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**MIDTERM EVALUATION OF THE
HONDURAS PRIVATE SECTOR
POPULATION II PROJECT (522-0369)**

by

William D. Bair
David Denman
Victor Jaramillo
Alberto Rizo

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Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

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Table of Contents

	Acronyms	v
	Project Identification Data	vii
	Acknowledgments	ix
	Executive Summary	xi
1.	Introduction	1
	1.1 Country Background	1
	1.1.1 Demographic Data	1
	1.1.2 Socioeconomic Background	1
	1.1.3 National Climate vis-à-vis Population Growth and Family Planning ...	1
	1.2 Project Background	2
	1.2.1 Project Evolution	2
	1.2.2 Project Design	3
	1.2.3 Project Performance: Accomplishments and Shortfalls	5
	1.3 The Evaluation	7
	1.3.1 Purpose of the Evaluation and Scope of Work	7
	1.3.2 Team Composition and Roles	7
	1.3.3 Summary Schedule and Methodology	7
	1.3.4 Constraints	8
2.	ASHONPLAFA: Central Operations	11
	2.1 Administration	11
	2.1.1 Overview	11
	2.1.2 Regionalization	11
	2.2 Finances	13
	2.2.1 Overview	13
	2.2.2 Budget and Expenditures	13
	2.2.3 Revenue Generation and Cost Recovery	17
	2.3 Management Information System, Statistical Data and Information	20
	2.3.1 Overview	20
	2.3.2 Computerized Accounting and Cost Accounting	21
	2.3.3 Service Statistics and Reports	22
	2.3.4 Hardware	22

2.4	Personnel Management	22
2.4.1	General	22
2.4.2	Personnel Authority	23
2.4.3	Training	23
2.4.4	Staff Financing	23
2.5	Information, Education and Communication	24
2.5.1	Overview	24
2.5.2	Public Relations Strategy	25
2.5.3	IEC Coverage	25
2.5.4	Cooperation with ASHONPLAFA Service Delivery Programs and PVOs	26
2.5.5	Administration	27
2.5.6	Audiovisual Equipment	27
3.	ASHONPLAFA Service Delivery Programs	31
3.1	Medical and Clinical Services	31
3.1.1	Overview	31
3.1.2	VSC	32
3.1.3	The IUD Program	33
3.1.4	Accessibility Issues	34
3.1.5	Cost-Recovery Issues	35
3.2	Community Services Program	35
3.2.1	Overview	35
3.2.2	Geographic Coverage	35
3.2.3	Trends in CYPs, Quantities of Contraceptives Distributed, and Revenues Generated	36
3.2.4	Logistics and Data Collection	38
3.2.5	Incentive Program	38
3.2.6	Cooperation with Other PVOs	39
3.2.7	Program Administration and Central Support	39
3.3	Social Marketing Program	39
3.3.1	Overview	39
3.3.2	Program Coverage	40
3.3.3	Program Sales	40
3.3.4	Implementation of the Marketing Strategy	42
3.3.5	Data Collection and Reporting	43
3.3.6	ASHONPLAFA Program Management and Administration	43
3.3.7	SOMARC Performance	43
3.4	Coordination among Service Delivery Programs	44

4.	Private Voluntary Organizations	47
4.1	PLAN in Honduras	47
4.1.1	General	47
4.1.2	Revision of Contraceptive Prevalence Goals	47
4.1.3	Training	47
4.1.4	Cooperation with ASHONPLAFA: Training and IEC	48
4.1.5	Referral System	48
4.1.6	Project Staffing	48
4.1.7	Budget and Expenditures	49
4.2	The Population Council Buy-In	49
4.2.1	General	49
4.2.2	Project Development	50
4.2.3	Potential for Meeting Cooperative Agreement Goals	51
4.2.4	Provision of Technical Assistance and Workshops	51
4.2.5	Cooperation with ASHONPLAFA	52
4.2.6	Financial Performance	52
5.	Lessons Learned	55
6.	Prospects for Meeting Fertility and Prevalence Targets, Major Conclusions, and Recommendations	59
6.1	Prospects for Meeting Fertility and Prevalence Targets	59
6.2	Major Conclusions	60
6.2.1	Revision of Project Goals	60
6.2.2	ASHONPLAFA Central Operations	61
6.2.3	Service Delivery Programs	63
6.2.4	Private Voluntary Organizations	65
6.3	Recommendations	66
6.3.1	Revision of Project Goals	66
6.3.2	ASHONPLAFA Central Operations	67
6.3.3	Service Delivery Programs	70
6.3.4	Private Voluntary Organizations	72

List of Tables and Figures

Table 1	Number of Temporary Method CYPs and VSC Procedure CYPs by Program Year	5
Table 2	1991 Expenses and 1992 Budget by Regions	12
Table 3	ASHONPLAFA Budget and Expenditures 1989-1991	14
Table 4	Comparison of ASHONPLAFA Actual Yearly Expenditures and the Yearly Local Currency Budget in the Project Paper	16
Table 5	Comparison of USAID PIL Assistance Budgets with Actual Expenditures from all Sources January 1, 1989 to December 31, 1991	16
Table 6	Project Paper Funding Levels for Various Components Compared to Local Currency and Dollar Expenditures and Commitments as of December 31, 1991	17
Table 7	Income of ASHONPLAFA by Main Sources 1989-1991	18
Table 8	Fees for Services Paid for by ASHONPLAFA Clients in 1989-1991	19
Table 9	Comparison of Costs and Locally Generated Income of Major Service Delivery Programs 1991	20
Table 10	Funding of ASHONPLAFA Staff by Source (1989 to 1992)	24
Table 11	Male and Female VSCs by Provider in Honduras (1991)	32
Table 12	Social Marketing Sales to CSP Program	42
Table 13	Commitments, Expenditures, and Disbursements for Major Grant Agreements	49
Figure 1	Couple Years of Protection, Community Service Program 1989-1991	36
Figure 2	Oral Contraceptive Distribution, Community Service Program 1989-1991	37
Figure 3	Barrier Contraceptive Distribution, Community Service Program 1989-1991 ..	38
Figure 4	Global Distribution, Social Marketing Program 1989-1991	41
Figure 5	Funds Generated, Social Marketing Program 1989-1991	41

Appendices

Appendix A	Scope of Work
Appendix B	Persons Contacted
Appendix C	Bibliography
Appendix D	Logframe

Acronyms

AHLACMA	Asociación Hondureña para La Lactancia Materna (Honduras Association for Maternal Lactation)
A.I.D.	U.S. Agency for International Development
A.I.D./W	A.I.D./Washington
ASHONPLAFA	Asociación Hondureña de Planificación de la Familia (Honduras Family Planning Association)
AVSC	Association for Voluntary Surgical Contraception
CDC	Centers for Disease Control
CREA	Regional Audiovisual Center
CPR	contraceptive prevalence rate
CSP	Community Services Program
CYP	couple year of protection
EFHS	Epidemiology and Family Health Survey
FCB	Foote, Cone and Belding
FHI	Family Health International
GNP	gross national product
GOH	Government of Honduras
IEC	information, education and communication
IHSS	Instituto Hondureña de Seguridad Social (Honduran Institute for Social Security)
INOPAL	Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean (project)
IPPF	International Planned Parenthood Federation
IQC	indefinite quantity contract
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
L	lempira
LAN	local area network
lempira	Honduran currency: 5.65 lempiras per dollar (was 2 lempiras per dollar at start of project, before devaluation occurred)
MCP	Medical and Clinical Program
MIS	management information system
MOH	Ministry of Health
ob/gyn	obstetrician/gynecologist
Pap Smear	Papanicolaou Smear
PCS	Population Communication Services (project)
PIL	project implementation letter
PIO/T	project implementation order/technician
PLAN	PLAN Internacional Tegucigalpa
PP	project paper
PVM	medicine store
PVO	private voluntary organization
SIES	integrated modular data system
SMP	Social Marketing Program
SOMARC	Social Marketing for Change (project)
SOW	scope of work

TECAPRO
TFR
USAID
VSC
WHR

Appropriate Technology, Inc.
total fertility rate
A.I.D. mission (in-country)
voluntary surgical contraception
Western Hemisphere Region (IPPF)

Project Identification Data

1. Country: Honduras
2. Private Sector Population II Project
3. Project Number: 522-0369
4. Critical Project Dates:
 - Project authorized: June 29, 1989.
 - Cooperative Agreement with ASHONPLAFA signed July 21, 1989. Seven amendments to above Cooperative Agreement. Last amendment signed February 29, 1992.
 - Grant agreement with Foster Parents Plan signed August 8, 1989. One amendment signed March 15, 1990.
 - Contract amendment with Population Council for Honduras Program signed July 29, 1990.
 - Project assistance completion date: December 31, 1994.
5. Project Funding (\$ millions):

USAID Bilateral	\$16.0
Other Donors	2.1
Host Country	7.1
6. Mode of Implementation:
 - USAID: Bilateral: Cooperative Agreement, Grant Agreement and USAID direct procurement.
 - A.I.D./W: Buy-ins to centrally funded projects.
7. Project Designers:
 - USAID Human Resource Development Division Staff
 - Honduras Family Planning Association Staff
 - Mission Development Finance Office Staff
 - Private Consultants
8. Previous Evaluations:

None
9. USAID/Honduras Mission Director: Marshall Brown
10. USAID/Honduras Project Officer: Francisco Zamora

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Personnel at USAID/Honduras provided a thorough initial briefing; documents were provided and personal time was available throughout the evaluation to clarify and to supplement information collected.

ASHONPLAFA personnel, both in Tegucigalpa and in the regional offices, were outstanding in their open and friendly support of the evaluation. They willingly prepared special reports, shared documents, gave unstintingly of their time in interviews, and accompanied the team as requested on field visits.

Personnel at MANDOFER, FCB/ArteFilme, PLAN en Honduras, The Population Council, Save the Children, and AHLACMA took time from their busy schedules to meet with the team and thoroughly explain their activities.

The contacts with dozens of pharmacists, shop keepers, and rural community leaders reflected a real openness to discussion of family planning and a commitment to extending this service to the community that goes beyond the small financial reward they get for their efforts.

The team also expresses appreciation for the fine hospitality extended at Casa Montes, which served both as hotel and office. Accommodations were excellent and the warm family atmosphere did much to make the stay extremely pleasant.

The team leader would particularly like to express his high regard for the work of his fellow team members. This group of dedicated professionals worked long and hard in a collaborative team effort to produce the evaluation in this document.

Executive Summary

Introduction

Honduras, a country with nearly 5 million inhabitants, has a population growth rate of approximately 3.1 percent per year. Its population will double in 22 years, with all the attendant problems of increased demands for social services and employment and the burden placed on the environment. There is little high-level government recognition of this problem and little direct government financial support of population or family planning programs. Private family programs, however, are free to operate, and there is a growing family planning program within the Ministry of Health, which is supported by the U.S. Agency for International Development (USAID). The 1987 Epidemiology and Family Health Survey (EFHS) measured a contraceptive prevalence of 41 percent, including 7.4 percentage points of traditional methods. Outspoken opposition to family planning from the Catholic Church has constrained the availability of family planning services.

The Honduras Private Sector Population II project, evaluated at midterm in this report, provides \$16 million in support from USAID/Honduras, primarily to ASHONPLAFA, the Honduran affiliate of the International Planned Parenthood Federation (IPPF). ASHONPLAFA has had years of experience in family planning and is the principal provider of services in the country. The project, which extends from 1989 to 1994, is a follow-up to the USAID-supported Private Sector Population I project.

The project was designed to assist ASHONPLAFA improve its management structure and institute more regionalization and delegation of authority. A collateral purpose was to expand coverage to the rural areas and increase self-sufficiency. Assistance was also provided to two organizations, PLAN Internacional Tegucigalpa, a Foster Parents Plan International affiliate, and the Population Council, to stimulate private voluntary organizations (PVOs) to become more active in family planning. The specific purpose of the project is to contribute 50 percent of the projected increase in contraceptive prevalence — from 41 percent in 1987 to 50 percent in 1994.

Findings

Accomplishments

The major accomplishment of the project has been its continued extension toward national coverage despite substantial criticism from the influential Catholic Church. ASHONPLAFA family planning services are now available in over 2,200 locations in all 18 departments and all but 26 of Honduras' 291 *municipios* (counties). Regionalization is progressing; high-quality clinical services, especially voluntary surgical contraception (VSC), are being provided in six ASHONPLAFA clinics and a network of eight private clinics supported by ASHONPLAFA to perform VSC procedures. These regional clinics also serve as a backup for the widespread Community Services Program (CSP) of community-based distribution, providing headquarters for the 30 CSP and 24 VSC promoters who work in the surrounding urban and rural areas. MANDOFER, one of Honduras' largest pharmaceutical distributors, was contracted to distribute ASHONPLAFA social marketing contraceptives, Perla and Norminest oral contraceptives and Guardian condoms. They are being sold in 533 pharmacies and medicine stores the Social Marketing Program (SMP) currently reaches and by the network of CSP distributors.

With the Community Services Program producing 50,000 couple years of protection (CYPs) in 1991, the Social Marketing Program 23,000, and the Medical and Clinical Program (through surgical and temporary methods) 138,000, the total output of 210,000 CYPs for 1991 was about 86 percent of the CYP target for that year. At the same time, ASHONPLAFA has increased the level of locally generated funds by 54 percent, largely through client charges. In 1991, both SMP and the CSP surpassed their targets of 100 percent and 50 percent self-sufficiency, respectively.

Other accomplishments were the computerization of the financial accounting portion of the management information system (MIS); the development of an information, education and communication (IEC) strategy and increased use of mass media to supplement the traditional interpersonal communication activities; development of a social marketing plan; the training of 1,491 persons by ASHONPLAFA, both in Honduras and abroad, and assistance to PVOs in the training of another 1,500 community workers; and the completion of the fieldwork of the 1991 EFHS.

Training and research have been accomplished in PLAN and Population Council's PVO component of the project.

Shortfalls

An indication that some things planned were not accomplished can be gained from the project's financial performance. The degree to which devaluation and inflation combined to make additional lempiras available to the project is difficult to quantify. This, together with slow performance in implementing some elements of the program, produced a situation in which at mid-project only 25 percent of the dollars budgeted had been spent. Shortfalls in the expenditure of foreign exchange for overseas training and for technical assistance represent missed opportunities for program improvement. Budget performance lagged in all three institutions supported: ASHONPLAFA, PLAN and Population Council.

ASHONPLAFA has underspent its lempira budget due to a combination of appropriate cost containment (e.g., use of MANDOFER for low-cost product distribution), delays in budget development and approval, policy differences with USAID, and failure to implement some needed actions. At the end of 1991, ASHONPLAFA had spent only 68 percent of its lempira budget for 1989 through 1991. The areas in which underspending of the lempira budget had the most significant programmatic implications were in inadequate promotion and advertising for SMP, insufficient development and consistent use of mass media, in-country training, and operations research on transportation and field support for CSP promoters.

Although considerable progress has been made in regionalization and delegation of authority, ASHONPLAFA remains a highly centralized institution. Insufficient progress has been made in developing lower level management skills through training, technical assistance, and the gradual increase in delegated authority. Volunteer participation in national and regional boards of directors needs to be revived in order to develop the local and national support vital to ASHONPLAFA's financial self-sufficiency and long-term independence as an indigenous institution.

The other PVO components (PLAN and Population Council) have been slow in developing subprojects and entering the phase of service delivery.

The status of fieldwork and analysis of the 1991 EFHS at this time did not permit any conclusion as to progress in meeting contraceptive prevalence goals.

Conclusions

Two major conclusions about progress to date set the stage for the recommendations for the project's future:

- The project is generally on track in meeting the significant targets of geographic coverage and CYPs provided, while lagging in participation of volunteers, regionalization and organizational development, and in certain programmatic areas necessary for achieving full potential, as evidenced in budget performance. None of the slower moving areas, such as mass media, promotion and advertising for SMP, research, training, transportation, and technical assistance, has problems of such an intractable nature that they preclude project success.
- Funds are available to extend the project for up to approximately 18 months.

Recommendations

Three principal recommendations follow. A complete list of recommendations is presented in Chapter 6 of the report.

- USAID and ASHONPLAFA should carry out the necessary programmatic and financial review to prepare the basis for an extension of this largely successful project activity.
- ASHONPLAFA should take steps to accelerate project programmatic performance, especially in the areas of mass media IEC and advertising and promotion in the SMP, training, research, transportation, and the utilization of technical assistance.
- ASHONPLAFA should revitalize its national and regional boards of directors and pursue more actively internal reorganization and training of lower level managers for implementation of increased delegated authority.

Lessons Learned

Of the several lessons learned in the project, the following three are considered the most significant for future project implementation:

- When there are conflicting objectives in a project (e.g., extending geographic coverage vs. cost containment, reaching the rural poor vs. self-sufficiency), clear policy determinations must be reached as to which of the objectives is to receive the greater emphasis under what circumstances.
- Cost saving through failure to implement essential program components is false economy.
- Significant institutional change is a long process and requires considerable understanding, patience, and nurturing.

1. Introduction

1.1 Country Background

1.1.1 Demographic Data

According to data published by the Ministry of Health (MOH), when the Honduras Private Sector Population II project got under way in late July 1989, the country had a population of 4.7 million, a crude birth rate of 44 per 1,000, and a crude death rate of 9.5 per 1,000, resulting in a growth rate of 3.1 percent per year.

The contraceptive prevalence rate of 41 percent reported in the project paper for the project may give a deceptive impression of considerable spread of effective family planning. It is not consistent with the continuing high birth rate — either the 44 per 1,000 the MOH quotes from the Anuario de la Dirección de Estadísticas y Censos or the 38 per 1,000 rate the project paper uses from the 1987 Epidemiology and Family Health Survey (EFHS). The 41 percent contraceptive prevalence level also includes 7.4 percentage points of traditional methods (rhythm and withdrawal). Moreover, like most contraceptive prevalence surveys, the calculation is based on "women in union." In Honduras, this omits roughly 40 percent of the women of fertile age, many of whom are said to be sexually active and many of whom are adolescents.

Honduras has a 3.1 percent growth rate, which implies a doubling of the population every 22 years, with the attendant problems of increased demands for health and educational services, rapid expansion of a work force presently underemployed, and environmental degradation.

1.1.2 Socioeconomic Background

Honduras has a per capita gross national product (GNP) of \$590 (World Bank estimate). The difficult economic situation is frequently mentioned as the reason people are seeking to plan their families. The EFHS showed that of the fecund women not using contraceptives, 65 percent declared their intention to do so, using a modern method.

Although Honduras is still about 60 percent rural, communication by road and air between various regions is relatively easy, and radio covers almost all of the country, with local stations in all the departments. The literacy rate is only 60 percent, but the problem of a multiplicity of languages and cultures does not exist. Political disturbances in neighboring countries have created personal safety problems for people working in some border areas and the flow of refugees has placed considerable burdens on ministries and private agencies.

1.1.3 National Climate vis-à-vis Population Growth and Family Planning

Recognition of the serious problem of rapid population growth is not apparent at high levels of the government. There is no effective national population policy nor is there any substantial expenditure of government funds in direct support of family planning. On the other hand, the government has allowed private organizations to expand their family planning programs with few restrictions, and there are no restrictions on the import or sale of contraceptives by pharmaceutical companies.

Abortions are illegal. The 1987 EFHS, however, found that 24 percent of the women reported having had at least one abortion. Legal sanctions are not aggressively pursued, and the only practical action that is being taken to prevent this serious public health problem is the family planning program.

The outspoken opposition of the Catholic Church and the influential position of the bishop in Honduran society and government have had a greater influence in constraining the availability of family planning services than in many other Latin American countries. They have made more difficult the task of ASHONPLAFA, the Honduran Family Planning Association (Asociación Hondureña de Planificación de la Familia), in attracting influential community leaders to its national and regional boards of directors and in attracting substantial private contributions. Contrary to the experience in other countries, the opposition of the church may even be affecting the decisions of individual family planning clients.

Experience in both the private and the public sectors has been gained in the provision of family planning services over many years. ASHONPLAFA, the International Planned Parenthood Federation (IPPF) affiliate, opened its first clinic in 1963 in an MOH hospital. Its gradual expansion was supported by IPPF, the Pathfinder Fund, and others. A substantial expansion into a six-region national program began with the help of the U.S. Agency for International Development (USAID), which funded the Private Sector Population I project in 1985. The MOH has provided limited family planning services since 1966, when a family planning program was assisted by USAID/Honduras. Until recently, the growth in this activity had been slow, despite provision for family planning support in several USAID/Honduras projects with the MOH.

Despite these constraints, the MOH is becoming increasingly aware of the impact of family formation patterns on maternal and child health.¹ This is resulting in an expansion of family planning services within the MOH under the rubric of the prevention of high reproductive risk. The inclusion of family planning in the Institute for Social Security (IHSS) suggests the medical profession is changing what was said to be previously a disinterest in, or even opposition to, family planning. The Medical School is reported to have finally included family planning in its curricula.

Thus, there is both good news and bad news in the socioeconomic and political backgrounds against which this project is being implemented. On balance, it appears that an aggressive program of providing family planning information and services to Honduran families will find a positive response despite the criticism that will be encountered from some quarters.

1.2 Project Background

1.2.1 Project Evolution

The project being evaluated in this report is the second phase of the Private Sector Population project (see Section 1.3 for a description of evaluation). The project, Private Sector Population II, is authorized for a five-year period, June 29, 1987 to June 29, 1994. The level of USAID/Honduras funding is US\$16 million, with an anticipated US\$2.1 million from other donors and US\$7.1 from the

¹Discussion with a special advisor to the MOH, a long-time proponent of family planning and former president of the board of ASHONPLAFA.

host country (i.e., from ASHONPLAFA and other private voluntary organizations [PVO], largely through client charges but also through some private donations).

The first phase of the project, the Private Sector Population I project (522-0286 — 1985-1989), was designed to assist ASHONPLAFA in its efforts to expand nationwide availability of voluntary family planning services and information. The project strategy was to assist ASHONPLAFA to become a large but efficient, well-managed, and relatively self-sufficient organization and one that would continue to provide the bulk of family planning services for a rapidly increasing fertile age population.

The first phase was successful to a considerable degree, but during implementation, it also became clear that a longer time would be necessary for ASHONPLAFA to develop the institutional structure required to service national demand and to become a more self-sufficient institution. It was also clear from the EFHS that there was a marked difference in the level of contraceptive use by urban and rural populations (63 percent in some urban areas compared to 30 percent or lower in some rural locations), suggesting the need to increase efforts to reach the rural population with correct information and services.

1.2.2 Project Design

Project Purpose

The Private Sector Population II project was designed to continue assistance to ASHONPLAFA to help it become a more effective, efficient, and self-sufficient organization. The project was also expected to stimulate other PVO involvement.

The specific purpose of the project was "to contribute half of the increase in contraceptive prevalence (percentage of couples in union of reproductive age using modern family planning methods) from 41 percent in 1987 to 50 percent in 1994."

Project Strategy

The project focuses most of its support on institutional changes in ASHONPLAFA, increases in regionalized services through clinical, community-based and social marketing approaches, expansion of information, education and communication (IEC) and establishment of cost recovery mechanisms. Additionally, it supports activities to stimulate other private and voluntary organizations to provide family planning services and information.

Objectives and Funding

The specific project objectives were to reduce the total fertility rate (TFR) from 5.6 in 1987 to 4.7 in 1995 and to provide 231,000 couple years of protection (CYPs) during 1994.

The project budget of US\$16,000,000 was allocated as follows:

- technical assistance, \$2.3 million
- contraceptives, \$1.11 million
- commodities, \$.554 million
- local support costs, \$12.036 million

Project Components

The project consisted of three principal parts: 1) four central ASHONPLAFA activities, including administration and management, monitoring and evaluation, training, and IEC; 2) three ASHONPLAFA service delivery activities, including the Medical and Clinical Program (MCP) of ASHONPLAFA; its Community Services Program (CSP), a community-based distribution effort; and its Social Marketing Program (SMP); and 3) subcontracting activities to involve additional PVOs in provision of family planning services.

The management, training, IEC, research, and service delivery actions described in the project paper can reasonably be expected to achieve the desired results in increases of CYPs.

Project Logframe

The project paper has clearly specified its targets and the logframe adequately summarizes them in measurable terms, with a few exceptions. The IEC targets could have been expressed in quantified terms to be verified by the contraceptive prevalence survey. The operations research (OR) targets, described as "aimed at improving efficiency and effectiveness of internal work system," could have been more specific and more clearly linked to support of ASHONPLAFA organization or program needs. Detailed training plans were not included in the paper (see Appendix D for the project logframe).

Implementation Plan

The implementation plan covers the key actions that must be taken and presents a reasonable time frame. It also includes a number of contracts and agreements, the most significant of which are USAID's cooperative agreement with ASHONPLAFA; a grant agreement with PLAN Internacional Tegucigalpa (PLAN), a Foster Parents Plan International affiliate; and a buy-in to a Population Council project, to subcontract with other PVOs in the country. These agreements are basically consistent with the project paper and make appropriate references to interrelations and coordination between the parties. One area that could be clarified is the relationship that was expected between the private PVO sector and the public sector (MOH and IHSS) and the commercial private sector (private physicians and commercial sales of contraceptives). It would also have been useful to include provisions for an annual update that would have included the interrelated actions of ASHONPLAFA, PLAN, and the Population Council to achieve project objectives.

Planned Actions

ASHONPLAFA was given a group of special conditions to complete in the grant agreement. These included establishing a pricing strategy, setting up of regional advisory boards, opening two vasectomy clinics, developing an incentive plan, and improving cost recovery and cost containment. PLAN was to train community leaders and set up family planning referrals in its areas of influence. The Population Council was to start six technical assistance projects.

1.2.3 Project Performance: Accomplishments and Shortfalls

Accomplishments

The project, despite the problems mentioned below, is well advanced toward meeting its objectives. During 1991, ASHONPLAFA had reached almost 86 percent of its CYP targets for that year (210,000 CYPs achieved vs. nearly 244,000 targeted — see Table 1 below). The major accomplishment of the project has been its continued expansion toward national coverage despite substantial criticism from the influential Catholic Church. ASHONPLAFA reports that through its three service delivery programs, its family planning services are now available in over 2,200 locations in all 18 departments and in all but 26 of Honduras' 291 *municipios* (counties).

Table 1

Number of Temporary Method CYPs and VSC Procedure CYPs
by Program Year (USAID/Honduras Project Targets in Parentheses)

	1988	1989*		1990		1991	
Temporary Method CYPs							
CSP	46,203	46,706	(24,950)	49,183	(53,400)	49,949	(56,600)
SMP	24,423	21,692	(11,561)	26,495	(29,125)	22,604	(29,423)
MCP	10,442	11,388	(5,378)	14,281	(11,079)	15,742	(11,413)
PVO	0	0	(0)	0	(0)	0	(0)
Total	81,068	79,786	(41,889)	89,959	(93,604)	88,295	(97,436)
Permanent Procedures**							
VSCs performed	7,290	8,384	(4,452)	9,533	(8,025)	9,754	(11,709)
VSC/CYP	91,125	104,800	(55,650)	119,162	(100,312)	121,925	(146,362)
Total CYPs	172,193	184,586	(97,539)	209,116	(193,916)	210,220	(243,798)

Source: ASHONPLAFA.

*The project target for 1989 was for six months only since the project year began June 29.

**These include VSC procedures at ASHONPLAFA clinics, private hospitals and IHSS hospitals only — see Table 11.

Regionalization is progressing, with high-quality clinical services, especially voluntary surgical contraception (VSC), being provided in six ASHONPLAFA clinics (three opened during the project) and a network of eight private physician clinics supported by ASHONPLAFA to perform VSC procedures. Two male VSC clinics were also opened. The CSP, ASHONPLAFA's community-based distribution effort, was expanded with the addition of 304 new, mostly rural distribution points, for a total of 1,700 delivery points. The SMP, another ASHONPLAFA subactivity, covered a total of 563 pharmacies and medical stores at the time of the evaluation, or over 80 percent of the total. In addition, a management information system (MIS) was established, staff were added and trained, and radio mass media campaigns were conducted for both the CSP and SMP. Funds were expended for

commodities, technical assistance, and training. Both the Population Council and PLAN were contracted and started to provide assistance to local PVOs.

A good start has been made on cost recovery. ASHONPLAFA increased its revenues by 54 percent between 1989 to 1991 (see Table 7), and the social marketing and community services programs have already surpassed their respective (100 percent and 50 percent) self-sufficiency goals for 1991.

The 1991 EFHS, on which ASHONPLAFA is collaborating with the MOH with project funding, is almost complete and family planning data reports are being published regularly.

Commodity purchases are on target.

All of the special conditions² were met except the last (cost recovery)³ and most of the implementation plan actions were carried out.

Shortfalls

The principal shortfall was the failure to utilize fully the budget available for the first half of the project. This was due in part to the declining value of the lempira in relation to the dollar. Additionally, all grantees and contractors were slow in making expenditures and there was considerable underspending for IEC, training, and technical assistance in comparison with project paper expectations. CYP targets for temporary methods have not been met (with the exception of the MCP), influenced by the large price increases for services in 1989. Male sterilization is increasing only slowly because of lack of physician training and the exclusive use of female promoters for male VSC.

Although a good start has been made on cost recovery, this requires a continuous effort on the part of ASHONPLAFA; some efforts at cost containment may have been counterproductive and some distortions have occurred because of efforts to save money or generate funds. Although regionalization has been implemented, delegation of authority and transfer of funds to the regions remain limited. Management policy still remains highly centralized both between the regions and the central headquarters and within the central headquarters itself. ASHONPLAFA remains overly dependent on one donor (USAID/Honduras) for support of its growing program. The IEC Department and the social marketing advertising firm have not cooperated fully on media campaigns. Installation of the MIS has not been completed.

None of the problems above, however, is of such an intractable nature as to preclude project success.

²These included establishment of a pricing strategy, regional advisory boards, a vasectomy clinic, an incentive plan, and cost recovery improvement.

³Cost recovery is not considered complete since it is an ongoing activity without a "completion date."

1.3 The Evaluation

1.3.1 Purpose of the Evaluation and Scope of Work

The Population Technical Assistance Project (POPTECH) was contracted to conduct the midterm project evaluation. The purpose, as stated in the Scope of Work (SOW), was "to assess project performance to date and identify needed adjustments to strategies and methodologies in order to accomplish the project objectives." The SOW contained a series of 92 specific questions that the USAID mission required be answered specifically to address this purpose (see Appendix A).

1.3.2 Team Composition and Roles

The team was headed by William Bair, a retired A.I.D. population officer with 23 years of experience in Latin America, West Africa, and Washington and subsequently worldwide as a private consultant.

The three other team members were as follows: Dr. Alberto Rizo, a medical doctor with 3 years of experience as chief of the Maternal Child Care Section of the Ministry of Health in Colombia and 17 years as regional director for the Pathfinder Fund; Victor Jaramillo, an economist with 15 years of private industry experience, 7 years with the private family planning association in Colombia and 5 years with the Pathfinder Fund, University Research Corporation, and private consultancies; and David Denman, an educator retired from A.I.D. with 8 years experience in health and population in Colombia, an assignment with the Asian Development Bank, and 8 years in Indonesia.

Bair and Rizo examined the service delivery, IEC, and PVO components of the project. Rizo also gave special attention to the clinical/medical aspects of the program.

Jaramillo and Denman collaborated on the management/administration components of the program. Jaramillo emphasized the financial, organizational, and personnel aspects of ASHONPLAFA, whereas Denman emphasized A.I.D. management procedures, cost recovery, MIS, and overall project accomplishments.

1.3.3 Summary Schedule and Methodology

The fieldwork took place from March 9 to April 11, 1992. The team spent the first week in briefings with USAID/Honduras and ASHONPLAFA and in document collection and review. During the second week, further interviews were held with ASHONPLAFA, PLAN and the Population Council; the five other ASHONPLAFA regional offices and pharmacies and community service distributors in those areas were visited; and USAID files and procedures were reviewed. The third week was occupied with further interviews at ASHONPLAFA, MANDOFER (the pharmaceutical distributor), Foote, Cone, and Belding (the advertising firm), and Save the Children; analyzing information and giving a preliminary briefing to the USAID/Honduras population staff. The fourth week was spent in report writing. April 6 and 7 the team provided a briefing for USAID/Honduras and ASHONPLAFA. Dr. Rizo and Jaramillo departed April 8, Denman April 10, and Bair departed April 12.

The methodology was straightforward; it consisted of reviews of the project paper, subsequent contracts, and agreements; reviews of other documents, including reports from ASHONPLAFA,

PLAN, the Population Council and other organizations; and interviews with staff from these organizations as well as a wide range of people in all regions (see Appendices B and C).

1.3.4 Constraints

This report is presented as a full response to the SOW. Various constraints, however, affected implementation of the assignment.

- Plans for preparatory work in Honduras and for a team meeting in Washington were dropped due to A.I.D. contracting procedures; required documents were not made available to team members until just before their departure.
- The contraceptive prevalence survey that was needed for basic information for the evaluation was not completed as planned before the evaluation.
- The USAID/Honduras population officer concurred that some of the individual questions of the SOW would require a much more in-depth study and more information than was available at this time. Nevertheless, USAID requested that each question be addressed, with an indication as to why if it could not be answered. To avoid an overly cumbersome main report, each of the 92 questions is addressed in detail in technical annexes, which constitute a modified response to the SOW annex requirements. (These were not published by POPTECH but were provided to the mission as a working document.)
- The report follows the format agreed upon with USAID. The team, however, could have better served USAID/ASHONPLAFA interests using the 92 questions as general guidance rather than specific points to be addressed. The time involved in reviewing all the questions reduced the time available for analyzing broader issues and added considerably to the volume of the report. Similarly, the requirement that each of the annexes be self-contained with findings, conclusions, and recommendations resulted in a report which required a great deal of editing and reorganization in order to reflect fully important details of the annexes.

2. ASHONPLAFA: Central Operations

2. ASHONPLAFA: Central Operations

2.1 Administration

2.1.1 Overview

A major emphasis in this project is providing family planning services and information in rural Honduras, including through establishment of five regional ASHONPLAFA family planning centers as well as through the SMP and the CSP. Regionalization has been physically accomplished, but ASHONPLAFA remains a highly centralized organization in its policies and procedures. Regional volunteers are being recruited and regional Boards of Directors have been formed. Some important improvements have been made in computerization of the MIS and in management procedures. It will take some time, however, before the tasks of establishing strong regional Boards of Directors, training regional directors for increased responsibility, and delegating more authority to them are accomplished.

2.1.2 Regionalization

ASHONPLAFA has established the six service and administrative structures that were planned — one central facility in Tegucigalpa and one each in the five other main cities of Honduras. The first two regional centers, in San Pedro Sula and Choluteca, were built under the first phase of the project. The other three, at La Ceiba, Juticalpa and Santa Rosa de Copan, were completed during the current project. The regional centers include a clinic and administrative structures suited to the area served. Although still highly centralized, the organization is adjusting to the many changes that the project requires.

The 1992 budget reflects a clear intention to increase funding at the regional level. During 1991, expenditures by the central office and Region I (which for all practical purposes are the same) represented 75 percent of total local currency expenditures. By contrast, the 1992 budget indicates that only 55 percent of total expenditures are expected to be made centrally (see Table 2).

Volunteers

Part of the regionalization effort was to regionalize volunteer support of ASHONPLAFA, by recruiting regional volunteers who would make up regional assemblies. These assemblies, in turn, would elect regional Boards of Directors, whose prime role would be to provide moral support to the ASHONPLAFA regional director (see below) and develop income generation activities, mainly through soliciting donations and collecting dues. The regional structure would resemble that at the central level, in which there is a National Assembly of Volunteer Members, which elects a National Board of Directors.

Initially, a large number of volunteers were recruited, both nationally and regionally. Regional assemblies were formed and regional Boards of Directors elected. Regional boards, however, have very limited powers. Regional volunteers are not invited to participate in the National Assembly of Volunteer Members, and the regional boards have no jurisdiction over financial matters, other than

Table 2

**1991 Expenses and 1992 Budget by Regions
(in lempiras)**

Region	1991 Expenses	1992 Budget
Central Office*	5,395,416	5,697,099
Region I*	3,947,822	3,388,678
Subtotal (Percent of total)	9,343,238 (75%)	9,085,777 (55%)
Region II	1,262,290	2,432,988
Region III	593,195	1,395,875
Region IV	604,238	1,552,109
Region V	320,512	952,540
Region VI	334,441	1,041,928
Subtotal (Percent of total)	3,114,676 (25%)	7,375,441 (45%)
Total ASHONPLAFA	12,457,914	16,461,218

Source: ASHONPLAFA.

*For all practical purposes, the central office (Region 0 for accounting purposes) and Region I can be considered the same unit with a total expenditure of L9,343,238 or 75 percent of the total expenditure for 1991. These two regions, with a total budget of L9,085,777 for 1992, were the only ones overspending the budget.

over the dues and donations that have been collected locally. In addition, some of these volunteers have been under pressure from the Catholic Church regarding their participation in family planning activities. These pressures, together with the circumscribed and unclear volunteer role, have led to the resignation or inactivity of many of the volunteers and regional board members.

Regional Directors

ASHONPLAFA is in the process of delegating authority to the regional centers, but is doing so slowly. There is no formal plan, however, to increase delegation to ASHONPLAFA's regional directors, who direct its programs at the regional level. The directors currently have jurisdiction only over routine matters. They did participate in developing a strategic plan for ASHONPLAFA's future, whose first draft was completed in March 1992, but they have little control over key administrative matters such as personnel or funds (see Section 2.4.2). For example, directors are authorized to pay bills only up to L1,200 or L1,300 and to sign contracts only up to L5,000. The directors receive no support from their boards in administrative matters and little supervision from the central department heads, as the central structure is overloaded. Accounting, budgeting, and program reports are not provided to them regularly, and when they are provided, it is not clear who is authorized to have access. In short, although some progress is being made, it will take some time before the tasks of

establishing strong regional boards, training regional directors for increased responsibility, and delegating more authority to them are accomplished.

Central Administration

ASHONPLAFA's operations continue to be highly centralized, limiting the development of regional and departmental capabilities and increasing the workload of the central office. As the program has grown, the workload at the central office has increased. With 15 units reporting directly to him, the executive director's span of supervision is currently too broad and full supervision cannot be provided to all areas. The assistant to the executive director is also overextended; her task is to coordinate the project, supervise the regions, and coordinate the Technical Council, which was created to advise the executive director on technical, financial, promotional and educational issues.

The central administration of ASHONPLAFA is conscious of the need to delegate authority to, and increase the participation of, both department heads and regional directors. Policies and procedures that lay out delegation of authority, however, are not clear and can be in conflict. The strategic plan represents a good start in clarifying ASHONPLAFA's future directions, but more work is needed in the definition of goals, objectives, strategies and policies, long-term planning, and budgeting. In particular, the goals and budget figures appear, in some instances, insufficiently challenging, and in others, unrealistic.

2.2 Finances

2.2.1 Overview

Although USAID/Honduras and the Cooperating Agencies are current in their project commitment processes (46 percent of the total is committed), expenditures for project activities are well below budgeted amounts, both the budget included in the project paper (expressed in dollars) and the lower ASHONPLAFA budget (in lempiras). At the project's midpoint, only 25 percent of the total US\$16 million budgeted for the full project life had been spent. The underspending reflects such factors as the devaluation of the lempira, cumbersome budgeting processes on the part of both ASHONPLAFA and USAID, and slow implementation of some project elements (e.g., IEC and training). Sufficient funds remain to allow the project to be extended an additional 18 months.

2.2.2 Budget and Expenditures

Expenditures

Expenditures have grown over the project period, from L1,781,000 during 1989 (five months) to L7,855,000 in 1991, but they have consistently lagged behind budgets, both the budget proposed in the project paper and the lower lempira budget agreed to by USAID/Honduras and ASHONPLAFA (see Table 3).

Table 3

ASHONPLAFA Budget and Expenditures
1989-1991
(L1,000)

Year	Budget	Expenditure	Percent Spent
1989 (5 months)	1,552	1,781	115%
1990	5,530	4,901	89%
1991	11,644	7,855	67%
Total for period	18,726	14,537	78%

Source: ASHONPLAFA

As of March 23, 1992, ASHONPLAFA had spent only 53 percent of the total expenditures anticipated in the project paper to have been spent at this point (\$3.0 million as compared with \$5.7 million). Likewise, over the three-year period 1989-1991, only 68 percent of the local currency budget (i.e., the USAID project implementation letter [PIL] budget) (L12.2 million rather than L18.0 million) had been spent (see Tables 4 and 5). With regard to the overall project (dollar) budget, at the end of 1991, only 25 percent of the total funding anticipated in the project paper had been spent (\$4 million out of \$16 million). Commitments, however, were as anticipated at this point in the project life, with 46 percent of the total committed (see Table 6).

The underexpenditures can be traced to several factors. For the dollar budget, the 1989 devaluation of the lempira from 2 lempiras per dollar to 5.65 lempiras per dollar was very significant. As a result of the lower dollar costs, substantially more lempiras were available for project implementation. Inflation offset the devaluation to some extent during the same period, reducing the purchasing power of the lempira. As the devaluation and inflationary processes were gradual, it was impossible to quantify the impact of either.

A second factor was slow implementation of several dollar project components, notably in use of technical assistance and in training, and in program implementation, both by ASHONPLAFA (e.g., IEC, advertising of SMP) and by PLAN in Honduras and the Population Council. A contributory factor was various USAID bureaucratic requirements (i.e., very detailed scopes of work for technical assistance, very precise specifications for equipment, and detailed accountability for funds).

Technical assistance expenditures were well below those that had been scheduled in the project paper (only \$335,676 spent to date against a total of \$2,300,000 allocated for the project life). The shortfall in this area may be related to the vacancy in the position of population liaison officer in USAID/Honduras. A main task of that position was to assist ASHONPLAFA to determine the scopes of work for technical assistance. (Training underexpenditures are discussed in Section 2.4.3.)

ASHONPLAFA's underspending of its lempira budget reflects several factors, and there are few instances in which it is possible to identify the precise reason for any given delay. Expenditures were slowed by both ASHONPLAFA project budget development procedures and USAID/Honduras funding and budget approval and updating procedures. ASHONPLAFA also pointed to underspending on expenditures for staff, which it claimed reflected a policy change by USAID, which

has attempted to switch staff costs to ASHONPLAFA (see Section 2.4.4). In addition, the association has instituted some appropriate cost containment measures (e.g., SMP's low-cost product distribution — see Section 3.3). ASHONPLAFA may also have overemphasized cost saving and self-sufficiency. Some of the delays mentioned below (e.g., in promoting and advertising the SMP or for IEC and research services) doubtless reflect efforts to save money.

The areas in which underspending of the lempira budget has had the most significant negative programmatic implications were in promotion and advertising for SMP, development and consistent use of mass media for general IEC, in-country training, and research on transportation and field support for promoters.

Disbursal of USAID/Honduras Funds

USAID/Honduras funds are disbursed based on advance payments, but USAID requires that each advance payment be mostly cleared before any new advance is made. Payments come through Mexico, which usually delays the process. This could be alleviated by adopting a level of advances adequate to ensure that ASHONPLAFA would not face cash flow problems, to be replenished each time a liquidation was processed.

Extension of the Project Life

As noted above, at project midpoint, only 25 percent of the total project budget of US\$16 million had been spent, reflecting among other things the underspending in the vicinity of 50 percent in local currency by ASHONPLAFA that is shown in Table 4. At the current rate of spending (US\$3 million a year) and with US\$12 million remaining, theoretically US\$4.5 million will still be left at the scheduled end of the project. If spending were to continue at the current rate, this should be sufficient to extend the project up to another 18 months, or until the end of 1995.

Even without further devaluation of the lempira, the remaining US\$12 million would include sufficient funds for all project elements for a four-year period extending from January 1, 1992 through December 31, 1995. Just over two-thirds (\$8,205,668) would be absorbed by the three implementing agencies for currently planned activities, with ASHONPLAFA receiving \$7,329,920⁴ and PLAN and the Population Council together receiving US\$875,748.⁵ The remaining one-third, \$3,754,391, could be absorbed approximately as follows (bringing the total to \$11,960,059):

•	contraceptives	\$1,500,000
•	technical assistance	\$1,000,000
•	other commodities, PVOs, training abroad, extension of PLAN and Population Council	\$1,254,000

⁴This figure is based on ASHONPLAFA's 1991 spending level of \$1,832,480 and assumes continued spending at this level over a four-year period. Program expansion beyond this level could come from ASHONPLAFA's use of its increasing local revenues.

⁵This includes funds both committed and reserved for these two activities.

Table 4

**Comparison of ASHONPLAFA Actual Yearly Expenditures
and the Yearly Local Currency Budget in the
Project Paper (midpoint of project)
(US\$1,000)***

Project Element	1989 PP	1989 Actual	1990 PP	1990 Actual	1991 PP	1991 Actual	Total PP	Total Actual	Total % Budget Expended
Community Service	219	146	450	283	621	227	1,290	656	51%
Social Marketing	133	60	77	16	73	76	283	152	54%
Medical & Clinical	409	238	859	595	870	430	2,138	1,263	59%
IEC	110	29	215	93	208	65	533	187	35%
Training	53	25	102	46	152	21	307	92	30%
Monitor & Evaluation	39	17	186	30	67	134	292	181	62%
Admin. & Mgt.	176	62	353	256	355	179	884	494	56%
Total	1,139	577	2,242	1,319	2,346	1,132	5,727	3,028	53%

Source: ASHONPLAFA

*During this period, the value of the lempira declined from 2 lempiras per dollar to 5.65 per dollar.

Table 5

**Comparison of USAID PIL Assistance Budgets with Actual
Expenditures from all Sources
January 1, 1989 to December 31, 1991
(L1,000s)**

Program	1989 Budgeted	1989 Expended	1990 Budgeted	1990 Expended	1991 Budgeted	1991 Expended	Total % Budget Expended
USAID FUNDS*							
IEC	213	67	465	440	662	376	66%
Training	97	62	222	143	426	93	40%
CSP	698	415	1,347	902	1,960	1,297	65%
Med&Clin	841	655	1,736	1,745	3,340	2,434	82%
SMP	457	96	556	119	974	446	33%
Mon&Eval	79	50	181	87	1,230	771	61%
Administration	311	265	738	770	1,524	998	79%
Total	2,695	1,610	5,245	4,206	10,115	6,416	68%

Source: ASHONPLAFA

*Note: 1989 A.I.D. financed expenditures include funds from both Projects 522-0286 and 522-0369.

Table 6

**Project Paper Funding Levels
for Various Components Compared to
Local Currency and Dollar Expenditures and Commitments
as of December 31, 1991
(US dollars)**

Budget Element	PP Budget	Expended	Committed
Total ASHONPLAFA Budget	\$14,900,000	\$3,815,689 (26%)	\$6,306,748
Community Services	3,222,087	715,967 (22%)	1,159,298
Monitoring & Evaluation	619,053	197,410 (32%)	385,673
Training	657,281	145,199 (23%)	248,658
IEC	1,104,018	197,850 (18%)	508,309
Social Marketing	636,359	229,983 (36%)	331,708
Medical & Clinical	4,454,383	1,461,846 (33%)	2,224,544
Administration	1,906,819	531,673 (28%)	876,265
Technical Assistance	2,300,000	335,761 (15%)	572,295
Total non-ASHONPLAFA Budget	1,100,000	224,252 (20%)	1,100,000
Foster Parents PLAN	355,700	81,566 (23%)*	355,700
Population Council	744,300	142,686 (19%)*	744,300
Total Dollar Budget	16,000,000	4,039,941 (25%)	7,306,748

Source: USAID

*USAID expenditure figures differ from those provided by PLAN and the Population Council and shown in Table 13.

Note: The table shows that USAID has been current in budgeting and committing funds, with 46 percent of the funds "committed" at midpoint of the project.

2.2.3 Revenue Generation and Cost Recovery

Overview

In 1991, ASHONPLAFA had increased by 54 percent its locally generated revenues over those of 1989 (see Table 7). This was accomplished primarily by increasing prices for services for almost all acceptors. These price increases, although within ASHONPLAFA's pricing strategy (see below), may have put these products beyond the financial reach of the poorest Hondurans (although this group comprises the anticipated beneficiaries of the USAID project). As long as this tradeoff is understood by USAID and ASHONPLAFA, it is a reasonable approach to increased self-sufficiency.

Both the SMP and CSP may be operating without project funding (with the exception of contraceptives) by the end of the project, but there is no possibility that ASHONPLAFA can become completely self-sufficient during this time span.

Income

ASHONPLAFA's total income nearly doubled between 1989 and 1991, and its locally generated income increased by 54 percent over the same period. On the other hand, as a percentage of total income, locally generated income dropped from 29 percent to 24 percent (see Table 7). Nonetheless, that ASHONPLAFA is now producing 24 percent of its total budget with internal revenues indicates marked progress since 1982, when it first started generating income from services.

Table 7

Income of ASHONPLAFA by Main Sources 1989-1991 (L1,000)

Year	Total Income	Donor Income	Percent of Total	Local Income	Percent of Total
1989 (5 months)	6,760	4,784	71%	1,976	29%
1990	8,049	6,046	75%	2,003	25%
1991	12,757	9,709	76%	3,048	24%
Total for Period	23,448	17,457	74%	5,991	26%

Source: ASHONPLAFA

Revenue Use and Self-Sufficiency

All revenues are placed in the general operating budget. None remain at the regions where they are generated, and thus operating units have no control over their allocation. The only exception is funds kept by the CSP distributors and the SMP distributors and pharmacies. Most likely, if regional and program units were able to use the funds they generate to enhance services and reward staff, this would lead to increased services and better efficiency.

In terms of cash flow, regions currently operate on the basis of revolving funds. These are small (L10,000 per region except for San Pedro Sula, which has L25,000) but sufficient because most costs (contracting and payments, e.g., for salaries) are paid centrally. The refunding procedure is efficient and presents no problems.

Rising Cost of Services

The rise in ASHONPLAFA's locally generated income over the project period reflects in part the 1990 decision to increase prices charged for services following the devaluation of the lempira in 1989. Price increases were consistent with the association's pricing strategy, which calls for prices to be 1 to 1.5 percent of the minimum wage and not to exceed one-third the price of commercial brands. The new prices also were probably within reach of most working Hondurans (about half the labor force was in salaried positions in 1990).

On the other hand, particularly as very few clients are exempted from the payment of fees, this policy may be a problem for residents of the rural areas and poor women. For example, a year's supply

(one CYP) of the cheapest condoms costs L50 and a year's supply (one CYP) of the cheapest pills, L15.6; these prices would be difficult for those on subsistence income to pay.

The increase in prices had two effects. It increased the proportion of ASHONPLAFA's income that was generated by charges for commodities and services from less than half to nearly two-thirds (see Table 8). (Other income sources include interest, laboratory tests, sale of medicines, and other clinic services.) It also was no doubt an important factor in a dramatic drop in sales that followed the price change.

Table 8
Fees for Services Paid for by ASHONPLAFA Clients in 1989-1991
(in lempiras)

ASHONPLAFA	1989		1990		1991		Average Percent
	Actual	Percent of Total	Actual	Percent of Total	Actual	Percent of Total	
MCP fees	139,600	7%	140,300	7%	221,500	7%	7%
SMP fees	335,900	17%	638,800	32%	707,900	23%	24%
CSP fees	422,400	21%	486,800	24%	1,129,400	37%	27%
Other income	1,078,800	55%	737,500	37%	989,600	33%	42%
Local Revenues (All Sources)	1,976,700	100%	2,003,400	100%	3,048,400	100%	100%

Source: ASHONPLAFA
Exchange rate: Lempiras (US \$1 = L5.40)

Self-Sufficiency

The project paper called for 100 percent self-sufficiency for the SMP and 50 percent for the CSP (excluding cost of contraceptives) by the end of the project. It did not call for the ASHONPLAFA itself to become self-sufficient, however,⁶ and there is no likelihood that it will, even if the project is extended 18 months. For example, in 1991, the MCP generated income equivalent to only 21 percent of its costs. Both SMP and CSP have made strong progress toward self-sufficiency. In 1991, the SMP covered 115 percent of its direct program costs and the CSP covered 67 percent (see Table 9). Most likely, both programs should soon begin to provide support for the central costs of the association.

Balancing the need to generate income against the other project goal of providing services to the rural poor presents a difficult challenge, and to some degree ASHONPLAFA may have leaned too much in the direction of seeking self-sufficiency. There is evidence, for example, that there was some underspending on the program side for advertising and publicity, for transportation, and for promotional materials and there may have been charges for unneeded services (i.e., excessive Pap

⁶Questions in section 3 of the evaluation SOW implied that ASHONPLAFA was expected to become self-sufficient.

smears — see below Section 3.1.5). Also, although provisions have been made for a sliding scale of fees, the pressure on ASHONPLAFA to be self-sufficient forces the association to make few exceptions to the rule that all must pay, jeopardizing the goal of providing services to the rural poor.

Accounting Issues

The current budgeting process does not clearly delineate between expenditures that are supported by ASHONPLAFA's locally generated revenues and those supported by donors. Thus, it is not clear exactly what USAID and what IPPF or other donors are supporting. Also, donors are unable to see whether ASHONPLAFA is moving toward program self-sufficiency or whether it is making expenditures that appear less appropriate (e.g., in 1991 ASHONPLAFA spent funds to purchase a pharmacy's inventory). The audit reports do not show clearly how the annual increases in assets in the balance sheet were achieved — i.e., whether they represent savings from revenue at a time when the program should be expanding with that revenue.

Table 9

Comparison of Costs and Locally Generated Income
of Major Service Delivery Programs
1991 (L1,000s)

Project Element	Costs	Local Income	Income as % of 1991 costs
Social Marketing	613	708	115%
Community Services	1,673	1,129	67%
Medical and Clinical	3,475	718	21%

Source: ASHONPLAFA

Note: The programs exclude contraceptives, except in MCP, in the cost figures.

2.3 Management Information System, Statistical Data and Information

2.3.1 Overview

Good progress is being made in developing the MIS called for in the project paper. This is an integrated modular data system (SIES) that will have the capability to track and produce data on personnel, bank accounts, accounting, budgeting and inventory systems, clinic administration (except in Tegucigalpa), cost accounting, social marketing data, community services data, fixed assets, and the warehouse. The purpose of this system is to produce information to allow program decisions to be made on a timely basis, using accurate information on project inputs and outputs.

A start in installing the system was made under the first project, with the establishment of a local area network (LAN), training of staff, and provision of some software systems. All of the systems are working well. Part of the follow-up effort is being supported by IPPF's Western Hemisphere Region (IPPF/WHR), which is providing technical support for installation of an effective, computerized, financial management system using the Appropriate Technology, Inc. (TECAPRO) system.

ASHONPLAFA has made good progress in setting up the MIS system, particularly in the areas of administration (i.e., the modules dealing with personnel, bank accounts, accounting, budgeting and inventory systems) and the gathering of family planning service statistics (not yet computerized but operating reasonably well). USAID-purchased computers for the regional offices have arrived. Still awaiting installation are the systems for clinic administration (except in Tegucigalpa), cost accounting, social marketing data, community services data, fixed assets and the warehouse. ASHONPLAFA is cooperating with the MOH on the EFHS, which will produce essential data for progress evaluation.

2.3.2 Computerized Accounting and Cost Accounting

With the introduction of the TECAPRO system, a set of accounting and administrative "modules," and the addition of personnel, ASHONPLAFA has improved its ability to track and account for project finances. The computerized system adequately handles routine accounting. The process is not yet complete, but sound financial information is available for 1991, with detailed data by regions and programs, allowing for significantly improved financial control and sound management decision making. For example, the new accounting system allowed for the comparisons between regions and programs for 1991 and 1992, shown above in Table 2. In addition, monthly financial reports are prepared that show the progress in executing the annual budget. These allow the Technical Council to be aware of how its programs are progressing.

One issue is that financial reports are closely held by the executive secretary, the assistant to the executive director, and the administrative chief, with the result that mid-level management are not fully informed about the funds available to them during the year. In addition, sufficient use is not being made of present financial reports in tracking program progress. A third issue is that neither upper- nor lower-level staff have received sufficient training in using these reports for management decision making, nor have they been trained in how to input data and use various software. It is difficult to understand why managers and staff members needing software training have not received it.

Neither the system to carry out cost accounting nor the budget control system had been installed at the time of the evaluation, but the plan was to activate these systems as soon as the rest of the SIES system had been installed. At the time of the evaluation, ASHONPLAFA still lacked data on costs for the delivery of each type of service and had no accurate way of ascertaining cost per CYP. If this information were available, it would make possible better pricing of services, particularly in relation to self-sufficiency.

Supplementary operations research studies are also planned that will give a clearer picture of costs and utilization of services. Family Health International (FHI) is conducting a cost study on ASHONPLAFA, looking at clinic and CSP costs. The Centers for Disease Control (CDC) are planning a patient flow analysis. Both should provide essential information for better cost analysis, which also can feed into the management decision-making process. Even without cost accounting figures, it is evident, when analyses are made of the number of users per day, that in some centers clinical personnel and equipment are underutilized.

2.3.3 Service Statistics and Reports

ASHONPLAFA has excellent service statistics even though the centralized database for service statistics has not yet been installed. Data continue to be hand tabulated and processing is a slow process (three months, for example, for CSP program data). (Discussion of the service statistics systems for the CSP and SMP is provided in Sections 3.2.4 and 3.3.5.)

Feedback on service statistics is provided to staff through quarterly and annual bulletins and a quarterly newsletter.

2.3.4 Hardware

Computer equipment seems to be adequate except for the system server. The LAN is currently served by two 386 personal computers with large hard disks. One of the hard disks is awaiting replacement; in the meantime, there are long waits to get input or output from the server. Additional computers and modems will become part of the network in the near future. New USAID-purchased computer equipment has arrived.

2.4 Personnel Management

2.4.1 General

ASHONPLAFA staff represent a cadre of enthusiastic, generally well-trained, and capable personnel, and they have contributed much to the success of the project to date. Staff are service oriented and cooperative and demonstrate a real commitment to the program. At the end of December 1991, there were a total of 212 employees, about half (49 percent) assigned to the central office (Regions 0 and I) and about half (51 percent) to the other regions.

The personnel system is highly centralized, with little delegation of authority to the regions. Within these limitations, the Personnel Department has been effectively contributing to achieving the project objectives by efficiently carrying out routine activities, such as maintaining payroll and personnel records. These functions are fully computerized.

The department has also succeeded in avoiding legal problems. This is not easy, since in Honduras (as elsewhere in Latin America) considerable time and expertise are needed to handle the very detailed and complicated labor law that regulates employment and, as a consequence, payroll functions (salaries and fringe benefits), personnel records, and other personnel activities. ASHONPLAFA deserves particular credit for having averted the legal problems that could easily have arisen.

The good personnel management was reflected in a low turnover rate for 1991. During that year, out of a total of 212 employees, 37 employees were hired by ASHONPLAFA while 31 left. Of these, one-third (10 employees) left voluntarily, mainly because of better opportunities, and two-thirds (21 employees) were fired for a variety of reasons.

2.4.2 Personnel Authority

The highly centralized Personnel Department at ASHONPLAFA allows for little delegation of authority to the regions. The executive director has final control over all personnel matters. All personnel contracts, hiring and firing and, in particular, any decision on salaries must have his written approval. The head of the Personnel Department reports directly to the executive director. Yearly salary increases and major personnel policy decisions go to ASHONPLAFA's Board of Directors for approval.

Recruitment

Staff recruitment for personnel for Regions 0 and I is the responsibility of the Personnel Department, with the active participation of the head of the department that is seeking the new staff member. Recruitment for regional positions can be carried out either centrally, or occasionally by the regional director, but selection of candidates and contracting are done at the central level.

Performance Evaluation and Rewards

Competency and performance evaluations take place twice a year, but information from these evaluations is not used for promotions or salary increases. Very little is done with regard to rewards and recognition, including instituting the incentives (bonuses) for regional directors called for in the project.

2.4.3 Training

ASHONPLAFA does not have a separate training department. Rather, the Evaluation Department conducts all training of ASHONPLAFA employees and the IEC Department conducts training of other persons and groups. These training responsibilities divert these two departments from their prime responsibilities of research, MIS, mass media, IEC, and public relations/policy development activities.

A good number of persons have been trained, including 1,491 individuals whom ASHONPLAFA reported as having trained directly, plus another 1,500 community leaders and volunteers trained by other PVOs, often with ASHONPLAFA assistance. Nonetheless, the training budget was one of the most seriously underspent of all budget line items. Only 40 percent of the amount budgeted during 1989-1991 had been expended and only 30 percent of the level anticipated in the project paper (see Tables 5 and 4). Shortfalls have been greatest in the areas of training for MIS, pharmacists, and program managers (see Sections 2.3.2 and 3.3.4).

2.4.4 Staff Financing

Spending for salaries and fringe benefits has been L754,419 below the amount budgeted over the period from 1989 to 1991. As mentioned in Section 2.2.2, ASHONPLAFA has maintained that the reason funds for staff have been underspent is that USAID has changed the policy and is now urging that more staff costs be assumed by ASHONPLAFA in return for USAID's picking up other operational expenses. Staff positions have remained vacant while this issue has been under discussion. In addition, there has been some dispute over the level of fringe benefits.

Since the project's start, ASHONPLAFA has made some progress in taking over from USAID some of the responsibility for funding staff salaries. In 1989, USAID financed 77 percent of the total ASHONPLAFA payroll; in 1992, the percentage is expected to drop to 74. At the same time, ASHONPLAFA will be funding a considerably larger number of employees by 1992 than it did in 1989 (32 compared with 5 — see Table 10).

Table 10

Funding of ASHONPLAFA Staff by Source
(1989 to 1992)

Source of Financing	1989	1990	1991	1992 Budgeted
USAID/Honduras	143	165	175	193
IPPF	34	31	26	29
ASHONPLAFA	5	9	8	32
Other	3	3	3	4
Total	185	208	212	258

2.5 Information, Education and Communication

2.5.1 Overview

ASHONPLAFA has developed a comprehensive IEC strategy, designed to improve its institutional image, provide materials and support for interpersonal communication, and develop and support a radio campaign. Implementing this strategy is a key element in the project. The thrust of the activities, however, has been on such labor-intensive areas as development of printed materials and educational activities in the community (e.g., talks and courses for leaders on reproductive health and family planning). This approach has left limited time and energies for innovations or, indeed, for the other anticipated outputs. Although a mass media radio campaign was mounted, the use of radio has been sporadic and the public relations campaign has not progressed very rapidly.

The component has spent about two-thirds of the amount anticipated to date in the ASHONPLAFA budget (L883,000 spent against L1,340,000 budgeted) (see Table 5). In terms of expenditures for IEC anticipated in the project paper, the shortfall was even greater, as only 35 percent of the anticipated amount was spent in this area (see Table 4). This in large part explains the shortfalls mentioned above.

The main reasons for the underspending include the failure to contract with publication agencies for mass media campaigns (see Section 2.5.3) and the slow hiring of regional IEC staff (see Section 2.5.5). Part of the problem may also reside in the design of the project itself. The communications strategy does not spell out with sufficient specificity simple and achievable interim goals, which would lend themselves to monitoring and evaluation of project progress or which could be verified by the contraceptive prevalence survey (e.g., "changes in knowledge and attitudes of rural and urban populations" instead of the difficult to assess "50 percent of efforts to be directed to rural population").

2.5.2 Public Relations Strategy

ASHONPLAFA deserves credit for having developed a public relations strategy, although, given the difficult environment in Honduras for family planning, the campaign must be viewed as relatively modest. ASHONPLAFA's image and programs have been challenged for many years by the Catholic Church and, recently, by a Pro Vida (Right-to-Life) local chapter and other rightist groups. Press attacks in 1989 and 1990, which included mention of this project, resulted in shelving of a bill on population after it was passed. Operations of this project are also being made difficult by church attacks, including on volunteers who have apparently become intimidated (see Section 2.1.2), and an organized attack on the CSP program, which led to a drop in sales (see Section 3.2.3). All these episodes show clearly how powerful the groups opposing family planning in Honduras can be and justifies the need for ASHONPLAFA's public relations activities.

ASHONPLAFA's strategy is generally to avoid confrontation and instead to attempt to improve the attitude toward family planning expressed in the media. Approaches in recent years have included avoiding the subject of abortion entirely and stressing instead that family planning should be freely chosen by couples, that it protects life, etc.

At times, however, ASHONPLAFA has sought out spokespersons among lawyers, physicians, women leaders, and prominent advocates of family planning to appear on radio or to write newspaper articles to defuse controversies when threats and attacks surface. For example, during the 1989-90 episode, the IEC director appeared on a radio talk program to inform the audience that he was aware of Catholic priests who were fathers of children as they were reluctant to use contraceptives. He added that he was ready to name names. The debate calmed down shortly thereafter.

The climate may be ripe at present for ASHONPLAFA to take a more aggressive stance in publicizing family planning and working toward development of a more positive population policy. Developments that encourage the use of contraceptives include advertising of contraceptives through the project, the economic situation, MOH efforts to provide contraceptive services with assistance from the separate USAID Health Sector II project, and the AIDS threat. The first three factors, in particular, may have affected the perspective of Honduran families toward the use of family planning.

2.5.3 IEC Coverage

The IEC Department implements 10 subprojects, of which 7 receive funds from the project. Five of the seven are family planning extension efforts, which consist primarily of giving talks, making home visits, providing courses in reproductive health, delivering promotional messages through mobile units, developing and distributing printed materials, and referring clients to ASHONPLAFA centers. The sixth is a VSC promotional campaign, and the seventh, a mass media campaign. IEC activities have been carried out in most of the regions and states of the country, with the exception of isolated areas such as Gracias a Dios.

IEC Materials and Presentations

On the whole, the IEC Department has used a very conservative approach, relying primarily on visits, talks, printed material, courses and seminars. For example, about 340,000 people attended 7,874 talks in 1991. These labor-intensive efforts have probably taken time that would otherwise have been available for mass media and innovative approaches that might have been more effective and had a

wider reach, particularly in rural areas. There has been little emphasis on mass media promotion of VSC (either male or female — see Section 3.1.2).

CSP promoters and distributors, supported by IEC Department activities, contribute a great deal to spreading the family planning message throughout the country. This form of interpersonal communication represents an important investment in public relations, and it should not be ignored for it brings support and good word-of-mouth advertising when bad publicity for ASHONPLAFA arises.

Mass Media

Newspaper Coverage. The project attempts to stimulate journalists to write about reproductive health and population-related matters. Some 225 articles on these subjects appeared in Honduran newspapers and magazines during 1990 and 1991. To increase the number of articles on these issues, ASHONPLAFA created the Ofelia Mendoza Award in 1990 for journalists for the best article on family planning. This was won in 1991 for an article by a writer for *El Tiempo* on the Honduran family.

Radio. In the mass media campaign, ASHONPLAFA has placed emphasis on using radio stations throughout the country to broadcast spots, talk shows, and messages about family planning and to inform listeners about the location of MCP and CSP services. Thirty-five different messages were repeated nearly 240,000 times (117,011 in 1990 and 120,711 in 1991) by 53 radio stations in 1990 and 55 in 1991. Only in Islas de la Bahia and Gracias a Dios was there little penetration; these areas have few radio stations and they have limited coverage. This effort was expected to reach primarily rural audiences, but no studies have been done to assess whether mass media have affected the knowledge and behavior of clients in rural areas.

The use of radio campaigns to promote programs and provide information to the target audiences has increased during the project period, but has been sporadic in 1992. This is mainly due to ASHONPLAFA's lengthy contracting process with publicity agencies, which prepare the promotional messages. Funds have been underutilized in this area and the technical assistance called for in the project has not been sought.

TV Programming. Relatively little work has been done in the area of TV, in part because TV stations reach only urban audiences, in part because of the high costs involved, and in part because of the limited experience of the IEC Department staff in this area. One low-cost, 14-minute video has been produced, which was shown by one of the TV networks on Father's Day in mid-March. This gave a positive image of ASHONPLAFA's program and is slated for considerably more use in the future, both for promotional activities and in training courses.

2.5.4 Cooperation with ASHONPLAFA Service Delivery Programs and PVOs

Support from the IEC Department to the service delivery programs has not developed to its full capacity. The department has, however, made progress in assisting PVOs with training and educational materials and this has been instrumental in developing the ability of PVOs to promote family planning.

Substantial amounts of printed materials have been provided to fieldworkers for PLAN, World Vision, AHLACMA (Honduran Association for Maternal Lactation), Save the Children, SOS (a child

care agency) and other PVOs for use in project-related activities. More materials are needed, however, to ensure that each worker has some. In addition, the IEC Department provides some technical assistance to help PVOs create printed and audiovisual materials themselves and to ensure that they do not duplicate materials already available elsewhere. Two meetings were held with PVOs to share and review materials each has produced. Still, quite likely, the IEC Department could be more active in this area.

Training under this component has been directed to reproductive health training for PVO staff members and field personnel from PVOs such as PLAN, World Vision, AHLACMA, and Save the Children. Two manuals on sex education and reproductive health were developed to assist in these efforts. The IEC Department is also involved in considerable continuing education for ASHONPLAFA staff. (See Sections 4.1.4 and 4.2.4 below.)

An inter-institutional committee was reactivated to improve coordination of IEC efforts in areas in which both PVOs and ASHONPLAFA work.

2.5.5 Administration

The IEC Department, whose chief also serves as the ASHONPLAFA public relations spokesperson, had a total staff of 44 as of March 1992, up from 30 at the start of the project. The hiring of these individuals took longer than anticipated, contributing to the underspending of the total budget. New staff are primarily promoters and educators, who work at the community level to stimulate local IEC activities, and communication specialists, who coordinate and direct efforts for each region. They should significantly improve the IEC work force in 1992 by strengthening the IEC presence at the regional level. They should also be adequate to meet all project needs, both the current activities and additional mass media, if strategic emphasis is shifted to a greater emphasis in this area and a publicity firm is contracted for major campaigns.

2.5.6 Audiovisual Equipment

The audiovisual equipment to be supplied to ASHONPLAFA during the project is appropriate and, when all supplies and equipment have arrived in-country, will be adequate for project needs. Delays in delivering VCRs have prevented the showing of family planning-related videos purchased by ASHONPLAFA some time ago. A scanner for production of printed material has just arrived but other audiovisual equipment, especially that ordered for the regional centers, remains in U.S. port facilities.

3. ASHONPLAFA Service Delivery Programs

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3. ASHONPLAFA Service Delivery Programs

3.1 Medical and Clinical Services

3.1.1 Overview

ASHONPLAFA's Medical and Clinical Program (MCP) provides high-quality medical services and has contributed in an important way to giving the association a good name as a responsible health institution in Honduras. Clients receive good quality, safe contraceptive services, both temporary and permanent, at MCP facilities. The regional facilities are clean, well kept, and well equipped; providers are skilled; universally accepted standards and procedures are observed; and informed consent, counseling, and follow-up are carried out by a dedicated staff. Major and minor VSC and IUD complication rates are within permissible limits.

The MCP was ASHONPLAFA's first service delivery program and is its most productive in terms of CYPs. It provides permanent and temporary family planning methods in the six regional centers, supplemented by eight private clinics in cities in which there are no clinical services directly provided by ASHONPLAFA. The regional clinics serve as a backup for the CSP, providing headquarters for the 30 CSP and 24 VSC promoters who work in the surrounding urban and rural areas.⁷ In addition, a new women's clinic opened in Tegucigalpa in 1991, and two more are scheduled to open in 1992 (in San Pedro Sula and Choluteca). These clinics offer a wide range of reproductive health services and demonstrate the willingness of the MCP to try out new alternatives to meet client needs and improve cost recovery.

Accessibility to medical and clinical services has greatly improved since the new regional centers opened. On the other hand, the rural population still has limited access to medical and clinical services, stemming from high fees, high transportation costs, and clinic hours that tend to be more convenient for doctors than for clients.

The program is coordinated by the medical director of MCP. Staff includes trained physicians, nurses, promoters, and auxiliary personnel.

In 1991, the program contributed some 65 percent of the total CYP output produced by ASHONPLAFA, or around 138,000 CYPs. Of this, permanent methods (VSC) provided the great preponderance (almost 122,000 CYPs) whereas temporary methods provided only about 15,700 CYPs (see Table 1).⁸ Most women having VSCs, however, are older, with a parity of four or more. Thus, the temporary methods distributed by this and other ASHONPLAFA programs play an important role

⁷VSC promoters were employed and trained for special emphasis on promoting VSC in the community and in various health facilities. At the time of the evaluation, they were being trained to be multipurpose promoters of all methods in support of all ASHONPLAFA programs. See Section 3.2 for discussion of CSP promoters.

⁸One male or female sterilization is calculated as contributing 12.5 CYPs to the program. Achievement of this same number of CYPs through other methods would require distribution of 163 cycles of pills, 1,250 condoms, or 3 IUDs. The equivalent of the program annual total of 109,253 CYPs would be 10,925,300 condoms or 1,420,289 cycles of pills per year. On the other hand, it should be noted that with the high (12.5) number of CYPs per procedure, the program would be meeting the needs of a lower number of women if it were to depend excessively on VSC to meet its CYP targets.

for as they address the contraceptive needs of younger women. Providing this choice also ensures that the overall association program is less vulnerable to attacks by family planning critics.

3.1.2 VSC

In 1991, a total of 11,307 female VSCs and 115 male VSCs were performed in Honduras (see Table 11). At this rate, it is likely that the goals for female (39-40,000) and male (500) sterilizations will be met by the end of the project.

Female VSCs

In 1991, over 50 percent of all female VSCs were provided in ASHONPLAFA facilities. These facilities include the six MCP clinics and the women's clinic in Tegucigalpa. In addition, another quarter of the procedures were provided in eight private clinics in towns where there are no ASHONPLAFA clinics (24 percent). The remaining quarter were provided in MOH hospitals, IHSS facilities, the Hospital Materno Infantil, and La Lima and D'Antoni Hospital. The MOH is just beginning to provide female VSCs; in 1991 it provided less than 10 percent of the total. ASHONPLAFA promoters visit MOH facilities to promote use of this procedure, although the prospect is that the MOH will eventually assume the promotional responsibility.

Private clinics are accredited by ASHONPLAFA's MCP Services Department and also take referrals from ASHONPLAFA promoters. They are reimbursed by ASHONPLAFA for sterilizations performed on clients referred by the promoters and other field personnel, a cost-effective approach that is less expensive than the alternative under discussion — building a clinic. Expansion of this modality would likely be beneficial to the program. The possibility of adding clinics, however, is limited by the need to identify satisfactory facilities and qualified, interested physicians as well as to meet additional monetary requirements. VSCs provided at IHSS and Materno Infantil and La Lima and D'Antoni hospitals, though also catalyzed by ASHONPLAFA, are funded primarily through sources other than the project and, thus, the sterilizations they provide should be discounted from service statistics (see Table 11).

Table 11

Male and Female VSCs by Provider in Honduras
(1991)

Provider	Female	Male	Total	% of Total	CYP
ASHONPLAFA	6,018	105	6,123	54%	76,537
Private clinics	2,702	7	2,709	24%	33,863
Hosp. Materno Infantil	596	-	596	5%	7,450
IHSS	677	2	679	6%	8,488
La Lima & d'Antoni Hospital	242	-	242	2%	3,025
Ministry of Health	1,072	1	1,073	9%	13,412
Total	11,307	115	11,422	100%	142,775

Source: ASHONPLAFA service statistics.

In the larger centers and in some of the private clinics, VSCs are performed by obstetrician/gynecologists (ob/gyns). At other locations, they are performed by general surgeons and general practitioners who have been trained in the procedures. One anesthetist is available and elsewhere anesthesia technicians are responsible for sedation and analgesia and for monitoring the patient undergoing surgery.

Tubal ligation with the laparoscope, under local anesthesia and sedation, is the most widely used technique for sterilizations, contributing 80 to 85 percent of the female VSCs. This high dependency on a rather sophisticated technique has program implications — the cost per case increases when the case load is low, the situation in most ASHONPLAFA clinics.

Vasectomies

Vasectomy services are unavailable in most parts of the country. They represented only 1.7 percent of the total sterilizations in 1991 and are performed by ob/gyn specialists (under local anesthesia) in only two locations, at male clinics in Tegucigalpa and San Pedro. At the rate of only 100 to 120 vasectomies per year, the program will most likely meet the modest target of 500 procedures during the project life. Observed demand is low, due in large part to the use of women-only promoters to recruit clients, the practice of training mostly ob/gyns to perform vasectomies, and the very limited mass media promotion.

Quality of Services

As might be expected in any surgical program, ASHONPLAFA has recorded some complications. Minor infection of the abdominal wall represents 1 to 2 percent of complications seen and treated by ASHONPLAFA during the first week after the procedure. One case required emergency abdominal surgery and there has been one death, in 1991, of a woman 11 days postpartum who had been sterilized by a private doctor in Danli. In this latter case, it was not possible for ASHONPLAFA to get conclusive evidence of what had happened. Anecdotal information on failed procedures reported to the supervisor in La Ceiba merits a more careful assessment of the physician in that city and the need that he may have for further training. With regard to vasectomy, scrotal hematomas have been reported in two cases.

Despite the above complications, the MCP meets most of the standards of quality that guarantee safe service delivery to clients. Some complications are seen in the best-run programs in the world; it is not unusual that a complication unexpectedly occurs.

Monitoring of complications is carried out by the medical director, who travels throughout the country 180 days every year. The system in place, however, restricts the reporting of any complication to the clinical record, rather than using the special report forms that are typical of most programs. Therefore, some problems may be undetected unless they become publicly known.

3.1.3 The IUD Program

With a 4.3 percent IUD prevalence rate (1987), Honduras has one of the lowest rates of IUD use among the countries in the Western Hemisphere. Copper Ts represented three-quarters of all IUDs inserted in 1991; the other quarter were Lippes Loops. Until a few years ago, only doctors could insert IUDs. A recent, and positive, ASHONPLAFA innovation now allows registered nurses to

carry out this procedure as well. Last year ASHONPLAFA inserted 3,435 IUDs in comparison to the MOH's 11,000. Low demand for IUDs may reflect lack of promotion for this method, intimidation by the church, fear of the device, and the relatively high cost at ASHONPLAFA facilities (L15) compared with MOH clinics (L1).⁹

3.1.4 Accessibility Issues

Access to clinics is a problem for rural and urban low-income women, due to fees for VSC, inconvenient and expensive transportation, and scheduling of female VSC services during morning hours only. Other populations for whom access is difficult are adolescents and women 24 years of age and under who wish a VSC.

Poor and Rural Populations

Fee Schedule for Services. After the devaluation and the subsequent increase in fees for services, revenues from fees for MCP services increased from L139,000 in 1989 to L221,500 in 1991. Despite these increases, fees for services paid by MCP clients continued to represent only 7 percent of total local revenues generated by ASHONPLAFA (see Table 8). (Implications of these price increases are discussed above in Section 2.2.3.)

Convenience. Fifty-six percent of the VSCs take place at the clinics in Tegucigalpa and San Pedro Sula. These clinics are crowded first thing in the morning, but by the afternoon, the premises are often empty. The new regional facilities have far less use. Operating rooms of all six clinics are underutilized.

Part of the underutilization may arise from lack of promotion, but there is also another problem. The MCP has decided not to hire physicians for the clinic in Tegucigalpa or at San Pedro Sula clinic for afternoon hours, apparently assuming morning hours are more convenient for them. Many rural women who wish VSCs, however, may find it difficult or impossible to make the long, slow trip via public transportation and arrive at the clinics in time for morning hours. Cost of transportation may also deter rural clients from using the clinics.

Age and Parity Criteria for VSC

In accordance with a June 1984 resolution (resolution No. 141-84) passed by the Honduran Medical Association and the MOH, it is virtually impossible for women under 24, even if they have three or more children, to acquire a sterilization. The regulation places such women in a high-risk group for induced abortion if they get pregnant.

Adolescent Fertility

Although the project paper called for an adolescent fertility strategy to be in place by the third year of the program, no strategy has been created and ASHONPLAFA has no adolescent program. Adolescent fertility is, however, a key demographic, social, and health concern. The 1987 EFHS indicated that age-specific fertility for 15- to 19-year-olds had increased from 115 births per 1,000

⁹The 1 lempira cost at MOH clinics was reported to be the general practice. USAID/Honduras states that in some MOH facilities, the charge is 10 to 15 lempiras and in some private clinics, 35 to 50 lempiras.

women in 1984 to 135 births per 1,000 in 1987. The EFHS also showed that 70 percent of this population had never used contraceptives, indicating that this sexually active group of women has been neglected with regard to access to and information about services that could prevent both unwanted pregnancies and maternal deaths.

3.1.5 Cost-Recovery Issues

As noted above, the MCP recovered only 21 percent of its costs and generated only 7 percent of ASHONPLAFA's total revenues. Most of the revenues come from fees charged for clinical procedures (sterilization and IUD insertion), and the low level may in part reflect the low utilization of the facilities. Pap smears, or screening for cervical cancer, are another source of income. The two main cytology laboratories, in Tegucigalpa and San Pedro, brought in income of about US\$40,000 for 1991 for Pap smears performed. These represent about one-third of the Pap smears done in the country, contributing to ASHONPLAFA's positive institutional image. The only issue relates to possible overzealousness with regard to these tests. Instances were observed of the tendency to overuse Pap smears to follow up women with benign lesions and for low-risk clients whose first test was benign.

3.2 Community Services Program

3.2.1 Overview

The Community Services Program, in operation since 1976, consists of a network of some 1,700 volunteer distributors. The distributors, supported by 30 promoters, offer a wide array of temporary contraceptive methods, including five brands of pills and three brands of condoms. The promoters and distributors also play a key role in ASHONPLAFA's overall IEC efforts, providing much of the interpersonal communication that is essential to any successful IEC effort. The 24 VSC regional promoters are not part of this program, but are being trained to promote other methods in cooperation with the CSP promoters.

Past successful experience with a community-based approach has allowed the CSP to expand with confidence and efficiency under this project. The program continues to operate smoothly and is making progress in cost recovery. It has been successful in extending its operations to previously underserved areas despite the increased costs involved. The number of users dropped significantly in the last half of 1990, but the program has recouped lost ground and is beginning to increase the number of users again. It is reasonable to expect that CSP user targets can be met by the end of the project period (32,150 CYPs for the first six months of 1994). This possibility will depend in considerable degree on factors beyond the CSP: namely, more IEC support, the degree of religious criticism, the growth of other channels of contraceptive supply and their and ASHONPLAFA's pricing policies.

3.2.2 Geographic Coverage

Project support is designed to enable the CSP both to continue its operations and to expand into rural, underserved locations through addition of 310 rural posts (distributors). With an increase of 250 distributors by the end of 1991 (from 1,478 in mid-1989 to 1,728 at the end of 1991), it is likely that the goal will be met by the end of the project. The majority have been added in rural areas.

CSP posts have been established in all 18 departments of the country and in the 291 *municipios*; only 26 *municipios* do not have at least one distribution point.

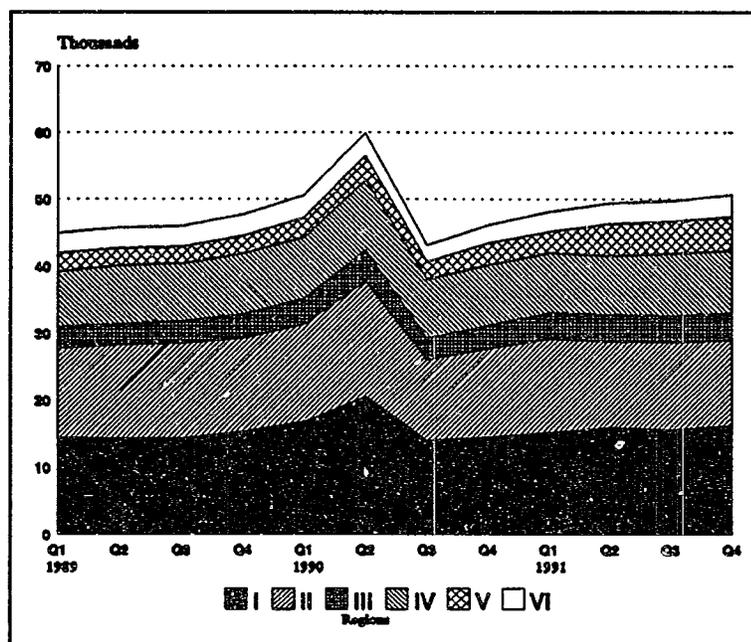
It is questionable to what degree greater efforts to provide coverage in some rural areas would be cost effective. About half of the *municipios* without coverage are in just two departments, Lempira and Gracias a Dios. Compared with a typical coverage of 1 post per 2,000 persons, coverage in Lempira is 1 per 8,000 and in Gracias a Dios, 1 for nearly 17,000. In Gracias a Dios, population density is very low, road access is difficult, and the cost of providing services would consequently be very high. In Lempira, problems of road access and personal security impede coverage. The project paper was not clear on how it expected a balance to be struck between the goal of coverage of rural areas of high cost/low productivity and the goals of cost efficiency and self-sufficiency.

3.2.3 Trends in CYPs, Quantities of Contraceptives Distributed, and Revenues Generated

CYPs

The CSP provided a total of nearly 50,000 CYPs during 1991, somewhat below the goal of 56,600 CYPs for that year, but nonetheless a substantial number (see Table 1). As seen in Figure 1 below, there was a substantial spurt of activity in early 1990, for reasons not entirely clear; it may have reflected to some degree the devaluation and the subsequent scarcity of commercial brands of contraceptives. Improvements in programming and provider incentives must also have played a role. The CSP attributes the sharp subsequent drop to the substantial increases in price of the contraceptives and an organized attack on the program by the Catholic Church. The CSP is now recovering lost ground and will likely meet its program targets of 32,150 CYPs for the first six months of 1994. Factors that will affect future performance will include the degree to which mass media IEC is effective and whether the growing MOH and social marketing programs supplant the CSP in some areas.

Figure 1
Couple Years of Protection, by Region
Community Service Program
1989-1991



Source: ASHONPLAFA

Quantities Distributed, by Brand

The program distributes a wide variety of oral and barrier contraceptives. Of the three low-dose pills and two progestin-only pills, the low-dose Lo Femenal appropriately provides the majority of contraceptive coverage. The presence of the progestin-only pill demonstrates awareness of the value of protecting lactation through appropriate contraception. (See Figure 2.) Barrier methods (see Figure 3) include two condoms (the standard CSP condom [Condomes] and the SMP Guardian) plus one vaginal method, Conceptrol. The proportion of SMP products (Guardian condoms and Perla oral contraceptives) is not large, but they were seen in the supplies of all distributors visited.

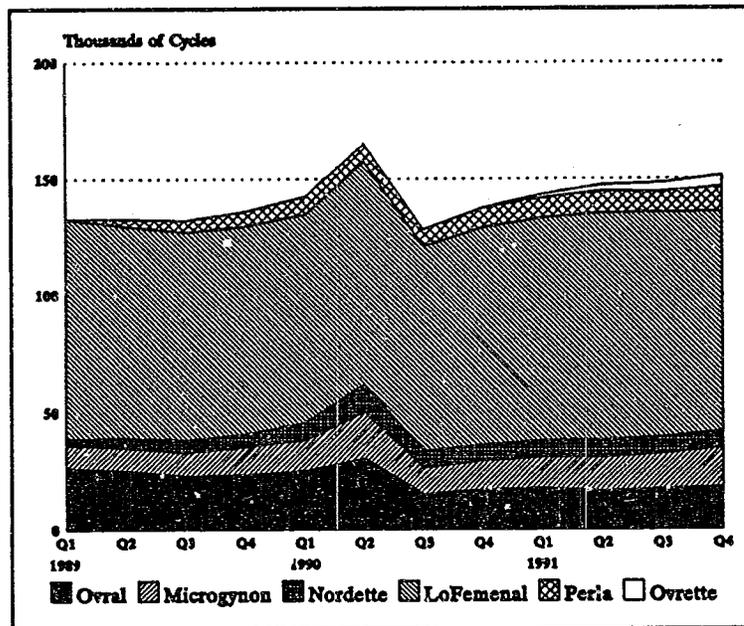
The major issue relates to the large variety of products. This may be attractive to some distributors and clients, but there are more products in the system than a predominantly rural program can handle with assured continuity of supply.

Cost Recovery

The CSP is performing well with respect to cost-recovery goals, presently recovering 67 percent of its direct costs (excluding contraceptives) as compared to the 50 percent target in the project paper. In 1991, L1,129,000 were generated as compared to L486,795 in 1990.

Figure 2

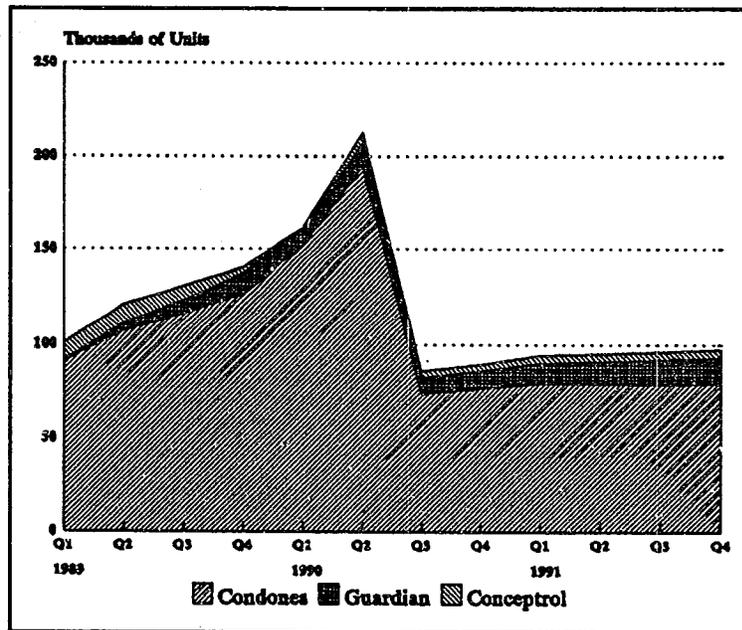
Oral Contraceptive Distribution
Community Service Program
1989-1991



Source: ASHONPLAFA

Figure 3

Barrier Contraceptive Distribution
Community Service Program
1989-1991



Source: ASHONPLAFA

3.2.4 Logistics and Data Collection

The logistics system works well. Generally, the materials were well stored at intermediate points and adequate supplies were available at distribution points for this widespread network of providers.

Data collection is complete, based on quarterly supervisory visits by promoters. The system could be simplified at the distributor level if the distributors were required to keep only their own financial records and a record of inventory of contraceptives, rather than the full details on users now required. Data could be processed more quickly if reports to the central office were based only on monthly distribution of contraceptives by the promoter, rather than the consolidated reports of distribution by distributors now required.

3.2.5 Incentive Program

An incentive program, initiated in December 1989, awards prizes to distributors and promoters in competition with others in their region and to supervisors in competition with other regional supervisors. The VSC promoters do not participate in the incentive program; this could create some disunity in the staff and does not provide the presumed stimulus to their performance that participation would entail. The program cost L36,820 in 1990. A May 1991 evaluation by ASHONPLAFA was not clear whether the incentives had any effect on productivity in 1990, given the number of other factors that may also have affected program performance at that time (see Section 3.2.3). At the time of this evaluation, the program had been temporarily suspended while ASHONPLAFA was reviewing ideas for reorganization.

The May 1991 evaluation found general satisfaction with the program and only a small amount of resentment at what some considered unfairness in the criteria used to judge performance. These attitudes were confirmed in field interviews during this evaluation. There was also concern expressed that providing incentives centrally was contributing to uncertainty about the program's future and some delays.

3.2.6 Cooperation with Other PVOs

Signs exist that good opportunities are being explored for the CSP to cooperate with the PVOs that are beginning to be active under the project (see Sections 4.1.3 and 4.2.5 for further discussion).

3.2.7 Program Administration and Central Support

The program is managed by a small staff of one director, four regional supervisors, one secretary, and one educator, in addition to the 30 promoters who work to support the 1,700 field-level distributors. This staff is supported by ASHONPLAFA central operations in areas such as training, IEC, evaluation, finance and logistics. This support appeared to be inadequate in several areas. More consistent mass media support and more audiovisual material and equipment would be helpful to promoters and distributors. Likewise, it was apparent that the work of many of the promoters was made less efficient by the limited support they had for their fieldwork in the areas of transportation and expenses. The project paper had suggested that a study be undertaken to investigate transportation options for CSP promoters but none had been initiated at the time of the evaluation.

3.3 Social Marketing Program

3.3.1 Overview

Contraceptive social marketing, which had its start in 1981 through an ASHONPLAFA contract with Triton Corporation and an in-house distributing agency, Drogueria NOBEL, has been reorganized under the current project to address the management and administrative problems that had characterized its early years. Under the current structure, the bulk of distribution has been placed in the hands of MANDOFER, one of the largest pharmaceutical distributors in the country. MANDOFER's efficiency and effectiveness have made possible the low-cost, widespread, and efficient distribution of SMP products. Products are also sold by one in-house distributor and through the CSP program. Together, these three efforts provide effective, nearly nationwide coverage, i.e., through 563 MANDOFER sales points, 74 sales points covered by the in-house distributor, and the 1,700 CPS voluntary distributors. The reorganization effort is being undertaken with technical assistance from the Social Marketing for Change (SOMARC) project.

The project has already expanded to cover 90 percent of the pharmacies in the country and is expected to be self-sufficient (excluding costs of contraceptives) by the end of the project. On the other hand, in 1991, it provided 22,604 CYPs, fewer than the goal of 29,423 for that year (see Table 1). Prospects are good, however, that, if advertising increases and additional distribution channels are developed, the program will reach its CYP targets for 1994 (19,299 CYPs for the first six months).

3.3.2 Program Coverage

The most significant accomplishment in the implementation of the marketing plan has been the contract with MANDOFER and the excellent results obtained in low-cost product distribution. Thanks to the work of MANDOFER, the project has already exceeded its goal of covering 90 percent of the country's pharmacies, having established distribution to 385 of the total of 421 pharmacies. In addition, it covers 178 of the 272 medicine stores (PVM) in the country for a total of 563 sales points, or 80 percent of the total number in the country. Approximately 54 percent of the sales are in the Tegucigalpa and San Pedro Sula metropolitan areas. In addition, the MANDOFER network includes all the departments in the country except Lempira, Islas de la Bahia, and Gracias a Dios.

Although the SMP products make up only 2 percent of MANDOFER business, the company has provided excellent support for the program. Its staff of 16 salesmen visit pharmacies as often as once a day in the larger cities and at least once a month in smaller towns. The warehouse is spacious and well organized. Orders are filled rapidly, within a day in one instance observed by the evaluation team, with delivery by prepaid commercial freight to a city 50 miles distant. Visits to a dozen pharmacies revealed SMP products in all locations and pharmacy personnel satisfied with the product and MANDOFER performance.

To supplement MANDOFER sales, SMP still utilizes one in-house salesperson, who makes direct sales to 74 pharmacies and PVMs in Tegucigalpa, San Pedro Sula, and scattered locations in the south of the country. CSP distributors also distribute two SMP products, the Perla oral contraceptive and the Guardian condom, which further extends the reach of the program.

Despite a few experimental efforts, MANDOFER does not deal comprehensively with informal marketing locations, such as supermarkets, gas stations, etc., nor should it be expected to. The client convenience and expansion of this coverage could be improved, however, with the addition of a non-pharmaceutical network of distribution. If the SMP wants to experiment further with this kind of distribution, another distributor should be contracted.

3.3.3 Program Sales

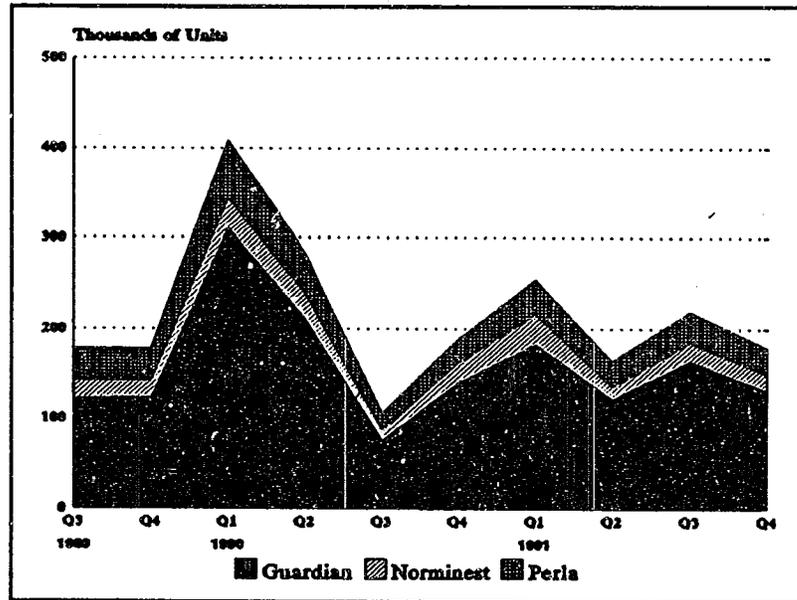
Currently, the program carries three brands of contraceptives — the Guardian condom, which accounts for the preponderance of the unit sales (if not the revenues) and two pills, Norminest and Perla. The Guardian sells for L2 for a package of 3 and the Perla pill for L3 per cycle. SMP has also been reviewing with several pharmaceutical firms the possibility of including a commercial brand of pills in the SMP program. Progress has not been at a rate consistent with project plans, however. The issue of whether carrying a commercial brand will require a competitive distributor is also being explored, but given the good performance to date of MANDOFER, there seems little justification for using a second commercial pharmaceutical distributor.

Distribution of all three products peaked during the first quarter of 1990 as a result of the devaluation, which temporarily drove other imported brands out of the market. Two smaller peaks occurred in 1991, but these were normal market fluctuations related to the way pharmacies handle their inventory. The 1991 trend was slightly upward as compared to 1989, but substantially lower than for 1990 (see Figure 4). The inability to maintain the 1990 level suggests that other brands came back into the market. In addition, prices of SMP products were abruptly raised, doubtless having a negative effect on units sold. Finally, it is likely that the low level of advertising and promotion had

a negative influence on the program (see below). The rise in prices, despite the negative effect on sales, seems to have had a positive effect on revenues. Although fewer clients were being served in 1991 than in 1990, the revenue peak for 1991 was L100,000 above that for 1990 (see Figure 5).

Figure 4

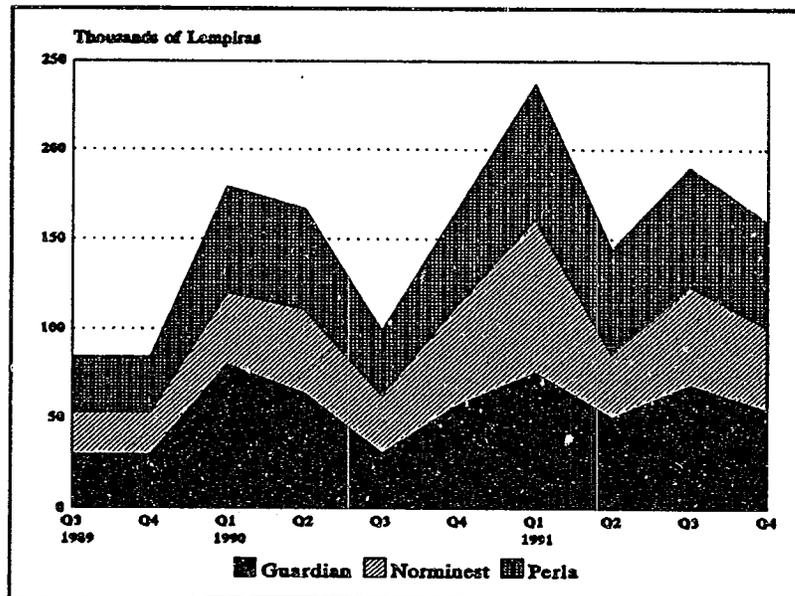
Global Distribution, Social Marketing Program
1989-1991



Source: ASHONPLAFA

Figure 5

Funds Generated, Social Marketing Program
1989-1991



Source: ASHONPLAFA

Sales of Guardian condoms and Perla pills through the CSP program have shown a gradual increase during the project life, except for a drop in Guardian condoms between 1990 and 1991 (see Table 12). Revenues are split between the two programs.

Table 12
Social Marketing Sales to CSP Program
(1,000 Units)

	1989	1990	1991	Total
Perla	37	37	44	118
Guardian	48	76	65	189

Social Marketing Sales to CSP Program
(L1,000s)

	1989	1990	1991	Total
Perla	22	35	36	93
Guardian	12	21	11	44

Source: ASHONPLAFA, Programa de Mercado Social.

It is difficult to project sales or CYPs into the future due to the uncertainty of such factors as the following: how far the program is willing to sacrifice its present low-cost delivery to extend services to less accessible populations through what may be more costly distribution channels; whether the advertising and promotion will be increased to make the program more effective; and what the impact will be of introducing new contraceptive products into the program. Even with these imponderables, however, if improvements in advertising are accomplished and if additional distribution channels are developed, the program can be expected to meet and even exceed its CYP targets and its self-sufficiency goals.

3.3.4 Implementation of the Marketing Strategy

A marketing plan, a year in preparation, was completed in August 1991. Although its contents have not yet been widely disseminated, its approach is sound, including the need to contract a commercial advertising firm, to undertake market research, and to develop a commercial product line.

The first step, contracting with the commercial distributor MANDOFER, has been a success. The research component has had a slow start, but focus group studies have been conducted and promotional materials pretested. A pharmacy audit has been contracted, but it is being implemented only in the two major cities. The baseline study for advertising is being developed for implementation by ASHONPLAFA, scheduled for April 1992.

On the other hand, although an advertising firm, a Costa Rican-based branch of the well-respected advertising firm Foote, Cone and Belding (FCB), has been contracted, it has not yet been as active as it might be. ASHONPLAFA's process for the approval of media materials has delayed matters,

and at the time of the evaluation, all media efforts awaited the baseline study. Advertising efforts to date have been limited. General discussion of family planning in a short question-and-answer format was aired on radio stations in all departments in late 1990 and early 1991. Product-specific advertising has included a series of special Guardian condom spots during broadcasts of soccer matches and the installation of very attractive billboards advertising Guardian, Perla, and Norminest. In addition, there was a promotional effort, consisting of placing 133 counter display cabinets in pharmacies or PVMs. As noted above, the overall weak performance in this area was most likely reflected in the somewhat laggard sales performance during 1991. It is likely that, if promotion and advertising were increased, coverage of the smaller cities would follow.

Effective training of pharmacists has taken place, but there is a continuing need for at least the level of effort already expended to complete the training needed. The SMP collaborated with the Evaluation Department in conducting 15 courses for 423 pharmacists and pharmacy salespersons representing 182 sales points, with the result that nearly half the pharmacies involved in the program have had one or more persons trained. Additional training is being planned for those not as yet covered. This should result in at least one trained person at each location. Pharmacy personnel interviewed confirmed the effectiveness of the training methodology and the utility of the training manual. No provision has been made as yet for materials that might serve as continuing education and initial training for those not yet in the formal course. Published materials or a newsletter could be useful in this area.

3.3.5 Data Collection and Reporting

MANDOFER reports sales monthly according to the two major regions served by its regular distribution system. It does not report sales regularly by individual outlets, city, or department. Thus, the current system does not allow for project tracking or analysis of expansion needs and advertising requirements the way a more detailed reporting of sales by location or city would.

3.3.6 ASHONPLAFA Program Management and Administration

The SMP is managed by an ASHONPLAFA department chief, a direct salesperson, an accountant, and a secretary. An additional staff person may return following her present assignment with the EFHS. SMP is supported by ASHONPLAFA's central office in areas such as finance, evaluation, and logistics.

As is the case with all central ASHONPLAFA departments (see Section 2.1.2), the SMP staff has too little authority over the program's operations. Many of the smallest decisions (e.g., going across town to visit MANDOFER or the advertising agency) need to be cleared by top ASHONPLAFA management. Funds generated by the project go into the central funds, and budgets and expenditures must be approved at the top. As the program grows larger and management becomes more complex, the department chief will need more authority in day-to-day operations and greater responsibility for financial aspects and ongoing training.

3.3.7 SOMARC Performance

Although the situation had improved as of the start of 1992, technical assistance provided through a July 1989 buy-in to the SOMARC project was found by both ASHONPLAFA and USAID to have fallen far short of the proposed level and to be of less than optimum utility. The buy-in called for approximately five person months of frequent and varied consultancies in 1990 and 1991.

USAID/Honduras and ASHONPLAFA, however, estimated that only about two person months of assistance were received in those years. The few SOMARC trip reports indicate that SOMARC provided practical assistance in the preproject stage, especially in identifying the distributor and establishing procedures for CSP involvement. The quality of the marketing plan indicates effective technical assistance. Both USAID/Honduras and ASHONPLAFA expressed satisfaction with the technical assistance received in January 1992. The shortfalls and future needs were in the areas of implementation of an effective advertising strategy, developing simple, inexpensive marketing research, the introduction of new products, development of new marketing channels with the informal sector or with industry, and developing a more effective management information system.

3.4 Coordination among Service Delivery Programs

The substantial expansion of CSP and SMP distribution posts, the growth of MOH family planning programs, and the expected greater involvement of other PVOs (see Chapter 4) suggest that it is time for a study of the most effective and efficient location of posts, modified supervisory schedules, and greater coordination among the CSP, the SMP, the MOH, and PVOs to ensure the most rational utilization of resources and gain maximum coverage of the population.

4. Private Voluntary Organizations

4. Private Voluntary Organizations

4.1 PLAN in Honduras

4.1.1 General

PLAN Internacional Tegucigalpa (PLAN), one of the three Foster Parents Plan International affiliates in Honduras, has a US\$355,700 grant from USAID that supports training of PLAN central staff and fieldworkers to promote family planning. Two major outputs were originally planned: 1) training for PLAN headquarters and fieldworkers, teachers, and health providers in the project area in reproductive health, breastfeeding, and contraception and 2) provision of temporary contraceptives by trained workers.

Overall, PLAN has given good institutional support to its project. Training of personnel was completed ahead of schedule, in March 1992. Shortly after implementation began, however, due to rumors that PLAN was promoting forced sterilizations, the organization decided it had to stop distributing contraceptives so as not to risk tarnishing its image. Its new goal is to refer 2,400 cases of women at high reproductive risk to ASHONPLAFA and MOH facilities. Systems have been developed for detecting high reproductive risk women and for referral, but implementation began only in July 1991, and very few women have been referred. Lack of transportation is seen as the most serious problem for clients willing to receive family planning services.

The initial goal was that at the end of the funding period, PLAN would have achieved a 20 percentage point increase in the use of family planning methods by women in union of fertile age in the rural communities in which it works. The decision not to permit contraceptive distribution in the project area will most likely have a negative effect on this proposed increase in prevalence.

4.1.2 Revision of Contraceptive Prevalence Goals

Even if contraceptives were being provided through this effort, the very ambitious goal of a 20 percentage point increase (from a CPR of 30 percent to a CPR of 50 percent) as a measurement of project outcome is clearly unrealistic. Indeed, in rural areas, a 5 percentage point increase per year is overly ambitious in the best of circumstances, and the PLAN project area is a particularly difficult rural area. The two rural zones, with four communities each (9,000 families and 14,000 women of fertile age), are characterized by considerable poverty and, according to studies carried out by PLAN, very low contraceptive use (a CPR of 7 to 24 percent). Added to this is the change in the project design, which has limited project activity to referrals.

4.1.3 Training

The training goals were accomplished well ahead of schedule. A total of 1,525 individuals have been trained, including 392 teachers, 337 midwives, 275 health guardians (community health aides), 164 volunteers, 147 community leaders, and smaller numbers of day care center personnel and others.

Early completion of the training activities offer PLAN fieldworkers a good opportunity to turn their efforts to IEC and referrals.

4.1.4 Cooperation with ASHONPLAFA: Training and IEC

Cooperation between PLAN and ASHONPLAFA has been good in the areas of both training and IEC. In the area of IEC, the excellent manuals on sex education and reproductive health developed by the ASHONPLAFA IEC Department were used extensively during the training described above (see Section 2.5.4). The training courses on reproductive health, contraception, and other family planning-related issues were designed to use ASHONPLAFA technical personnel as trainers of trainers and in some case as teachers.

4.1.5 Referral System

PLAN has developed two systems to support its referral program. The first, which went into effect July 1991 when referrals became the center of the program, are numbered coupons given by fieldworkers, promoters, and field personnel to clients who make known their intention to use services from ASHONPLAFA or the MOH. PLAN supervisors and regional coordinators check on a monthly basis to identify which staff referred clients and how many clients actually went for their referrals. According to these records, only 160 individuals were reported to have been referred for family planning services during the last six months of 1991.

PLAN has also developed a reproductive risk census form, with questions on age, parity, use of contraceptives, etc., which fieldworkers use to identify women at greater reproductive risk. The form is quite cumbersome, however, especially for inexperienced community workers, and its proper use would require close monitoring and good quality control. Although the reliability of both new systems needs to be further studied, these tools should help PLAN to improve project management, implementation, and monitoring.

Another issue relates to lodging and transportation costs for prospective VSC clients. PLAN has been exploring offering reimbursements for transportation and one-day lodging for rural women referrals, indicating its genuine interest in improving the project output. If the system under consideration is successful, it may be duplicated by other PVOs that are also facing this transportation barrier.

The referral of potential users to services in the regions and to CSP distributors requires permanent feedback and cooperation. The ASHONPLAFA reporting system does not now account for referrals from PLAN fieldworkers.

4.1.6 Project Staffing

A coordinator (physician) and an assistant project coordinator (physician) are in charge of managing the project. At the time of the evaluation, two positions were unfilled: a health specialist and a programmer. PLAN regional coordinators (eight) are responsible for project field operations. Each has about nine promoters, one community advisor, and one volunteer. These and the project coordinators are trained in family planning.

PLAN regional coordinators have demonstrated some reluctance to cooperate fully with the family planning project. This reluctance may reflect fear of facing opposition from priests or from other groups in the communities in which they work. The problem needs to be addressed, however, because project activities (e.g., referrals, training, and IEC) may not receive adequate attention.

4.1.7 Budget and Expenditures

As of the end of February 1992, 60 percent of the way through the PLAN grant, a total of US\$140,000, or about 39 percent of the \$355,700 grant, had been spent (see Table 13). The most serious underspending was for personnel, commodities, and training. Unfilled slots explain the first and the decision not to distribute contraceptives explains the second. At the time of the evaluation, sufficient funds existed for an 18-month extension of the project.

Table 13

Commitments, Expenditures, and Disbursements for Major Grant Agreements
(US Dollars)

Document	Grantee/Contractor	Commitments	Expenditures	Percent Disbursed	Remaining
PIL #1	PLAN in Honduras	355,700 ¹	140,000 ³	39%	215,700
DPE 9019 00	Population Council	744,300 ²	363,016 ⁴	49%	381,284

Sources: PLAN and Population Council

¹for two years

²for two years

³through February 29, 1992

⁴through December 31, 1991

4.2 The Population Council Buy-In

4.2.1 General

The purpose of this component is to increase rural Hondurans' knowledge of, access to, and use of family planning by involving local PVOs in promotional activities. The project paper specified that a buy-in would be made to a centrally funded project to coordinate subprojects with selected PVOs and provide technical assistance. A number of PVOs were identified for assistance (including PLAN — which was accorded its own grant agreement).

USAID had some difficulty in identifying an appropriate Cooperating Agency, but finally selected the Population Council's Latin America operations research project — Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean (INOPAL II) for a US\$744,300 buy-in. The selection was based in part on convenience, because the Population Council already had experience in Honduras. At the same time, the strength of the council lies in operations research whereas the thrust of this activity was to step up the ability of small PVOs to promote family planning service delivery. There has, therefore, been some tension between two somewhat different objectives — small PVO service delivery vs. research.

This difference in emphasis has affected the way that USAID and the Population Council have interpreted the goals of the buy-in. The buy-in stipulated that the council was expected to develop a total of six technical assistance and/or OR projects, at least three of which will be "with PVOs that are not currently providing services ... [and] an estimated three additional projects with large service delivery organizations." USAID has taken the position that the intent was that the council would act

as an umbrella agency to manage assistance to small service delivery PVOs, but not necessarily with the large service delivery organizations (of which there are only three in the country — IHSS, the MOH, and ASHONPLAFA). The Population Council perceives that USAID prefers it not to work with either the MOH or ASHONPLAFA (USAID already has projects with both). The council, however, could use its abilities in the area of operations research more profitably by developing subprojects with larger organizations that could support such activities than with small PVOs (see Section 4.2.3).

Despite some tension between these two somewhat different objectives, some progress has been made in this effort. Six subprojects have been developed with the following organizations: IHSS, AHLACMA, La Leche League, Save the Children, and CARE.

4.2.2 Project Development

The Population Council's efforts were directed primarily to continuing work with institutions with which it had ongoing successful projects, including IHSS, La Leche League, and AHLACMA. A new PVO, Save the Children, was added, since it was deemed large enough to have some impact and also to offer some opportunity for operations research.

Six projects are either under way or are being developed:

Extension of Previous Efforts

- Extension of previous work with the IHSS, a program to deal with high reproductive risk by emphasizing prevention through family planning, was implemented; the project developed training materials such as manuals, brochures, videos on reproductive risk, family planning, pregnancy care, care of newborns, lactation, etc., opened family planning clinics, and developed an MIS system.
- Extension of the previous work with AHLACMA and the IHSS in San Pedro of an educational/policy development effort to include a stronger emphasis on family planning within the training and promotional programs for breastfeeding.
- Technical assistance every two months for a total of 10 to 12 weeks in evaluation for a project of Georgetown University and La Leche League in San Pedro Sula, emphasizing postpartum lactation as a means of contraception.
- An umbrella project with AHLACMA to support various small PVOs with family planning/breastfeeding information and training (under development).

New Organizations

- A project with CARE to add family planning training and assistance with contraceptive logistics to ongoing CARE projects with MOH health posts (under development).
- Assistance to Save the Children to provide family planning information and promotion among the approximately 6,000 families in five marginal barrios of Tegucigalpa and two areas of rural Honduras.

It was not possible to develop a subproject with the Campesino (small farmer) Union, in which the project paper had expressed interest, due to the organizational structure and interests of that organization.

4.2.3 Potential for Meeting Cooperative Agreement Goals

At the time of the evaluation, the Population Council was well on its way to satisfying the requirement for involvement of small PVOs in family planning. If the AHLACMA project is approved, it should satisfy the requirement for the umbrella support for small PVOs called for in the project paper. If both the AHLACMA and CARE subprojects are approved, they, along with subprojects with La Leche and Save the Children, will exceed the target for three PVOs.

Efforts with these small PVOs, however, will likely do more in the area of public relations and promotion of family planning than for increasing service delivery. This may be justified in the present circumstances if it is not too costly. For example, although the small number of families involved in the Save the Children subproject is not significant in terms of national coverage targets, the project's involvement is a good move. This is a highly respected organization and its activities should provide a stimulus to other PVOs and to government ministries at the local and national level. In addition, the subproject may provide some good lessons to other programs; the thrust is primarily one of promotion of family planning and referral of clients to ASHONPLAFA or MOH distribution posts, and any referral and transportation mechanisms tested successfully here may be used in other programs. At the same time, little has been done to date in terms of actual promotion or referral. Rather, activities have included completion of a baseline study and training of 137 community volunteers, 69 breastfeeding counselors and 10 Save the Children staff. Likewise, AHLACMA as an institution has a good reputation for training and seems to be committed to including family planning in a positive way in training programs for PVO personnel.

Given that the Population Council's skills lie in operations research, the question remains how best the project should capitalize on this strength. Efforts to develop operations research with small PVOs are not likely to be very effective in this area. These small groups do not have the requisite skills nor can they apply their findings to a substantial population. For example, Save the Children's emphasis on a baseline study may have reflected an inappropriate overemphasis on research activities as opposed to service delivery. On the other hand, larger organizations including ASHONPLAFA could respond to the research requirements and would be able to apply the findings to a substantial population.

4.2.4 Provision of Technical Assistance and Workshops

The Population Council has had some difficulties in meeting its objectives to provide technical assistance in project development and design, but actions have been taken that should put it back on track. Technical assistance is available from two sources: the council's local office in Tegucigalpa and its regional office in Mexico. Interviews with Save the Children and AHLACMA indicated satisfaction with the technical assistance from the Mexico office but reflected difficulties with technical assistance received locally. With a new local director having been assigned to the Tegucigalpa office, most likely the technical assistance problem has been resolved.

The Population Council sponsored two high-level workshops in 1991, which were attended by 45 Honduran government and PVO leaders representing 15 to 20 PVOs. Evaluations were not available, but it is safe to assume that these were the typically high-quality workshops carried out under Population Council auspices.

4.2.5 Cooperation with ASHONPLAFA

As intended in the project paper, this subcomponent has provided some stimulus for various PVOs to work with ASHONPLAFA. These cooperative efforts, however, have consisted in the PVOs' seeking out ASHONPLAFA as a source of training and educational and informational services and referring clients to ASHONPLAFA service delivery points. Much more could be done with ASHONPLAFA if the Population Council were directed to work with it on some of the operations research/rapid assessment studies that are sorely needed and called for in various sections of this evaluation.

4.2.6 Financial Performance

The US\$744,300 buy-in to the Population Council represented about two-thirds of the total of US\$1,100,064 available for this activity under the project paper. The buy-in was anticipated to cover two full years of operation, from the end of June 1990 through the end of June 1992. It was estimated that expenditures had reached US\$363,000 as of December 31, 1991, and, depending on new subproject approvals, the contract may well have depleted its present funds by mid-1992.

At that time, it will be necessary to renew the project implementation order/technical services (PIO/T). Financial resources are still available to permit the financing of the proposed projects and also to change the direction of the project as suggested above. Depending on the performance during the first six months of 1992, a grant extension and refunding may be required in mid-1992.

5. Lessons Learned

5. Lessons Learned

A number of lessons have been learned in the course of implementing this project to date. These are taken into account in the major recommendations for the project's future that are presented in Chapter 6.

1. When there are conflicting objectives in a project (e.g., extending geographic coverage vs. cost containment, reaching the rural poor vs. self-sufficiency), clear policy determinations must be reached as to which of the objectives is to receive the greater emphasis under what circumstances.
2. The goal of reaching the rural population tends to be incompatible with that of increasing contraceptive prevalence in the most cost-effective way. Rural populations are often dispersed and not as ready for family planning as urban populations, and thus excessive pursuit of increasing prevalence in rural areas may lead to few acceptors at great effort. Intensified efforts in the urban areas might serve greater numbers of persons at lower cost. Both emphases can coexist but confusion will exist if all parties are not in agreement in managing the trade-off.
3. Cost savings through failure to implement essential program components is false economy. In Honduras, for example, the emphasis on cost saving and self-sufficiency has been such that these seem very likely to have been contributing factors to delays in program implementation. The time lags in purchasing necessary equipment, contracting needed IEC and research services, sending key personnel for training, acquiring essential technical assistance, and promoting and advertising the SMP have all indeed saved money, but at a cost to program progress.
4. Expectations of what can be quickly accomplished in institutional change must be realistic; clear statements of objectives are required and an agreed upon time frame for significant changes. The maturing process may well be a long one, requiring considerable understanding, patience, and nurturing if it is to be successful. Supportive technical assistance must be readily available.
5. Even though an institution may begin its life with substantial external support, it must soon begin the process of developing a local constituency and local organizational support structure. ASHONPLAFA is still in the stage of substantial dependency on one major external donor and is forced to seek self-sufficiency largely through client charges. This may be justified by the serious nature of the problem (rapid population growth) for a short period, but it is not healthy for the long term.
6. Organizations should not attempt to undertake activities for which they are not well suited. For example, the Population Council, a research organization, has been asked to service small PVOs, a fit that does not make the best use of the strengths of either the Population Council or the small PVOs.

**6. Prospects for Meeting Fertility and Prevalence Targets,
Major Conclusions, and Recommendations**

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6. Prospects for Meeting Fertility and Prevalence Targets, Major Conclusions, and Recommendations

6.1 Prospects for Meeting Fertility and Prevalence Targets

Preliminary information from the 1991 EFHS is presently being analyzed by the MOH, ASHONPLAFA, and FHI. The early results do not contain information from San Pedro Sula, the second largest city in the country, or from three other of the nine MOH zones being studied. Neither is any information available as yet on where clients are getting their services.

The project has come close to reaching its goals for increasing CYPs, with a good potential for reaching the user targets of the project paper. There have also been substantial increases in the continued expansion toward national coverage, with ASHONPLAFA family planning services now available in over 2,200 locations in all 18 departments. Comment on how these developments will affect reaching fertility reduction targets, however, must await further information from the 1991 EFHS on probable changes in the method mix, the profile of users, and the institutions from which they get services. Likewise, any conclusion about contraceptive prevalence based on this incomplete sample would be quite speculative.

Contraceptive prevalence surveys are excellent policy development tools, and the 1991 EFHS will offer an opportunity for exploring a number of policy issues. For example, there is the relationship between various health factors and family formation patterns; this was addressed effectively in further analysis of 1987 data in the doctoral thesis of one of the chief EFHS researchers from FHI. From a policy formation perspective, some questions could be raised about the way the 1987 report identifies unmet need for contraceptives. As mentioned above in Section 1.1.1, by focusing on women in union, it left out the 40 percent of women not in union (but many said to be sexually active and many who are high reproductive risk adolescents). Its estimates on unmet need among these women also discount the 7.4 percent using traditional methods, the 17.9 percent depending on postpartum amenorrhea, and the 15.5 percent pregnant (who at least should be recognized as needing information).

The inclusion of women using traditional methods in the CPR has policy implications with relation to the targets included in this project, which calls for measurement of contraceptive use in terms of modern methods of contraception. This is appropriate, as use of modern methods provides a more accurate indication of effective services provided. On the other hand, if the project goal is to be measured against the current method of counting CPR, a fairly high 16.4 percentage point increase in the CPR over a seven-year period is implied (from 33.6 percent modern method CPR in 1987 to 50 percent in 1994).

This discussion is not to cast a shadow on the excellent work done and helpful report of the 1987 survey, but merely to suggest ways in which the next report might be even more helpful for policy formation purposes.

6.2 Major Conclusions

6.2.1 Revision of Project Goals

Project Design

The project paper clearly specifies its targets and the logframe adequately summarizes them in measurable terms. The implementation plan covers the key actions that must be taken and presents a reasonable time frame. The contracts and agreements stemming from the project paper are consistent with it and make the necessary references to interrelated, coordinated, and mutually supportive actions of the various parties. The management, training, IEC, research, and service delivery actions described in the project paper can reasonably be expected to achieve the desired results in increases of CYPs.

On the other hand, the IEC targets could have been expressed in quantified terms to be verified by the EFHS. The operations research targets could have been more specific, demonstrating their support of ASHONPLAFA's organizational or program needs. Detailed training plans were not included in the paper. No annual update was called for that included the interrelated actions of ASHONPLAFA, PLAN, and the Population Council to achieve project objectives. Likewise, the project paper did not clarify the relationship of actions of the MOH, the IHSS, private physicians, and the CSP, or how PVO private sector actions would relate to, complement, or support the public sector and the commercial private sector. This is not to suggest losing the autonomy that this project provides for the private sector or to suggest a formal coordination that could easily be restrictive.

Overall Project Accomplishments: Impact

ASHONPLAFA was within 15 percent of its mid-project CYP targets, had increased its revenues by 54 percent, and the SMP and CSP had surpassed their respective (100 percent and 50 percent) self-sufficiency goals. The EFHS is almost complete and family planning data reports are being published regularly.

Without the results of the EFHS, it is impossible to do more than conjecture about the impact of this project. Observations during the evaluation, however, together with reports of ASHONPLAFA service delivery, suggest that family planning is more widely accepted than in the past and more widely available throughout the country from all programs. The increase in numbers of IUD and VSC acceptors in areas where these methods were not available before also suggests that a wider choice of methods is available. Partial preliminary results of the EFHS suggest that contraceptive prevalence is increasing in some regions of the country, with use of IUDs and VSC making up a larger percentage of the contraceptive mix.

Project Future

At the time of the evaluation, the project was well on its way toward meeting its objectives, and there appeared to be no problems that would preclude project success. The slow rate of expenditures of project funds suggests that there will be funds sufficient for up to another 18 months of activities at the time of the scheduled end of the project. The good project performance, together with evidence of good will on the part of ASHONPLAFA, suggests that there is every reason to extend the project, rather than deobligating funds.

6.2.2 ASHONPLAFA Central Operations

Administration

ASHONPLAFA has completed establishment of six regional offices, and volunteers have been recruited and a board of volunteers elected for each region. A Technical Council was created to provide technical assistance to the executive director.

Pressures from the Catholic Church, the circumscribed and unclear role of volunteers and regional board members, and the lack of participation of regional volunteers in the National Assembly, together with their lack of information and authority, are leading to the resignation or inactivity of many volunteers and regional board members.

Decentralization remains to be completed. The ASHONPLAFA organization is horizontal and highly centralized with too many people reporting directly to the executive director and his assistant and too little authority at the department head and regional levels, particularly over financial matters. Accounting, budgeting, and program reports are not provided regularly at these levels, and there is no clear definition of who is authorized to receive them.

The strategic plan needs more work in the definition of goals, objectives, strategies and policies, long-term planning, and project analysis to develop challenging and realistic goals.

Finances and Cost Recovery

Locally generated revenue has increased well during the project, primarily due to increases in prices for services. During 1991, these revenues represented 24 percent of the ASHONPLAFA budget. The SMP and the CSP have made good progress toward their self-sufficiency goals, although, as anticipated, ASHONPLAFA itself will not become self-sufficient. If the project is extended by up to 18 months as proposed in this evaluation, the self-sufficiency goals may be exceeded.

Budget implementation has been slower than planned, due to devaluation of the lempira, which made additional lempiras available for project implementation; bureaucratic bottlenecks in budget approval; policy changes related to personnel; an apparent overemphasis in some cases on cost savings and self-sufficiency; and slow project performance in some areas. Funds remaining at the end of the scheduled implementation period should be sufficient for up to an 18-month no-cost extension.

The current budgeting process does not clearly delineate between expenditures that are supported by locally generated revenues and those supported by donors.

Delays sometimes occur in disbursing USAID/Honduras funds, due primarily to requirements for clearing advance payments.

Most ASHONPLAFA operating units do not have sufficient control over their revenues. If regional and program units were able to use some of the generated funds to enhance services and reward staff, this might lead to increased services and better efficiency.

A number of additional opportunities exist to increase ASHONPLAFA's revenue base. These include approaching large private enterprises to support family planning services for their employees

and seeking charitable donations. The Government of Honduras might also help pay for costs involved in serving the poor and indigent.

Management Information System

ASHONPLAFA is developing an effective accounting system, which when completed, will include a cost accounting system. Computer resources are efficiently used. With these developments, plus the addition of personnel, ASHONPLAFA has improved its ability to track and account for project finances. Tools are not in place to develop accurate cost accounting; neither is sufficient use being made of present financial reports in tracking program progress. The FHI cost study and the CDC-assisted patient flow analysis will provide essential information for better cost analysis.

A LAN has been installed and software provided although it is not clear whether the LAN is adequate to serve the current and future computer needs of ASHONPLAFA.

Training has been insufficient in a number of areas. The chief of the data analysis section has not been adequately trained in the LAN; personnel using computers are not properly trained in software programs; and management is not fully aware of the value and use of new reports available from the SIES.

ASHONPLAFA has excellent family planning service statistics, although they are not fully computerized and are not processed as rapidly as they might be. Neither the CSP nor the SMP reporting systems provides information that is entirely compatible with ASHONPLAFA's information needs.

Personnel Management

Staff are motivated and capable. Personnel management runs smoothly, turnover is low, and legal problems have been avoided.

ASHONPLAFA's highly centralized personnel system, with hiring and firing limited to the executive director, allows for little delegation of authority to department heads or to the regions.

Competency and performance evaluations are not used for promotions or salary increases. No bonuses are provided for regional directors.

Some good training has been carried out. The absence of a separate training department, however, and the consequent assignment of training responsibilities to the Evaluation and IEC Departments, diverts these units from their prime duties and diminishes the ability of the association to coordinate overall training. ASHONPLAFA is beginning to absorb some of the costs of personnel, but there has been no formal agreement between ASHONPLAFA and USAID/Honduras with regard to details of its picking up personnel costs in exchange for USAID's assuming some operational costs.

Information, Education and Communication

A communication strategy has been developed and a mass media radio campaign launched. The strategy, however, has not been described in terms of specific quantifiable goals and has not been fully implemented. Considerable work has been done at the level of interpersonal educational

activities in the community, including development of printed materials and the giving of talks and courses for leaders on reproductive health and family planning.

The use of radio campaigns increased during the project period but has been sporadic in 1992 due to contracting problems between ASHONPLAFA and the publicity agencies that were expected to carry out different parts of the campaigns. This may be because ASHONPLAFA has little in-house expertise in the areas of mass media and publicity agencies. Additional technical assistance might help in this area.

Use of TV has been limited.

ASHONPLAFA's communication strategy remains too conservative and does not take advantage of new openings resulting from changes in public opinion about contraceptive use produced by the economic situation, AIDS, and efforts by the MOH to provide contraceptive services with Health Sector II assistance. If these positive changes were taken into account, ASHONPLAFA could take a more aggressive stance in publicizing family planning and work toward development of a more positive population policy. Additional technical assistance might help in this area.

Support from the IEC Department to the service programs has been helpful in enhancing their ability to promote family planning, although this has not been developed to its full capacity.

Support to the PVOs has also been helpful, with some useful training materials provided, but more could be done in this area.

6.2.3 Service Delivery Programs

Medical and Clinical Services Program

ASHONPLAFA's MCP offers high-quality contraceptive services, which are both safe and effective. The very high use of laparoscopic sterilizations is questionable in the Honduran environment, in which low utilization of costly equipment is not cost efficient. The current monitoring system for VSCs may not detect a number of complications.

The MCP is responsible for approximately two-thirds of the CYPs provided by ASHONPLAFA, mostly reflecting VSCs provided. This does not imply that ASHONPLAFA should focus only on VSC. The temporary contraceptives distributed by this and other ASHONPLAFA programs play an important role because they address the contraceptive needs of younger women. Providing this choice also ensures that the overall program is less vulnerable to attacks by family planning critics. At the same time, efforts are required to remove restrictive age and parity regulations for young women seeking sterilization.

The growing problem of adolescent fertility also requires more attention.

Cervical cancer screening, a service that enhances ASHONPLAFA's institutional image, contributes approximately \$40,000 per year to ASHONPLAFA's locally generated income. An excessive number of Pap smears are sometimes requested from low-risk patients or those presenting with benign conditions.

Accessibility has improved since the new regional centers opened. ASHONPLAFA's medical/clinical facilities are underutilized, however, particularly outside the two main cities, increasing costs. Access to VSC services may be difficult for poor rural populations; fees for services may be beyond their financial reach, transportation costs are high, and hours are inconvenient. Little has been done by way of exploring opportunities to make hours more client-oriented or to use available time to develop new income-generating activities.

The goals for both female and male sterilization are likely to be met. A goal of 500 male sterilizations is modest for Honduras. Lack of mass media promotion, use of ob/gyns to perform the procedure, and women-only promoters all contribute to this low level of performance.

The contracting of private clinics has proven to be a cost-effective means of expanding VSC services. If new clinics were to be added, the need to identify satisfactory facilities and qualified, interested physicians, as well as to meet additional monetary requirements, would be limiting factors that would have to be considered. Some expansion of this modality would likely be beneficial to the program, however.

Community Services Program

The CSP program continues to operate efficiently and is making progress in cost recovery. It has been successful in extending its operations to previously underserved areas despite the increased cost involved. Although numbers of users dropped significantly in the last half of 1990, they had begun to increase at the time of the evaluation. It is reasonable to expect that CSP program user targets can be met by the end of the project period.

The appropriate balance between further expansion into rural areas and cost saving and efficiency has not been thoroughly explored by ASHONPLAFA and USAID/Honduras.

Reporting procedures are too complex and time consuming (they are not yet computerized) and too many contraceptive brands are currently distributed through the CSP system.

Support in the areas of transportation and expenses is insufficient, both for field staff and for clients referred to the clinics.

The incentives program appears promising, but it is currently too centralized and thus cannot respond well to specific local situations. Sufficient funds exist from local cost recovery to cover costs of incentives. VSC promoters are not included.

Social Marketing Program

The SMP is cost effective and is nearing self-sufficiency. This is largely due to the efficiency and low cost of the MANDOFER distribution. MANDOFER distribution, together with in-house supplementary direct sales and CSP distribution, provides effective, nearly nationwide coverage. The marketing strategy that was completed in 1991 is sound, comprising all the necessary elements to increase sales.

MANDOFER is unlikely to explore developing sales in informal marketing locations, although coverage could be expanded with the addition of such a non-pharmaceutical network of distribution.

The SMP staff have too little authority over the program's operations and budget. This will become of greater concern as the program continues to expand and management grows more complex. The program would also benefit from the addition of a highly qualified person who focuses on the advertising and promotional aspects of the program. The department will continue to need the logistics, research, training and accounting support of other departments of ASHONPLAFA.

For a number of reasons, including lagging advertising, sales fell in 1990. If improvements in advertising and promotion are accomplished, coverage might increase in smaller towns as well as the larger urban centers. If improvements in advertising are accomplished and if additional distribution channels are developed, the program can be expected to meet and even exceed its CYP targets and its self-sufficiency goals.

The program is behind schedule in its efforts to introduce a commercial brand of pills. A competitive distributor is unlikely to be needed, if another brand is added.

Technical assistance from SOMARC has been inadequate to meet the requirements of the SMP, especially in the areas of advertising and promotion, in market research, and in the development of new product lines and new channels of distribution.

Effective training of pharmacists has been provided and there are plans to continue, requiring at least as much effort as has been produced to date.

Coordination among Service Delivery Programs

The substantial expansion of CSP and SMP distribution posts, the growth of MOH family planning programs, and the expected greater involvement of other PVOs suggest that it is time for better coordination between these programs, perhaps by undertaking a study of the most effective and efficient location of posts and supervisory schedules.

6.2.4 Private Voluntary Organizations

PLAN in Honduras

PLAN has completed 100 percent of the training activities described in the project paper and is now implementing community work. The PLAN management decision not to permit contraceptive distribution in the project area, however, means that this component will not meet its goals for increases in prevalence. An alternative approach, referral of high-risk clients, has not been implemented to any appreciable degree. Implementation has been delayed and budget execution has lagged; funds will therefore be available for an 18-month extension.

PLAN's new reproductive risk form and a referral system may be difficult for inexperienced community workers to implement and may lead to some misreporting. This implies a need for close monitoring for close quality control.

PLAN's decision to offer reimbursements for transportation and one-day lodging for rural women referred for a VSC is worth documenting, for it might lead the way to finding a practical solution to overcoming the most serious barrier rural women have to obtaining a VSC in Honduras.

Coordination with ASHONPLAFA has been good.

The Population Council

The Population Council is moving toward increasing participation of PVOs in family planning through implementing the requisite subprojects and conducting two high-level workshops involving international participation and representatives from 15 to 20 Honduran PVOs.

The Population Council has had some difficulty in meeting its technical assistance objectives but actions are being taken to put it back on track.

Focusing mainly on small PVOs in this component is questionable. These efforts may lead to useful promotional efforts but are unlikely to increase service delivery in any substantial way. They are justifiable only if not too costly. Likewise, efforts to develop operations research with small PVOs are not likely to be too effective; this type of expertise could be more effective if focused on larger institutions, like ASHONPLAFA, that can respond to research requirements and apply findings to a substantial audience. Expanding the scope to include operations research activities with larger institutions would improve the cost-benefit ratio.

Financial resources are still available to permit the financing of the proposed projects and shifting of project priorities. Depending on performance during the first six months of 1992, a grant extension and refunding may be required in mid-1992.

6.3 Recommendations¹⁰

6.3.1 Revision of Project Goals

1. **USAID/Honduras, together with ASHONPLAFA, PLAN, and the Population Council, should update the logframe and implementation plan of the project based on progress to date, the findings of this evaluation, and the 1991 EFHS, which would give the correct level of contraceptive use and source, allowing revision if necessary of project CPR goals. The MOH and IHSS should be consulted and a comprehensive strategy should indicate where and how increases in coverage are to be achieved. Contraceptive prevalence targets should be updated in light of the CPR findings in the 1991 EFHS and expressed in terms of modern methods.**
2. **Training plans should be updated and IEC targets clarified. ASHONPLAFA and USAID/Honduras should review technical assistance requirements as suggested in this evaluation. It may be necessary to ensure that the position of Population Liaison Officer is filled to carry out this task.**
3. **USAID/Honduras, with ASHONPLAFA, should prepare a no-cost, up to 18-month extension for the project. The financial plan should be redesigned to take into account evaluation findings and a detailed review by USAID and ASHONPLAFA should take place on the reality of present commitments, accruals, and current expenditure rates. This should occur by July 1992 to allow time for developing ASHONPLAFA's next budget. The major change in the implementation plan would be to set a time, preferably before July 1992, for an updating of strategy and development of an action plan (see also recommendation 10).**

¹⁰Recommendations in boldface type are the principal recommendations in this report.

Revision of Logframe Indicators

4. Most of the logframe indicators can remain as they are. A few changes are suggested below in keeping with the recommendations of the evaluation. References (e.g., A.2) are to the section of the logframe under discussion — see Appendix D.

Narative Summary

Purpose - Should be clarified

1992 level of modern contraceptives (X%) will increase to X% by the end of 1995.

Clarify: A.2

Add: B

Add: C.3: MCP improved in quality and strategy for availability of resources

Objectively Verifiable Indicators

Should also take into consideration prevalence for all women of fertile age to avoid undercount of sexually active group.

8 PVOs will be difficult to reach without implementation of Population Council AHLACMA subcontract.

5. One or more additional distributors for non-pharmacy channels contracted.

Association for Voluntary Surgical Contraception (AVSC) technical assistance will assist in improving quality and strategy.

D. IEC Changes: After EFHS and technical assistance from the PCS project, make more specific and quantifiable objectives. Strategy for adolescents may lag, because of slow progress.

E. Training Changes: PP should have a Training Plan prepared. Should add computer operation, MIS systems use, overseas and other ongoing staff training to this logframe and the PP training plan since A.I.D. supports most of this budget.

G. Add: Self-sufficiency. Clarify objective and relate to trade-off in reaching rural poor in A.1. above.

H. Add: Regionalization: Create time-phased plan with specific actions to delegate more authority and train Regional Managers. Identify nature and timing of technical assistance requirements.

The budget should also indicate funds set aside for PVO programs.

6.3.2 ASHONPLAFA Central Operations

Administration

5. ASHONPLAFA should define and develop a clear description of the role of regional board members and volunteers. It should actively recruit them and provide them with effective tools and mechanisms to fulfill their goals, adequate information, training, and authority. Board and assembly meetings should be made more relevant through provision of interesting presentations, guest speakers, and up-to-date materials.

6. **ASHONPLAFA should consider a reorganization that narrows the span of central supervision by creating three assistant director positions for administration and finance, program, and regional affairs. This reorganization should promote the delegation of authority to both department heads and regional personnel. The plan should include increased supervision of regional activities, a clarification of the level of authority, the role, and the functions of both the board and the assembly, and evaluations in relation to awarding incentives (see recommendation 22).**
7. **Technical assistance should be sought to strengthen ASHONPLAFA's administrative structure, with special consideration given to its ability to manage project activities.**
8. **Regional directors should receive timely and adequate statistical, programmatic, and financial (accounting) information, with a clear definition of who can have access to it. A revision of MIS should help in this process (see Section 2.3).**
9. **ASHONPLAFA should continue its work on the strategic plan with special attention to definition of goals, objectives, strategies and policies, long-term (five or ten years) planning, and project analysis.**

Finances and Cost Recovery

10. **If the project is extended, ASHONPLAFA and USAID/Honduras should work together to develop a new four-year budget that reflects priorities of both parties and makes clear what each will contribute in funding the budget. They should also review ways to resolve bureaucratic bottlenecks in budgeting and finance and to identify the potential for accelerating key program area performance (see also recommendations 1 through 4).**
11. **USAID/Honduras should discuss the goal of self-sufficiency clearly with ASHONPLAFA, pointing out, for example, that achieving savings by keeping down expenses for essential program activities is counterproductive. ASHONPLAFA should be encouraged by USAID to utilize the generated funds to improve infrastructure, such as vehicles and any necessary capital improvements, so that in the future it will be in a better position to seek other national and international donors.**
12. **USAID/Honduras and ASHONPLAFA should adopt a level of advances adequate to eliminate cash-flow problems for ASHONPLAFA, to be replenished each time a liquidation is processed.**
13. **Consideration should be given to allowing the regions or program elements to retain some of the funds generated locally to cover program costs and to offer incentives for program personnel.**
14. **ASHONPLAFA should continue its revenue-raising efforts by increasing prices for services on an annual or semiannual basis, expanding demand (e.g., through promotion and advertising), exploring private enterprise contracting of services, and increasing local charity donations and support from the government.**
15. **USAID/Honduras should provide technical assistance and local cost support for expanding fund raising efforts and should urge ASHONPLAFA to develop operations research that**

would result in models for these services. This could assist ASHONPLAFA to secure additional support from international donors at the end of the project.

Management Information System, Statistical Data, and Information

16. ASHONPLAFA and USAID/Honduras should prepare a technical assistance scope of work to review the LAN to determine whether it needs modification to meet present and future needs.
17. The chief of the data analysis section should receive additional training in LAN systems through an A.I.D./W course. Training in-country in software used should be provided for all personnel operating computers. Training should be provided to management on the value and use of the new reports that can be generated by the SIES.
18. ASHONPLAFA should install a cost accounting system for each type of service as soon as it is practical. Reports are needed that indicate the direct and indirect cost load on each service aspect.
19. ASHONPLAFA should reduce the reporting requirements of the CSP to simple promoter reporting of monthly sales to distributors. Promoter/supervisor reporting should be computerized. MANDOFER should keep sales records at least by region, if not by city or sales point.

Personnel Management

20. USAID/Honduras should provide technical assistance to the Personnel Department in order to develop a structure that would allow the active participation of department heads and regional directors in personnel management.
21. In order to facilitate the delegation procedure, ASHONPLAFA should develop clear policies on delegation of authority at the executive director level on hiring, firing, and remuneration.
22. Competency and performance evaluations should be used by ASHONPLAFA for promotions and salary increases and a system of rewards and recognition incentives should be developed, including the incentives called for in the project for regional directors.
23. ASHONPLAFA should create a separate training department that would provide better coordination of training activities and a centralized statistical system. The central training department should consult regularly with all departments, including personnel, on training needs.
24. USAID/Honduras and ASHONPLAFA should reach a formal agreement on ASHONPLAFA'S absorption of personnel costs in exchange for USAID'S assuming some operational costs, and on the fringe benefits issues.

Information, Education and Communication

25. The communication strategy should be implemented as approved. The use of radio should be reactivated and intensified. Emphasis should be given to rural areas and to male and female VSC and the IUD.
26. ASHONPLAFA and USAID/Honduras should arrange a buy-in for technical assistance from the PCS project and from the Regional Audio Visual Center (CREA) for implementing the communications strategy and for developing skills needed to work with TV and publicity agencies.
27. The ASHONPLAFA communication strategy should take into account positive changes in public opinion about family planning, allowing ASHONPLAFA to take a more aggressive stance in publicizing family planning and working toward development of a more positive population policy.
28. The strategy needs to be operationalized in terms of simple and achievable goals, which would also be used for monitoring and evaluation. Progress could be assessed through various studies, which could be developed as a package for bids from publicity agencies.
29. A buy-in for RAPID model presentations¹¹ to leaders should be considered. Politicians and private sector leaders should be targeted for public relations and population policy development and increased support should be sought from professional groups, women's leaders, and the military.
30. ASHONPLAFA should provide continued support and technical assistance to Honduran PVOs in development and supply of greater amounts of printed materials.

6.3.3 Service Delivery Programs

Medical and Clinical Services Program

31. ASHONPLAFA/USAID should buy into AVSC for technical assistance to improve the monitoring of quality and safety issues in VSC services, establish a complications reporting form to be processed by the MIS, improve counseling, and develop strategic policy for VSC and for training of physicians in Honduras and abroad. This technical assistance or assistance from IPPF should also review the issues of age and parity for sterilization and frequency of PAP smears.
32. The MCP Department should deemphasize tubal ligations with the laparoscope. Laparoscopes should be restricted to use in centers with a minimum average of 8-10 procedures per day.

¹¹The RAPID presentation developed by the Resources for Awareness of Population Impacts on Development project is an interactive computer simulation model that uses colorful graphics generated on a large screen to show population and development relationships.

33. **ASHONPLAFA should promote actions that would lead to reconsideration by the MOH and the Honduran Medical Association of resolution No. 141-84, which discriminates against women younger than 24, even with three or more children, who wish to be sterilized.**
34. **ASHONPLAFA should request technical assistance for development of a strategy for adolescents. This should include actions through IEC and the SMP, the CSP, and the MCP. ASHONPLAFA should strive to have the issue of adolescent fertility included in the country's family planning agenda.**
35. **ASHONPLAFA and USAID/Honduras should explore innovative service delivery patterns and transportation assistance to increase client convenience, expand VSC levels, and make full use of clinic facilities. Solutions might include offering VSC services in Tegucigalpa and San Pedro Sula during one or two afternoons or evenings a week and reimbursing clients for one day's lodging, meals, and transportation costs.**
36. **Consideration should also be given to increasing clinic incomes through leasing the operating rooms to doctors for ambulatory surgical procedures, e.g., ophthalmic, gynecologic, urologic, hernia repair, plastic surgery, etc. Routine laboratory examinations might also represent a source of income if the costs and fees are shared with the laboratory owner, etc.**
37. **Consideration should be given to modifying a number of current practices in provision of vasectomies, e.g., hiring and training urologists rather than ob/gyns to provide the procedure, using men rather than women to promote them, having a physician trained in vasectomy surgery available to each clinic, and launching a well-thought-out publicity campaign with full involvement of mass media.**
38. **Before new construction of clinics is undertaken, ASHONPLAFA should consider additional contracting of private clinics to provide subsidized VSC services. ASHONPLAFA, using technical assistance from the Population Council, should undertake an operations research study that documents strengths and weaknesses of the private clinic model and feasibility of extension to other places in Honduras.**

Community Services Program

39. **ASHONPLAFA should continue its modest expansion of the CSP program. This expansion should be based in part on the study recommended below (see heading below, "Coordination among Service Delivery Programs"). It should also include review with USAID/Honduras of the degree to which expansion to underserved areas should be balanced with cost and self-sufficiency concerns.**
40. **Fewer brands of contraceptives should be distributed through the CSP.**
41. **Transportation and field support should be improved for promoters, and steps should be taken to provide transportation for clients referred to the clinics.**
42. **Consideration should be given to funding incentives with lempiras generated by local sales, to awarding individual improvement in performance rather than choosing among peers for awards, and to managing the program on a regional level thus allowing judges to take into**

account regional differences that might account for varying levels of performance from one area to another. The VSC promoters should be included in the incentives program.

Social Marketing Program

43. ASHONPLAFA should continue the Social Marketing Program, placing major emphasis on the MANDOFER distribution network, maintaining the NOBEL distribution, and increasing SMP sales through CSP. The SMP department should increase its efforts to develop other non-pharmaceutical channels of distribution.
44. ASHONPLAFA should seek ways to delegate increased authority to the SMP department without losing central policy guidance and the support of other departments. It should recruit an additional highly qualified staff person, experienced in the supervision of commercial advertising agencies, for the SMP department.
45. SOMARC and ASHONPLAFA should develop a realistic plan of technical assistance that takes into consideration the shortfalls in 1990 and 1991 and that attempts to meet the critical needs of the project, especially in managing the advertising program, in developing an adequate program of market research, and in developing new product lines and non-pharmaceutical channels of distribution.
46. Planned training of pharmacists and salespersons should be carried out as soon as possible to guarantee that there is at least one trained person and training manual in each sales location; continuing education material should also be developed and disseminated.

Coordination among Service Delivery Programs

47. A study should be undertaken of the most efficient location of posts related to MOH and SMP expansion and varied levels of supervision for different kinds of areas and distributors.
48. ASHONPLAFA should continue and intensify coordination with other PVOs and the MOH to determine the best means to achieve total country coverage efficiently.

6.3.4 Private Voluntary Organizations

PLAN in Honduras

49. PLAN and USAID/Honduras should procure technical assistance from a centrally funded Cooperating Agency to assess PLAN's reporting system on referrals. Technical assistance should also be sought to design a simple and effective monitoring system for screening high-risk women and referrals. The technical assistance should help PLAN develop a system to monitor and document experience with reimbursing for transportation and lodging of VSC clients and to share results with ASHONPLAFA and other PVOs.
50. PLAN and USAID/Honduras should reassess the project target of increasing contraceptive prevalence in the project area by 20 percentage points and should, at the same time, extend the project for 18 months.

The Population Council Buy-In

51. USAID/Honduras and the Population Council should review the actual budget performance of this component through March 1992 and make realistic projections of costs of new subprojects under consideration. This review should include consideration of full funding of the Population Council project and time extension.
52. A major emphasis of the Population Council should continue to be to work with small PVOs, with an emphasis on cost-effective approaches. USAID/Honduras, however, should also encourage the Population Council to develop operations research projects with ASHONPLAFA. Presumably most of the operations research project expenses would be charged to the ASHONPLAFA budget, with either this Population Council subproject or the central INOPAL grant carrying the cost of technical assistance.
53. The Population Council and USAID/Honduras should proceed with the development and review of the CARE and AHLACMA umbrella project.

Appendices

Appendix A
Scope of Work

Appendix A
Scope of Work

IV. STATEMENT OF WORK

The primary purpose of this evaluation is to assess the project's progress to date and recommend changes to project design that would enhance achievement of project goals and objectives. In addressing the specific questions/issues set forth below, the contractor should keep in mind that the following outputs are of utmost importance to the redesign effort:

- An overall assessment of project strategy and achievement of project goals, purposes and outputs as set forth in the Logical Framework. This will include recommendations for revision of project design.
- A review of expenditure levels under all components to determine the impact of (a) the recent devaluation of the Lempira and (b) a possible extension of the project without increased funding (budget stretch-out).
- An assessment of progress made on the decentralization of ASHONPLAFA's responsibilities.
- An evaluation of cost recovery mechanisms and an assessment as to whether self-sustainability is achievable. This should include recommendations for improving self-sustainability of project activities.

The evaluation team will also undertake the work necessary to answer the following questions regarding Project activities. The analysis should take into account such things as organizational structure, personnel system and operational policies and procedures:

A. ASHONPLAFA

1. Administration:

Regionalization:

- a) What is the status of the regionalization efforts?
- b) How much authority do the Regional Directors have to operate their local programs?
- c) What decisions are made at the local levels? at ASHONPLAFA headquarters?
- d) How much influence and input do the local regional advisory boards have in directing local programs?
- e) Is the revolving fund at each regional center adequate to meet operational needs?

General Issues:

- a) Which administrative practices and procedures are necessary or are slowing down the execution of the programs?
- b) Are the policies and procedures describing the different delegations of authority followed?

- c) How appropriate is ASHONPLAFA's strategic planning? What are some suggested improvements?
- d) What is the function of the "Consejo Tecnico" committee? What types of matters are handled by them? Are there any suggested changes that may improve their role in decision-making?
- e) Are routine administrative decisions related to personnel, purchases, and needs made at the appropriate level?

2. Finances:

- a) What information does ASHONPLAFA have regarding the costs of delivering each type of service (surgical, IUD insertion, social marketing and community services contraceptives, educational, training)?
- b) How are computer resources used to record, analyze and collect information on costs per service?
- c) Are any resources such as equipment and staff being severely underutilized/overutilized? What improvements can be suggested?
- d) Is the staffing (number and type) in the different programs appropriate for the work to be carried out?
- e) Provide a financial analysis of project expenditures to date as compared to the budgets in the Project Agreement and the Project Paper. Provide recommendations on resource allocation among project elements specifying which level of future expenditures need to be reduced or amplified based on changes in the program.
- f) Determine the implications of a possible budget stretch-out on project activities.
- g) Examine the impact of the recent devaluation of the Lempira on project local cost activities. Make recommendations regarding the allocation of savings (windfall) over the various components of the project to counteract any negative impact of a possible project stretch-out.
- h) Evaluate project expenditure and control mechanisms within A.I.D. and ASHONPLAFA; identify obstacles and bottlenecks and make recommendations for any necessary and feasible administrative or policy changes which will facilitate project implementation including:
 - Disbursement mechanisms within the USAID/Honduras Controller's Office.
 - Functioning of rotating fund
- i) What percentage of ASHONPLAFA's personnel costs are being subsidized by USAID? By other donors? What percentage are paid through own revenues?
- j) What percentage of ASHONPLAFA's operating costs are being subsidized by USAID? By other donors? What percentage are paid through own revenues?
- k) What recommendations can be made to reduce ASHONPLAFA's dependency on USAID funding?

3. Cost Recovery and Revenue Generation:

- a) How much have revenues increased since the project started?
- b) Are the fees affordable to the patients receiving the services?
- c) How are these revenues being utilized? Which recommendations are there for a better use of these funds?
- d) How are the revenues being used to increase ASHONPLAFA's self-sufficiency?
- e) Is ASHONPLAFA paying more of its personnel and recurrent operational costs than before the project started?
- f) Do units that generate funds have influence on how those funds are used?
- g) What are the prospects for self-sufficiency by the end of the project? What actions have been taken towards self-sufficiency now?

4. Statistical Data and Information:

- a) What problems exist and what improvements have taken place in:
 - financial and statistical record keeping?
 - financial management?
 - inventory systems?
 - budgeting and long range planning?
- b) Are there any improvements that should be considered in these areas?

5. Personnel Management:

- a) How effective has the personnel management system been in contributing to achieving the projects objectives as it relates to:
 - staffing
 - training
 - recruitment
 - salaries
 - competency and performance evaluations
 - rewards and recognition
 - turnover
- b) What problems have occurred in the above areas that need resolution?

6. Management Information System (MIS):

The evaluation team will provide a thorough description of the MIS system and its components and answer the following:

- a) How are service statistics tracked and used? What problems exist?
- b) How timely are MIS reports?
- c) Does costs per service information exist?
- d) How is the MIS data used to make decisions and solve problems? Who uses it?
- e) Who makes important administrative and/or policy decisions using the MIS?
- f) What is the adequacy (number and type) of computer equipment and software to produce the required information?

7. Medical/Clinical Services

The evaluation team will become familiar with the medical/clinical services component and answer the following:

- a) Is the voluntary surgical contraception (VSC) program meeting all accepted medical standards of quality with regard to privacy, informed consent, treatment, and standard medical practice? Is the surgical infection rate for sterilizations within accepted limits?
- b) Is the vasectomy program meeting its goals? What can be done to improve it? What have been some problems?
- c) Is the IUD insertion program meeting the potential demand? Could services be increased or expanded? How do they compare in cost, efficiency and quality with services provided by the public sector?
- d) Is the new fee schedule for services equitable, just, and uncomplicated? How much have revenues increased in this particular component since the fee schedule was initiated?
- e) Are the surgical and medical facilities being used efficiently with respect to capacity? Which facilities have the highest cost for service delivered? How can costs be reduced?
- f) How much is being paid to private clinics for surgical services? Could the funds be better used in other ways? How does the cost per procedure compare with services provided directly by ASHONPLAFA clinics?
- g) Are the medical/clinical services reaching the rural population? What are the constraints and recommended solutions?
- h) Are the rural populations getting adequate access to surgical contraception services? IUD services?
- i) Give a breakdown of hospital versus non-hospital sources of surgical contraception patients. Where do VSC promoters get most of their referrals for contraception?
- j) Will the program meet the service goals established by the project for sterilizations?
- k) Are the newly established women's health clinics effective in attracting more women to accept family planning services? Are these clinics generating significant revenues? How much?

- i) Are there any other medical services that ASHONPLAFA could initiate that will provide them with additional revenues?

8. Community Services Program

The evaluation team will become familiar with the Community Services Program component to answer the following:

- a) How much has program coverage increased since the project began? Which areas of the country are not well covered?
- b) Will the program reach the sales goals established by the project? Chart quarterly sales of contraceptives since the project began. Provide an analysis of performance by product.
- c) How well has the incentive program worked? Is it cost effective? What modifications are needed to make it more effective and less complicated?
- d) How much have revenues increased since the start of the project?
- e) How well do the program personnel cooperate with PVOs in the areas of training and establishing new distribution posts?
- f) Does the program have good inventory management and control?
- g) What are some of the data collection problems? What are some recommendations to solve these problems?

9. Social Marketing

The evaluation team will become familiar with the Social Marketing Program component and answer the following:

- a) Is the marketing strategy being implemented? If not, why not?
- b) Is the publicity campaign being implemented? If not, why not? How well has the publicity agency (FCB) worked in implementing the publicity campaign?
- c) Chart sales and revenues during the project period and make projections of these into the future. Provide an analysis of performance by product.
- d) What are the prospects for self sufficiency of this component?
- e) How many pharmaceutical personnel have been trained? How many more should be trained?
- f) Is staffing adequate for the proposed work to be done? Describe number and type of staff involved.
- g) How responsive and useful has the SOMARC technical assistance been?
- h) Does the program have good inventory management and control?

- i) Does the Program Manager have enough flexibility and authority to manage this program effectively? How much control does he have over the use of the revenues?
- j) What locations are covered by the program? Which locations are not being reached by the program? (please chart on a country map).
- k) Is MANDOFER, the distributor for Social Marketing products, performing adequately according to its contract?

10. Information, Education and Communication (I.E.C.)

The evaluation team will become familiar with the I.E.C. program component and answer the following:

- a) How much coverage does this program have? Which areas of the country are not adequately served? Why?
- b) How responsive has this office been in providing PVO support through educational materials and availability of technical assistance? List type of assistance given. How can this be improved?
- c) Is the office for public relations adequately educating decision makers and the public about family planning and defending attacks on the organization? List some examples of this.
- d) How is the mass media being used to promote family planning? Are all mass media sources being well exploited? What are the costs involved?
- e) Is the staffing (number and type) adequate for meeting the goals of the program?
- f) Does the program have the necessary equipment to develop educational materials and carry out its mandate?

11. What are the prospects for arriving at the target fertility and contraceptive prevalence rates at the end of the project? (see preliminary results of the 1991 Epidemiology and Family Health Survey).

B. FOSTER PARENTS PLAN

- 1. How likely is it that PLAN will achieve a 20 percentage point increase in contraceptive prevalence in its communities by the end of the project?
- 2. How effectively has ASHONPLAFA and PLAN cooperated in the following areas?:
 - production of training materials (manuals)
 - production of educational materials
 - establishing additional contraceptive distribution posts
 - training of medical personnel
 - implementing workshops for the community
 - accepting referrals for IUD insertion, sterilization, etc.

What problems have occurred in the above areas that need resolution?

91

3. How is PLAN meeting its training goals?
4. What are the major problems within the program?
5. Has the referral system been successful in identifying potential acceptors of family planning services? How can it be improved?
6. How adequate is the staffing (number, type, skills) to implement the program?
7. Analyze the budget and expenditures to recommend modifications to the project that will help it better meet its objectives.

C. THE POPULATION COUNCIL BUY-IN

1. How successful has the program been in assisting PVO's drafting proposals for possible funding? What have been the principal problems?
2. How frequent and effective has been the monitoring and assistance the local office provided to local PVOs? (Please interview these PVOs).
3. How effective has the program been in reaching PVO's to participate in The Population Council sponsored workshops?
4. How has the local office worked collaboratively and closely with ASHONPLAFA to implement family planning programs and increase the number of contraceptive distributors in rural communities?
5. What are the prospects of completing the goals of having at least three new PVO's integrating a family planning program in their activities with the assistance of the local office through this project?
6. Has Save The Children implemented its proposed activities as planned? Why or Why Not?
7. Analyze the budget and expenditures and make recommendations to modify the project in order to better meet its objectives.

D. REVISION OF GOALS

For the project as a whole, what adjustments should be made in the Project goals and objectives? Specifically,

1. What indicators in the Project LOGFRAME, if any, should be revised to reflect what the Project can actually expect to accomplish? If revisions are indicated, what should the revised figures be?
2. What changes, if any, should be made in the implementation plan?
3. What has the impact of the project been in the country?

The evaluation team will present the answers to these questions in an organized form reflecting its findings, conclusions, recommendations and lessons learned. The logical sequence followed to arrive at recommendations should be clearly defined and presented.

Appendix B
Persons Contacted

Appendix B

Persons Contacted

PERSONS CONTACTED

Tegucigalpa

Alejandro Flores, ASHONPLAFA/Executive Director
Juanita Martinez, ASHONPLAFA/Deputy Executive Director
Yolanda P. de Vargas, ASHONPLAFA/President, Board of Directors
Renan Vasquez Gabrie, ASHONPLAFA/Secretary, Board of Directors
Joaquín Nuñez, ASHONPLAFA/Director of Medical and Clinical Services
Margarita Suazo, ASHONPLAFA/Evaluation and Training Director
Nelly Funez, ASHONPLAFA/Director of Community Services Program
Oscar García, ASHONPLAFA/Director of Human Resources
Luis Fernando Pineda, ASHONPLAFA/Director of Social Marketing
German Cerrato, ASHONPLAFA/Director of Finances and Administration
Lenin Flores, ASHONPLAFA/Director of Information, Education, and Communication
Carlos Nieto, ASHONPLAFA/Systems Analyst
Dr. Manuel Sandoval Antonio Lupiac, ASHONPLAFA, Tegucigalpa/Women's Clinic
Dr. Herman Alejandro Maradiaga, ASHONPLAFA, Tegucigalpa/Male Clinic
Roberto Salgado, ASHONPLAFA/Warehouse Chief
Lastenia de Cerrato, ASHONPLAFA, Tegucigalpa/Clinical and Medical Services
Ans Morvan, PLAN en Honduras, Tegucigalpa/Field Director
Vircher Floyd, PLAN en Honduras, Tegucigalpa/Associate Field Director
Dr. Dennis Velasquez, PLAN/Project Coordinator
Julio Torres, PLAN/Administrator-Accountant
Eliseo Alvarado, PLAN-Salama/Regional Coordinator
Dr. Ricardo Vernon, Population Council/Regional Director
Rebecka Lundgren, Population Council/Advisor, Honduras
Aida Cora De Castro, Save the Children/Executive Director
Dra. Patricia Redondo, Save the Children/Project Director
Felipe Acosta, MANDOFER/Marketing Manager
Cora Sue De Rodriguez, FCB/Artefilme/General Manager
Carlos Flores, FCB/Artefilme/Account Manager
Jorge Mondragón, PSM/Salesperson-Field Representative
Dr. Rigoberto Alvarado, MOH/Advisor

Choluteca

Nathan Bonilla Regional Director, Choluteca
Oscar Erazo Supervisor, Community Services Program
Mireya Mondragon CSP promoter
Amadeo Garcia CSP promoter
Gladis Alvarez CSP promoter
Carmen Maradiaga VSC promoter
Elsa Herrera VSC promoter
Two rural CSP distributors
Dr. Manuel Maldonado, Martha Estrada, Olivia Reyes, María Elena Cruz, and Lidia Osorto/Surgical Area Team

Comayagua

Dr. Joaquín Montes, Clinica Montes

San Pedro Sula

Edwin Roberto Lopez Regional Director, San Pedro Sula
Dr. Manuel A. Calderone Romero President Regional Board of Directors
Ofelia Matute, Temporary Methods
Ramiro Hernandez Supervisor CSP
Edith Castro Registered Nurse, IUD Program
Apolonia Torres VSC promoter
Dr. Antonio Yacaman Ob/Gyn
Deisy Dolores Caballero VSC promoter
María del Carmen Garcia and Alicia Muñoz, Pap Smear Program
Consuelo Boden Nurse working with the Honduran Evangelical Association in Rio Chiquito
Operating Room Personnel
Pharmacists and pharmacy sales persons in two pharmacies in San Pedro
Two CSP distributors in San Pedro and rural area nearby

Santa Rosa

Jesus Humberto Chaves Regional Director and CSP Supervisor
Dr. José Antonio Leiva MD
Leana Tabora De Pineda VSC promoter
Norma Puerto Registered Nurse
Mayra Garcia De Venetis VSC promoter
Pharmacists and salespersons in four pharmacies in Sta. Rosa, La Entrada and Sta. Rita
Three CSP distributors in Seis de Mayo, La Entrada, Sta. Rita
Broadcaster from Radio Sultan in Sta. Rosa
Mobile audio promotion driver/broadcaster from San Pedro contacted in Las Ruinas de Copan

Juticalpa

Pablo Dominguez ASHONPLAFA/Region IV Director

La Ceiba

Pablo Dominguez ASHONPLAFA/Region Director and staff

USAID Tegucigalpa

Francisco Zamora USAID/Population Officer
Dr. María del Carmen Miranda USAID/Population Advisor
Dr. Angel Coca USAID/Population Advisor
Carmen Zambrana USAID/Evaluation Specialist
Betty Carcamo USAID/Assistant Evaluation Specialist
Kelly Flowers USAID/Development and Finance Officer
Robert Haliday USAID/Health Officer
Roberto Figueredo USAID/Human Resources Development Officer
Frank Caropreso USAID/Controller
John Bratt FHI/Researcher on Cost Study with ASHONPLAFA
Patsy Bailey Family Health International (FHI), North Carolina (FHI person responsible for the 1987 EFHS)

Appendix C

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Appendix C

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Appendix D

Project Design Summary

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Appendix D

Project Design Summary Logical Framework Matrix

Life of Project
From FY89 to FY94

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>COAL</u></p> <p>Reduce the National Total Fertility Rate (TFR)</p>	<p><u>MEASUREMENT OF GOAL ACHIEVEMENT</u></p> <ul style="list-style-type: none"> - Reduce TFR from 5.6 to 4.7 - Reduce TFR for rural women from 6.9 to 5.8. - Reduce TFR among urban women from 3.8 to 3.0 	<p>Data from Contraceptive Prevalence Surveys (CPS) of 1991-2 and 1993-94</p>	<p>GOH will continue its pro-family planning stance. USG will continue support of family planning programs in its foreign assistance program.</p>
<p><u>PURPOSE</u></p> <p>Contribute 50% of the increase in modern contraceptive use.</p>	<p><u>CONDITIONS INDICATING PURPOSE HAS BEEN REACHED</u></p> <ul style="list-style-type: none"> - Of couples in union, 40% in rural areas and 65% in urban areas are using a modern contraceptive, of which 50% will be doing so as a result of this program. 	<p>Data from the CYPs of 1991-2 and 1993-4.</p>	<p><u>AFFECTING GOAL - PURPOSE LINKAGE</u></p> <ul style="list-style-type: none"> - That other national groups, private and public continue to provide contraceptive services at the same ratio as a present. - That all groups providing contraceptive services continue to receive adequate funding for their programs. - ASHONPLAFA's present good image continues. - IPPF will continue to provide funding and contraceptives.

NARRATIVE SUMMARY OBJECTIVE VERIFIABLE INDICATORS MEANS OF VERIFICATION IMPORTANT ASSUMPTIONS

OUTPUTS

MAGNITUDE OF OUTPUTS
End of Project Status

<p>A. <u>Community Services</u> 1. <u>ASHONPLAFA services</u> expanded, especially in rural areas. 2. Private Voluntary Organizations referring 90% of potential acceptors to nearest ASHONPLAFA service delivery post.</p>	<p>1-1 Increase family planning service distributors by 310 posts, 295 of which are in rural areas. 2-1 64-65,000 active users in 1994 1-2 Eight PVOs, all in rural areas, making referral of potential acceptors to MOH, ASHONPLAFA or other service providers.</p>	<p>ASHONPLAFA Quarterly Reports Supervisor Reports Reports from PVO's</p>	<p>IEP activities will motivate additional potential acceptance to use FP services.</p>
<p>B. <u>Social Marketing</u> Program reorganized and coverage increased.</p>	<p>1. Contract plan between ASHONPLAFA and Drogueria MANDOFER implemented. 2. Distribution network supplying 90% of pharmacies and other authorized prescription drug point-of-sales outlets. 3. Program providing 40,000 CYP in 1994. 4. 100% of operating costs (excluding product cost) being defrayed by program income.</p>	<p>Narrative Reports Quarterly Sales Reports from MANDOFER Sales Reports Financial Reports</p>	<p>College of Chemistry and Pharmaceuticists does not oppose importation of contraceptives by ASHONPLAFA. Present legislation continues with favor program activities.</p>
<p>C. <u>Medical/Clinical Services</u> 1. Service Availability increased through the addition of three regional centers. 2. Private clinics and 60H hospitals continue providing services at the same proportional levels.</p>	<p>ASHONPLAFA and private clinics providing 39-40,000 female VSC, 500 vasectomies and 12,00 acceptors of temporary methods. 81,589 citological examinations and 59,000 other laboratory examinations done.</p>	<p>Statistical Reports Supervisory Reporting Clinical Reports</p>	<p>Availability of funds Availability of a wide range of reversible methods to offer. Continued support of the medical school and the OB/GYN society. Continue support by Regional Health Directors of the MOH.</p>

Project Title and Number: Private Sector Population II
522-0369

NARRATIVE SUMMARY OBJECTIVE VERIFIABLE INDICATORS MEANS OF VERIFICATION IMPORTANT ASSUMPTIONS

D. Information Education,
Communication (IEC)

1. Expansion and intensification of the Information and Education Programs.

1. 50 % of all educational efforts directed at rural target population.
- 1-2 50 % of promotional efforts directed at rural target populations.
- 1-3 25% of promotional activities directed at men to increase acceptance of male methods (condoms and vasectomies).
- 1-4 Strategy for adolescents developed and in operation by 3rd year of project.

IEC Division Reports

IEC Division Reports

IEC Division Reports

Written strategy completed

2. Institutional Strategy for Communications established

- 2-1 Strategy defining and coordinating actions needed for communication activities supporting the service delivery division implemented.
- 2-2 Advertising agency producing radio and TV spots, maintaining billboards, developing newspaper advertising and press releases.

Existence of Strategy Document

Observation and Reports

E. Training Institutional Training

1. Training manual completed and in use.
2. Orientation for 310 new distributors.
3. Orientation for all distributors on CPS/SMP link-up.
4. Two new promoters and 1 new supervisor trained formally and on the job.
5. Pharmacists' employees training program established.
6. Training provided to personnel of 8 PVO's.
7. Refresher training for all ASHONPLAFA personnel.

Training Records

Supervision Reports

Church and other opposition groups are unsuccessful in discouraging use of modern FP.
Present atmosphere of acceptance of modern FP methods among the general public continues.

Attitude of media towards FP continues to be favorable.

Project Title and Number: Private Sector Population II
522-0369

IMPORTANT ASSUMPTIONS

MEANS OF VERIFICATION

OBJECTIVE VERIFIABLE INDICATORS

NARRATIVE SUMMARY

P. Monitoring and Evaluation
1. Management Information

1-1 MIS producing information for informed decision making on a timely basis. 1-2 System totally computerized.	Statistical Reports
2-1 OR aimed at improving a more efficient and effective internal work system. 2-2 Management decisions taken on basis of information generated by OR.	Observation Observation
3. Program Evaluation 1. Evaluation directed at measuring institutional improvements in relation to stated program goals.	Evaluation Results

INPUTS

LEVEL OF EFFORT (Budget)

MEANS OF VERIFICATION

ASSUMPTIONS

Activity
Technical Assistance
Contraceptives
Other Commodities
Local Support Costs

AID
\$ 1,900,000
\$ 1,110,000
\$ 554,000
\$12,436,000

Financial Reports
Obligation Documents
Annual Budget and Expenditures Reports

Timely Availability of AID funding
AID Funding
Income Generations and other donor contributions total \$9,100,000 over LOP.