diarrheal Diseases (CDD) program under the auspices of the Division of Epidemiology. The MOH also made a significant new commitment to health education; it increased the DHE staff, raised funding, and expanded the application of the public health communication methodology developed during the initial ORT work to four priority MOH programs--malaria control, tuberculosis control, immunizations, and diarrhea control. This second phase of the project, which began in 1983, was called PROCOMSI II. Its goal was to apply the public health communication methodology developed to these four areas, and to pursue institutionalization of methods within the DHE as staff and responsibilities increased. ACT continued to evaluate the impact of this work, extending its evaluation into the new areas addressed by PROCOMSI II.

In 1985, a transition was made in Honduras from the MMHP Project to HEALTHCOM. Around this time, the MOH had become committed to a major new child survival initiative through Child Survival Mobilizations which was funded by UNICEF and the European Economic Community (EEC) as well as by A.I.D. They requested that HEALTHCOM assist the DHE in these two aspects--strengthening training at the community level and assisting in the development of the child survival public health communication program. The objectives of HEALTHCOM were to (1) continue institutional development of large-scale health communication activities, expanding from a pilot to a national focus; (2) implement sustained communication components directed at health personnel and infant caretakers in the areas of acute respiratory infection (ARI),

CDD, and expanded program on immunization (EPI); and (3) expand PROCOMSI's mass media focus to include the interpersonal channels as well.

Under HEALTHCOM I, the Academy for Educational Development provided long-term technical assistance to continue training MOH counterparts in the systematic use of a health communication methodology for behavior change. To achieve project goals, the HEALTHCOM Project in Honduras conducted a 48-month public health communication effort focusing on four health themes and using mass media, print materials, and interpersonal support. The project produced training modules and methodologies for community health workers on three themes. It also provided training for DHE staff on behavior observation and communication planning and management; materials design and pretesting; administration; and training program design. The project assisted with the design of a major new private sector initiative for ORT.

### **AUTHORIZING MANDATE FOR COUNTRY PROGRAM**

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The delivery order from the USAID Mission in Honduras authorizing the startup of HEALTHCOM II was signed August 15, 1990, after a no-cost extension of HEALTHCOM I brought the first phase of HEALTHCOM activities to a close. (The initial letter of agreement was signed by the Republic of Honduras and the Agency for International Development's Office of Health on September 27, 1979, for the MMHP Project.)

### **III. Project Goals and Relationship to National Programs**

HEALTHCOM II project goals, outlined in detail below, fit into the MOH program priority areas of intervention. The new administration that took office in January 1991 modified the MOH horizontal child survival strategy to emphasize "integrated child health programs." To meet MOH needs, HEALTHCOM II has worked to develop integrated communication plans and to decentralize activities to the regional level. HEALTHCOM II goals include training regional teams in the health communication methodology in order to institutionalize communication capabilities at the local level.

## IV: Project Inputs

During a three-year period, technical and administrative support will be provided to the MOH as follows:

- Ten months of technical backstopping and project and financial management;
- Thirty months of local and Washington administrative support;
- Twenty-four months of technical assistance by a resident advisor (RA);
- Four and one-half months of short-term technical assistance to the DHE and DMCH for in-service training of their staff;
- Short-term technical assistance to the CDD program and the DHE in the new initiative for diarrheal disease control. Extensive private sector market research, which will be used as a basis for expanding and improving the MOH/CDD program and for designing the new private sector initiative;
- A fourth survey to continue the longitudinal study of diarrhea and ORS use, to be conducted by ACT;
- A desktop publishing facility and three weeks' training of MOH's DHE counterparts.

## **V. Activities and Goals of Participating Institutions**

HEALTHCOM enjoys the collaboration of the A.I.D. Health Sector II projects: Management Sciences for Health and Population Council. In addition, we receive support from USAID/Honduras staff, including Robert Haladay, Emily Leonard, Ross Hicks, Gustavo Bardales, Stanley Terrell, Vilma Padilla, and Roberto Figueredo. The primary institutions with which we are involved in the MOH are DHE and DMCH. With the Ministry of Education, we plan to have secondary school students participate in national EPI mobilizations. Our goal with the Social Security Institute (IHSS) is to collaborate in the women's health and reproductive risk educational components. The armed forces will provide logistical support for child survival campaigns and local governments will participate in promotions and actual mobilizations. Collaborating donor agencies with whom we will work are UNICEF, the Pan American Health Organization (PAHO), WHO, EEC, and the United Nations Fund for Population Assistance (UNFPA).

## **VI. Major Program Components**

The proposed HEALTHCOM II project would operate for three years. For the first two years, assistance would be provided through a full-time RA and short-term technical assistance. In year 3, assistance and phaseout will be accomplished through short-term technical assistance only.

Year 1 will concentrate on continued support of child survival interventions. Year 2 will concentrate on infrastructure development. The specific activities will support MOH program objectives as follows:

### **CONTROL OF ACUTE RESPIRATORY INFECTIONS**

Assist the DHE and the DMCH to expand the ARI education strategy from a pilot program of eight health centers to a national program including 720 health centers nationwide. This will include the development and use of both mass media and interpersonal educational media.

### **CONTROL OF DIARRHEAL DISEASES**

Assist the DHE and DMCH in consolidating the ORT marketing strategy, including developing a central monitoring system and continuing the guided self-instruction of 15,000 medical and community personnel.

### **PRIVATE SECTOR ORS**

To facilitate private sector distribution of ORS, HEALTHCOM II will help train private sector distributors. In addition, HEALTHCOM II will consult on and monitor private sector marketing strategies.

### **REORIENTATION OF IMMUNIZATION COMMUNICATION STRATEGY**

Help the MOH (DHE and DMCH) implement an EPI communications plan with emphasis on regular and continuous "horizontal" demand through developing decentralized training and promotional activities in the health regions and areas. In addition, HEALTHCOM II will assist the MOH in developing strategies for targeting mass campaigns to areas underserved by the horizontal services.

## **EXPANDED USE OF HEALTHCOM METHODOLOGY**

Through consultation and quality control, HEALTHCOM II will provide communications and training support for MOH priority areas as needed. Anticipated areas include child spacing and family planning, AIDS, malaria, and dengue.

## **STRENGTHENING REGIONAL CAPABILITIES**

Decentralize technical advisory assistance to the eight health regions, upgrading the communication and education skills (particularly in relation to planning, implementation, and evaluation) of at least 25 regional health educators (now in place), administrators, and eight central level members of the DHE.

## **SUPPORT OF NUTRITION COMMUNICATION ACTIVITIES**

Integrate HEALTHCOM II areas of intervention (EPI, ORT, ARI) and other child survival communications and education efforts of the MOH with those of the Nutrition Communication Project, which will include infant feeding, breastfeeding, weaning, and growth monitoring.

## **DEVELOP IN-HOUSE DESKTOP PUBLISHING CAPABILITIES**

Establish a microcomputer desktop publishing facility with trained personnel at the national level to facilitate the in-house design and production of educational documents and materials.

## VII. Institutionalization Plan

HEALTHCOM II in Honduras has two main purposes: (1) to consolidate and institutionalize a systematic communication and education model that has proven to be effective and efficient in producing self-sustaining behavioral changes; and (2) to integrate the various maternal and child health interventions that are being developed, such as ARI control and infant feeding.

### **MANAGEMENT PROCESS**

As part of the institutionalization process, HEALTHCOM II will provide opportunities for officials at the decision-making level to develop skills for communication project planning and management. HEALTHCOM II assistance to the MOH will parallel the activities of the *Plan de Conducción y Gerencia* (management process), which works to optimize the functional operations of the MOH through the organized participation of personnel from all levels of the health care system. HEALTHCOM II will develop management mechanisms and procedures required to ensure appropriate MOH funding, logistic support, and decision-making processes. The latter will be compiled in a procedures manual providing both central and regional administrative units with concise and applicable information for planning, implementing, and monitoring communication and education activities.

### **TRAINING**

HEALTHCOM II will provide systematic training to regional health teams for one year. Part of this effort will be to train regional educators to train trainers. As a result, the MOH will have a cadre of professionals capable of designing and conducting tailor-made communication plans compatible with the epidemiological and cultural characteristics of each area. The effort will also facilitate the development of more decentralized communications approaches to regional health problems.

Regional training will be conducted simultaneously with the implementation of the communication plans for ARI, EPI, and ORT. Edited versions of each one of these plans will serve as reference and training materials. Case study and hands-on participatory methods will be used for this in-service training. MOH personnel will acquire the necessary skills to design, implement, and monitor educational materials and activities.

By the end of HEALTHCOM II, there will be a group of trained personnel at the central and the regional levels capable of designing, conducting, and evaluating health communications and education programs that respond to national and local needs. These persons will also be capable of training other personnel to do the same, thus providing skills and resources for sustainability and decentralization.

## Appendix: Budget

HEALTHCOM II will operate in Honduras for three years. To coordinate project signing with the USAID fiscal year, the budget was divided into four project years, as detailed below.

### HEALTHCOM / Honduras Delivery Order #4

CATEGORY	AMOUNT
1. Salaries and Benefits:	\$275,846
2. Consultants:	21,568
3. Travel & Transportation:	54,337
4. Direct and Indirect Costs:	185,312
5. Overseas Allowances:	43,436
6. Equip. & Field Oper. Exp.:	9,062
7. Participant Expenses:	0
8. Subcontracts and G&A:	0
TOTAL	----- \$589,560