

**EVALUATION OF THE AIDS/STD
PREVENTION AND CONTROL PROJECT (522-0216)**

USAID/Honduras

**Submitted by:
The Synergy Project
TvT Associates, Inc.**

**Clifton Cortez, USAID/Washington
Ann Mary Fitzgerald, PASCA
Douglas Heisler, USAID/Washington
Jorge Sánchez, The Synergy Project
Michele G. Shedlin, Sociomedical Resource Associates**

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ACRONYMS AND FOREIGN TERMS

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
Albergue	Shelter, housing
APES	AIDS Policy Environment Score
BCC	Behavior change communication
CDC	Centers for Disease Control and Prevention
CESAMO	Centro de salud con medico (government health center with a doctor)
CSM	Condom Social Marketing project
CTRPN	Counseling, Testing, Referral and Partner Notification project
DDHH	Derechos humanos (human rights)
FFS	Fundacion Fomento en Salud
FSW	Female sex worker
FY	Fiscal year
Gasolinera	Convenience store attached to a station that sells gasoline
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IHSS	Social Security Institute
IMPACT	Implementing AIDS Prevention and Care Project
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
IUD	Intrauterine device
Lempiras	Honduran currency (Lps.)
Maquila	Factory
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PASCA	Programa Acción SIDA de Centro America
PASMO	Pan-American Social Marketing Organization
PSI	Population Services International
PVO	Private voluntary organization
PWA	People living with AIDS
RPR	Rapid plasma reagin
SO	Strategic Objective
STI	Sexually transmitted infection
TB	Tuberculosis
TFR	Total fertility rate
UMIETS	Unidad de manejo integral de ETS (STD reference center)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WIU	Women in union

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EXECUTIVE SUMMARY

BACKGROUND

The perception of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic in nonindustrialized countries is that it is a heterosexual epidemic involving men and women equally. This perception can be misleading in that the evidence shows that while women are becoming more and more vulnerable, the epidemic is still being driven by men because it is men who most often engage in high-risk sexual behaviors. In Latin America, including Honduras, this male-driven epidemic includes a significant amount of men having sex with men (MSM), a high-risk behavior. Even so, in Honduras, the impact of the epidemic and men's high-risk behaviors is now being clearly felt among women, as the sex ratio of AIDS cases moves towards parity.

HIV/AIDS rates in Honduras are the highest in Central America and have already reached the level of a **generalized epidemic**. It should be noted however, that there are important regional differences in HIV prevalence rates in specific groups, which reflect different levels of progression of the epidemic.

Current thinking to increase the use of improved, effective and sustainable responses to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic follows synergistic approaches: strategies to reduce the sexual transmission of HIV; managing and preventing sexually transmitted infections (STIs), eliminating barriers to providing HIV/AIDS services to youth, women, people living with HIV and AIDS, and other vulnerable populations; increasing the capacity of nongovernmental, community-based, and commercial organizations to respond to HIV/AIDS; increasing the quality, availability, and use of evaluative and surveillance information; and, developing and promoting effective strategies for providing basic care and support services for people living with HIV and AIDS. Prevention of sexual transmission of HIV entails the adoption of safer sexual behaviors and norms and the reduction of unsafe sexual situations. Programs that target high-risk behavior populations can break the chain of transmission to women and children in the general population and have been proven to be effective.

The strategic plan for USAID/Honduras calls for the establishment of a sustainable Honduran nongovernmental organization (NGO) that can serve as an AIDS Awareness and Prevention Center for other Honduran HIV NGOs that are providing HIV/STI prevention and counseling services to high-risk populations. The Center would provide subgrants to NGOs implementing activities as well as administrative and technical assistance to those NGOs. The Center would also serve as a source of advocacy and clearinghouse for sharing information and best practices between the organizations in the private sector as well as between the private sector NGOs and the public sector. Additionally, the Center would assist in organizing a national behavior change communication (BCC) campaign. Fundación Fomento en Salud (FFS) was chosen by the

United States Agency for International Development (USAID)/Honduras to serve as this Center.

The Ministry of Health (MOH) is receiving funding to assist it in complementing the work of the private NGOs by having in place effective STI treatment and using the syndromic approach in government health clinics. The MOH is also responsible under its funding grant for implementing HIV/STI surveillance and case reporting systems as well as national education campaigns. This is to be accompanied by the distribution of free condoms to high-risk behavior and low-income groups.

The purpose of this review is to determine if the current model is an effective and efficient strategy for preventing HIV/AIDS transmission in Honduras.

MAJOR FINDINGS

In general, the project is a well-planned, well-designed attempt to develop a three-pronged approach to HIV prevention. The project combines behavior change and condom distribution with an STI control program, and the private sector-focused Center mechanism envisioned by USAID/Honduras is a sound one.

FFS staff is knowledgeable, innovative and motivated; the administrative assistance provided by FFS to the NGOs is viewed as excellent; and, the NGOs working under this umbrella organization have set up several distribution points for condoms. However, all FFS staff is based entirely in Tegucigalpa, and no one on staff has intimate, first-hand knowledge of the high-risk behavior groups. Furthermore, the referral system from NGO to STD services, set up primarily through peer educators, is weak.

The MOH has already implemented a national second-generation surveillance system, and its HIV case reporting system is providing improved data. Also, a large number of distribution points for condoms have been set up. However, there has not been much accomplished in the training of syndromic management and implementation of STD services, and there is poor monitoring, supervision and evaluation.

According to the AIDS Policy Environment Score (APES) developed by Programa Acción SIDA de Centro America (PASCA), Honduras has the most resources, research, policy support, and policy formulation in Central America, but it has a low score in program components. It is important to note that Honduras has made significant progress in two key areas of policy dialogue during 1999. The MOH presented its national strategic plan in August 1999 and the AIDS law, which has been pending for over a year, was passed on September 9, 1999.

A large gap in the project is the limited coordination among key stakeholders, a core reason for USAID support. There are no joint planning processes between FFS and the MOH and many opportunities are being missed to bring NGOs together with each other (both those funded by FFS and others performing related work in the same communities).

It was noted that there is “no coordination between NGOs and the state.” In addition, there is no coordination among donors and there are many overlapping activities supported by different donors.

USAID/Honduras’ goals in the area of HIV/AIDS could be attained effectively if the recommendations presented in this report are followed.

SUMMARY OF RECOMMENDATIONS

1. The Mission should not drastically alter course midstream of the overall strategy of the project. Intervention activities through the MOH, FFS and different NGOs should focus on the current geographic areas and high-risk behavior/vulnerable populations (i.e., female sex workers [FSWs], MSM, garifunas), applying crosscutting issues, such as gender, youth, community ownership, sustainability, and local capacity. FFS should either consider realigning its network of NGOs by cutting out some of the NGOs that do not reach the highest risk behavior groups and supporting more that do, or FFS should provide assistance in reaching the highest risk behavior groups, and add these to its already existing network. An evaluation plan is urgently needed.
2. USAID/Honduras should take an active role in the development of a joint planning process between FFS and the MOH and in donor coordination.
3. FFS should create an advisory body to help FFS set general policy as well as guide the organization in expanding its funding base and sustainability. Also, a coordinating body made up representatives from the NGOs that are funded by FFS would serve the purpose of institutionalizing coordination among the NGOs.
4. FFS should hire someone from the affected community as a staff member. This person should work out of one of the FFS-supported NGOs in San Pedro Sula, and travel to Tegucigalpa to work in the FFS offices at least once a week.
5. The implementation of the model STI prevention and care package at the public health services should continue to be strengthened, including STD services for at-risk populations (e.g., FSWs, MSM), and expanded to the private and informal sectors, including pharmacies. Important components of this implementation are strengthening the referral system from the NGOs to STD services and the monitoring, supervision and evaluation process at the HIV/STD/tuberculosis (TB) Division.
6. USAID/Honduras should work with the Pan American Social Marketing Organization (PASMO) and a Honduran commercial sector distribution company to build a sustainable market for a moderately priced condom. In addition, it should review its sustainability objectives for HIV/AIDS (FFS) and its family planning (ASHONPLAFA) programs and assess how different sustainability requirements for one may negatively affect the sustainability of the other.

7. The national second-generation surveillance system should continue to be strengthened. Integration of the current Honduras surveillance system to a regional surveillance system proposed by PASCA would allow better characterization of the epidemic, considering the migration patterns in the region.
8. A targeted policy dialogue strategy should be designed to disseminate the plan and the law truly to multisectoral audiences, including big business, the human rights sector, the women's sector, and other programs.
9. Future outputs of the USAID/Honduras program should include operational research in STD services, behaviors and condom social marketing.
10. New interventions appropriate to the current stage of the epidemic require more funding, **not** reallocation of current funds. The program should be expanded, working with the Ministry of Health to develop the general availability of HIV testing and counseling and to develop and promote effective strategies for providing basic care to people living with HIV/AIDS, including legal and human rights, but additional funds are needed.

CONCLUSION

Given the observations and suggestions of the assessment team on the various areas of FFS mission and responsibility, it seems clear that the agency has reached a juncture at which new structure and directions are advisable and feasible. However, changes are suggested not only in the content of specific areas in this next phase of institutional development, but also in reconceptualizing needed services and products as well as how they are used and delivered. It is not only necessary to revise the format and content of educational materials, for example, but to develop utilization strategies that go beyond dissemination. It is necessary to rethink the support of activities pertaining solely to HIV activities and to respond to the overwhelming perceived need for integrating HIV prevention into other priorities of the target populations as well as integrating these priorities into HIV prevention. This means addressing sex workers as mothers with maternal and child health needs as well as the need for STD care, and adolescents' need for a sense of involvement in their community as well as promoting their use of condoms. These changes will thus address some important issues, such as stigma, representation, the potential impact of interventions, and addressing the perceived needs of NGOs and their staffs.

The administration of FFS is aware that change is necessary and has expressed an openness and readiness to explore alternatives internally and with external technical assistance in areas in which additional expertise is necessary. This is encouraging and hopeful for the future successes of this important institution.

I. INTRODUCTION

BACKGROUND

HIV Epidemiology in Honduras

Honduras has the most severe human immunodeficiency virus (HIV) epidemic in Central America, with 51.6 percent of all cases in the region. The first case was reported in 1985; in the last several years, the annual number of reported cases has remained around 1,000. With an estimated population of 5,607,890 in 1998, the incidence density that year was 24.84 cases/100,000 population. The cumulative number of reported acquired immune deficiency syndrome (AIDS) cases through May 1999 was 10,547. The epidemic is predominantly sexually driven, and although it was never primarily an epidemic of men who have sex with men (MSM), the contribution of heterosexual transmission has risen from 60 percent of the AIDS cases in 1987 to 84 percent in 1999. This is also reflected in the sex ratio that declined from 1.7:1 in 1990 to 1.1:1 in 1998, and in the rates of vertical transmission. Such cases were 1.8 percent of all cases in 1987, but increased to 9.0 percent in 1998. The epidemic is concentrated in the main urban and economic centers of the central corridor of development, the geographic focus of the U.S. Agency for International Development (USAID) program. The two largest cities in the country, San Pedro Sula and Tegucigalpa, account for 47.8 percent of all AIDS cases.

According to mathematical modeling, it is estimated that in 1997, there were about 36,000 people already infected with HIV, and there will be 72,000 new infections and 53,000 AIDS deaths in the next 10 years. The epidemic is reaching a plateau, with prevalence stabilizing at about 1.2 percent in the general population.

Several prevalence studies have been carried out since 1991. During 1998, with the support of the current USAID Implementing AIDS Prevention and Care (IMPACT) project, a considerable effort was put into the development of a second-generation surveillance. Available data from 1998 surveys indicate that HIV prevalence in the general population ranges from less than 1 percent to 3.6 percent (Tegucigalpa: 0.7 percent; San Pedro Sula: 2.0 percent; Puerto Cortez: 3.6 percent) and that HIV prevalence is much higher among high-risk behavior groups and vulnerable populations, such as MSM (6.3–10 percent), street-based sex workers (3–14.1 percent), garifunas (5.7–14 percent), and incarcerated persons (4.1–9.2 percent).

Given these prevalence rates, and according to the World Bank classification of HIV epidemics, Honduras has already reached the level of a **generalized epidemic**. It should be noted, however, that there are important regional differences in HIV prevalence in specific groups, which reflect different levels of progression of the epidemic.

Current Thinking about HIV Prevention

Act as Soon as Possible

There are several reasons why early intervention to change high-risk behavior is preferable to later action. Early in an epidemic, HIV spreads exponentially. Because few people are infected, the probability is high that unprotected sex involving an infected person and a random partner will result in a new infection. However, since few people are infected, a prevention campaign focusing on the high-risk behavior and vulnerable population can significantly reduce the transmission rate among members of these subgroups and ultimately to members of the general population. Also, interventions cannot be put in place instantly, requiring a period of trial and error to discover which approach works best in a particular setting. Finally, it is far less costly to prevent HIV infections than to treat people with AIDS.

The Multiplier Effect of Changing the Highest Risk Behavior

The HIV epidemic is largely influenced by the degree of mixing among people with different degrees of risky behavior. Preventing HIV infection in someone with a high rate of partner change will indirectly avert many more future infections than preventing infection in a person who practices low-risk behavior, has few partners, and, therefore, is less likely to infect others.

A simple calculation illustrates the power of reducing sexually transmitted infection (STI) or HIV transmission among those with the highest rates of partner change. A successful STI prevention program for female sex workers (FSWs) provides gonorrhea screening and treatment to 500 sex workers (25 percent of whom are already infected) who have an average of 4 partners a day. The proportion of men infected through vaginal intercourse with an infected woman is 30 percent. The intervention would avert 165 new gonorrhea cases per day among their clients. This intervention would, of course, also avert many secondary infections to other partners of these clients, including their wives.

Suppose, instead, that the program provides gonorrhea screening and treatment to 10,000 pregnant women. At that time, about 5 percent of the women were infected, and the average woman had one partner per year. Using the same assumptions about transmission rates, the intervention program would have prevented only 300 gonorrhea cases per year.

Cost-effective Interventions

Few HIV interventions have been rigorously evaluated with respect to their impact on the incidence and prevalence of HIV; among those evaluated, interventions targeted to those who practice high-risk behavior have been proven to be more effective than those targeted to other groups. The effectiveness of alternative interventions will be strongly influenced by the nature of the intervention itself and by the heterogeneity of the behavior

that is fueling the epidemic. Van Vliet et al. (1999) have simulated the impact of increased condom use and increased treatment of curable STIs on a heterosexual HIV epidemic and have concluded that although the overall pattern of sexual behavior in the population does affect the impact of interventions, prevention of infection among those with the highest rates of partner change has the largest effect. Also, increasing rates of condom use among those with high rates of partner change as well as focusing condom subsidies and promotion efforts on changing the behavior of these groups are likely to be highly cost-effective. Thus, interventions should have the greatest impact if they are effectively focused and delivered among individuals who have many partners and are in dense sexual networks.

Prevention of HIV Sexual Transmission

Global strategies to prevent sexual transmission of HIV have focused on three primary approaches: increasing access to and demand for condoms, mainly through condom social marketing programs; reducing sexual risk through behavior change communications (BCC); and, treating and controlling STIs.

STIs have long been implicated as a cofactor for HIV transmission and are a major public health problem in most developing countries. Studies in both industrial and developing countries have found that individuals with current or past STIs are 2–9 times more likely to be infected with HIV. Subsequent studies have shown that urethral and endocervical infections caused by nonulcerative STIs increase genital shedding of HIV–infected cells, and thus increases infectivity of the person with HIV infection.

The rate of spread of STIs, including HIV, is determined by three factors: the average rate of exposure of susceptible people to infected people, the average probability that an exposed susceptible person will acquire the infection, and the average time that newly infected persons remain infectious and able to continue spreading infection. Thus, interventions can prevent the spread of an STI within a population by lowering the rate of partner change, reducing the efficiency of transmission, or shortening the duration of infectiousness of that STI.

From the above information, it is clear that the distinction between behavioral and biomedical interventions for STI prevention is artificial, since both behavioral and biomedical approaches are often required, whether the objective is preventing exposure, preventing acquisition, or preventing transmission of STIs. In fact, behavioral and biomedical approaches are complementary, and interdisciplinary approaches are essential. Biomedical interventions are ineffective without behavioral components to support them and behavioral approaches need to address all of the factors responsible for sustaining transmission of infection.

Service Delivery and STI Control for High-Risk Populations

The provision of accessible, acceptable and effective care services is a cornerstone of any program for the control of STIs. In Mwanza, Tanzania, a randomized trial to evaluate the impact of improved STI case management using syndromic management at primary health care level demonstrated an HIV cumulative incidence over two years of 1.2 percent in the intervention community, compared with 1.9 percent in the comparison group—a 40 percent reduction. This study demonstrated that STI treatment is an important prevention strategy in HIV infection for the general population. However, this strategy addresses STI care for symptomatic STI patients at the primary health care level. For asymptomatic STI patients with low- or high-risk behaviors, a different approach is necessary.

STI clinics in urban settings are useful in providing primary care for specific groups, such as sex workers and their clients, migrant workers, truckers, and any other group with poor access to health care. Also, because of a concentration of STI expertise, these clinics can offer referral services for primary care clinics, hospital outpatient clinics, private practitioners, etc. These clinics should also be strengthened by providing their personnel with training in STIs and with epidemiological information (e.g., prevalence of etiologic agents within syndromes and antimicrobial susceptibility) and operational research (e.g., studies on the feasibility and validity of algorithmic approaches).

Few studies have shown that effective diagnosis and treatment of STIs have influenced the prevalence and incidence rates of STI/HIV among FSWs. In 1994, Project SIDA in the Democratic Republic of Congo (former Zaire), reported success in reducing HIV incidence among FSWs through condom promotion and STI treatment.

Few countries in Latin America have established effective STI diagnosis and treatment for FSWs. Sanchez et al. (in Peru) have evaluated a limited periodic examination program and concluded that the scope, quality, and efficacy of STI control programs must be technically appropriate, well managed, and adequately financed, and that the safety of marginal programs warrants scrutiny. The same team proposed and implemented a model for STI care that includes

- initial ethnographic research on health-seeking behavior and perceived needs,
- modification of STI services configuration to meet perceived needs and reduce perceived barriers,
- communication and counseling on risk reduction,
- social support or easy access to related social services,
- motivation to seek care for new signs or symptoms,
- regular periodic examination for symptoms or signs of STI and appropriate treatment,
- monitoring prevalence and incidence of STIs to guide the frequency of testing,
- examination of cost-recovery practices and actual allocation of funds recovered to the services provided,

- extension of services to FSWs not traditionally served by existing programs,
- consideration of anonymous or confidential HIV serology, and
- evaluation of the acceptability and effectiveness of the program.

Global USAID Response to HIV/AIDS

USAID has undertaken a comprehensive review of its strategy to respond to the HIV/AIDS pandemic. The Agency's new strategic objective is to increase the use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic. This objective was built on two overarching themes: the need for continued and expanded emphasis on sustainable responses to prevent HIV transmission, and a new emphasis on mitigating the epidemic's impact on individuals and communities while more closely studying its social, economic, and policy impacts.

USAID will use six approaches to achieve this strategic objective:

1. Strategies to reduce the sexual transmission of HIV,
2. Managing and preventing sexually transmitted infections (STIs),
3. Eliminating barriers to providing HIV/AIDS services to youth, women, people living with HIV and AIDS, and other vulnerable populations,
4. Increasing the capacity of nongovernmental, community-based, and commercial organizations to respond to HIV/AIDS,
5. Increasing the quality, availability, and use of evaluative and surveillance information, and
6. Developing and promoting effective strategies for providing basic care and support services for people living with HIV and AIDS.

Programs should incorporate the following crosscutting issues into the design, implementation, and evaluation of their activities: gender, sustainability, community ownership, contextual change, youth, and local capacity.

Project Results Framework

The current strategic plan for USAID/Honduras covers fiscal years (FY 1998–2000). The Strategic Objective for Health (SO3) focuses the Mission's efforts on sustainable improvements in family health. Three of the indicators for this strategic objective are directly related to STI/HIV prevention. These indicators measure HIV seroprevalence in women, in particular mothers and sex workers, with an emphasis on decreased HIV seroprevalence in young mothers and young sex workers (15–24 years old). Another strategic objective indicator measures syphilis prevalence in pregnant women and measures decreased seroprevalence in young mothers.

The four intermediate results for SO3 address reproductive health services, child survival services, STI/AIDS prevention, and household food security. Intermediate Result 3.3

calls for increased use of STI/AIDS prevention practices. The indicators for this result are:

- Increased condom use reported by sexually experienced single men, aged 15–24, in the last 30 days,
- Increased condom use reported by men, aged 15–59, with more than one sexual partner in the last 12 months,
- Increased condom use reported by sexually experienced single women, aged 15–24, in the last 30 days, and
- Increased number of Ministry of Health (MOH) hospitals and clinics in target health regions assessing and treating STIs syndromically.

The strategy employed by the Mission to reach these results is multifaceted. The strategy establishes “a sustainable nongovernmental Honduran AIDS awareness and prevention center, in place of external technical assistance.” The Center provides subgrants and administrative and technical assistance to Honduran private voluntary organizations (PVOs) for their work to promote STI/HIV prevention practices and counseling services among high-transmission groups. The Center also serves as a source of advocacy and as a clearinghouse for sharing information and best practices between the public and private sectors and for organizing national behavioral change communication campaigns. The MOH will complement this work by having effective STI treatment in place (using the syndromic approach) in government health centers with doctors (CESAMO) throughout Honduras. The MOH will also operate STI/HIV surveillance and case reporting systems and national education campaigns, accompanied by the distribution of free condoms to low-income groups.

A cooperative agreement was awarded to the Fundacion Fomento en Salud (FFS), in February 1998, to establish a National Center for AIDS Awareness and Prevention and to promote STI/HIV prevention and STI treatment throughout the country. USAID funding for the project is US \$2,145,179.

The Ministry of Health agreement was signed in July 1997, before the award to FFS. The MOH project is designed to strengthen public sector STI/HIV programs and policies. USAID funding for this project is 3,492,370 lempiras (approximately US \$249,000), with the Ministry committing counterpart funds of 1,647,295 lempiras, for a total of 5,139,665 lempiras (approximately US \$367,115).

The Results Framework that guides these cooperative agreements is shown in appendix A. Activities for IR 3.3.1.1.4 for FFS and IR 3.3.1.2.2. for the MOH are complementary; the same is true for IR 3.3.1.1.5 and IR 3.3.1.2.4. FFS policy dialogue activities focus on meetings, research activities, and dialogues with government officials and legislators, while the MOH activities focus on feasibility studies for new technologies, pilot prevalence surveys among high-risk transmitters, and the development of a medium-term plan for the STI/AIDS division, specifically highlighting information sharing and coordination. Both projects receive technical support from the regional and global

programs. Programa Acción SIDA de Centro America's (PASCA) tools for measuring nongovernmental organization (NGO) systematic planning and progress in policy dialogue (ICA, AIDS Policy Environment Score [APES], respectively) are to be used by FFS in evaluating their progress.

PURPOSE OF THE EVALUATION

The purpose of this review is to determine if the current model is an effective and efficient strategy for preventing HIV/AIDS transmission in Honduras (see appendix B, Scope of Work). The USAID/Honduras Mission provided questions to guide the review process. Recommendations are made about adjusting the current strategy and activities to the state of the epidemic in Honduras with an emphasis on strengthening the quality of the response of the Mission's current partners (FFS, MOH and ASHONPLAFA).

METHODOLOGY OF THE EVALUATION

The evaluation was carried out by a team of STI/AIDS specialists from PASCA and USAID/Washington and an independent consultant (funded by the Synergy project) with STI/AIDS programming experience in Latin America. The evaluation team conducted a comprehensive evaluation using interviews, site visits, observations, and other appropriate evaluation techniques, using a participatory process that seeks input from key stakeholders. The team based its findings and recommendations on the review of all project documents, supplemented by interviews with project staff, representatives of local partner organizations, and other local officials and key informants as appropriate. (See appendices C: Persons Contacted, D: Documents Reviewed, and E: References.) Due to time constraints, only one and one-half hours were available at each site, which permitted only a brief introduction to the institutions and their activities. Nevertheless, all NGOs, Ministry and Social Security Institute (IHSS) representatives were open and informative about their programs. An understandable reticence to be critical of any aspect of FFS was obvious from some NGO individuals supported by FFS.

II. GENERAL PROJECT STRATEGY, IMPACT AND ACCOMPLISHMENTS

COORDINATION AND SOUNDNESS OF APPROACH

Conservatism of Approach

A review of FFS–supported activities permits the conclusion that these activities are limited in creativity more by FFS direction and conservatism than by funding or NGO desires and abilities. NGO participants have commented on restrictions that have been placed on their ideas and materials for their target populations. Cultural and subcultural factors, rather than being used as building blocks, appear to be largely ignored, except in a few instances and at some NGOs where such efforts are funded by other donors. The IHSS, for example, is providing prevention “spots” to factory workers between music selections while they work. This audience is ideal for such strategies as novelas with accompanying trifolios, but only more traditional activities, such as the “spots” and workshops, have been implemented. In addition, NGOs targeting groups with high-risk behaviors, such as MSM, have not been allowed to creatively use visuals in BCC materials that have proven to be most effective in reaching target audiences. The reason given is that the visuals and graphics are too suggestive and “pornographic” for Honduran society, even though they would be targeted to specific groups and not general society. Yet, target audience appropriate visuals for HIV/AIDS prevention have successfully been employed in countries around the world that are as traditional as Honduras. This example points to a real lack of technical knowledge among the FFS staff regarding effective BCC strategies. While FFS should have the right to choose not to produce inappropriate materials, common sense and technical expertise should be employed regarding the images that would most effectively reach MSM audiences, for example.

Also regarding the FFS approach, it is important to note that representatives of governmental and NGO institutions and agencies discussed the value of considering a more holistic and integrated approach to prevention. “Salud integral” (integrated health care) was the issue discussed and recommended, unsolicited, by most of the individuals interviewed. A more integrated approach to prevention, they noted, would reduce the stigma attached to programs and activities and would address the related issues supporting prevention as well as making better use of the skills of personnel. Opportunities for prevention are lost by not addressing the whole body, the whole person, or the whole family. Doctors want to practice medicine, not just attend STIs and HIV; gay men are seen as needing occupational training, not just AIDS prevention support; and, sex workers are viewed as needing pediatric care for their children and STI treatment for their partners. “People are bored with HIV,” noted one doctor in his argument for integrated medicine.

Coordinating Role

FFS staff described a number of types of technical committees within FFS and jointly with NGOs and governmental institutions. Attention has been paid to some areas of collaboration and coordination; however, as a primary objective of FFS as an institution, this is an area needing renewed strategizing and attention. Many opportunities are being missed which could bring NGOs together (both those funded by FFS and others doing related work in the same communities). It was noted that there is “no coordination between NGOs and the state,” and that NGOs feel isolated (aislada).

Professionals noted the competition rather than collaboration between NGOs, an issue that needs addressing by FFS in its coordination role.

No mechanism exists for donor coordination because the various donors do not have systematic meetings, the MOH does not provide leadership in bringing donors together, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) does not function in a mode of “expanded theme groups.” It may be that because there is a relatively large amount of donor money available for HIV in Honduras, stakeholders have thus far overlooked the need to coordinate.

FFS AND THE NGOs

Leadership and Administration

Uniformly, observers of the FFS administration indicated that authoritarianism and conservatism are hallmarks of the leadership. This style of administration affects not only staff but also the interpretation of the FFS mission as well as the design, content and implementation of activities. Additionally, the dismissal of staff and advisers appears to be the sole decision of the director.

Staffing

FFS staff members are talented, energetic, and clearly committed to their work. While the staff is large, little attention has been paid to the incorporation of individuals who could bring a first-hand perspective and experience to the team. No staff appeared to represent people living with AIDS (PWAs), sexual minorities, garifuna, or sex workers. Additionally, since the incorporation of **diversity** and attention to **representation** have been shown to be important in the development and implementation of effective prevention programs, this is a significant shortcoming of staff composition. The fact that all staff members are located in Tegucigalpa is also problematic since this limits routine feedback from other FFS program areas, especially San Pedro Sula. There are numerous ways to place staff in San Pedro Sula without the efforts and costs of establishing other administrative locations.

Numerous staff changes at FFS were reported to be difficult for NGOs, as they needed to continually adjust to new personnel and their methods of collaboration.

Selection and Funding of NGOs

Regarding the topics discussed, staff members reviewed the process by which the 12 NGOs received subcontracts from FFS as well as the subcontract to the IHSS. They described a public contest in February 1998, which resulted in 38 proposals from Tegucigalpa, La Ceiba, Comayagua, and San Pedro Sula. Most of the proposals came from Tegucigalpa; many were weak or from NGOs without sufficient infrastructure. Staff described the evaluation committee that reviewed the proposals and the workshop held with all 38 applicants to clarify procedures and expectations. The evaluations of the projects, the identification of strengths and weaknesses, and the analysis meetings every two months with projects were discussed briefly. While this review was useful, it was not possible to assess evaluation and analysis strategies, which should be reviewed through documentation.

Technical Assistance

FFS has paid close attention to NGO needs regarding the creation of infrastructure, administration and reporting—areas of weakness identified for many of the agencies, especially the newer ones. One agency, in fact, asked for a manual to clarify these issues. It was noted by FFS staff and the NGOs that the NGOs were not used to reporting.

Follow-up and technical assistance workshops for NGOs were reviewed with FFS staff, including sexuality, counseling, EPI–Info, administration, hotlines, and communication as well as proposal preparation. It was not possible to obtain staff impressions or details on these workshops and documentation should be reviewed. NGO participants were appreciative of these workshops and reported that they had been very beneficial. FFS staff also mentioned bringing the NGOs together to work on common themes. Because little was heard of this during NGO visits, the documentation of these types of activities should be reviewed to assist in planning future coordination and exchange.

Technical assistance visits to individual NGOs, especially for administrative support, have been well received and appear to take place on a regular basis to most NGOs, who are pleased with both the content of the visits and the FFS staff. NGOs believe they can also request support when needed and that the frequency of visits seems appropriate.

Technical assistance to FFS is needed in a number of crucial areas; however, it should be noted that FFS staff members recognize the need for technical assistance to better understand MSM and issues of bisexuality in their country. During the meeting with FFS staff members, they requested support in researching bisexuality to inform their interventions. They also requested additional behavioral research to better understand the increasing heterosexual/vertical transmission being discussed with them.

NGOs requested additional information and technical assistance in the following areas:

- HIV updates,
- Illicit drugs,
- Contraceptive technology,
- Anal and oral sex,
- Use and safety of condoms,
- Perinatal transmission, and
- Gender issues.

The Health District requested assistance with research and data collection, especially in the areas of illicit drug use. Also requested was support to assist funds to flow more appropriately at a few of the agencies.

Monitoring

Many of the NGOs visited commented on the monitoring of their projects by FFS staff. They reported being pleased and appreciative of training and support in accounting and management of funding and believed that the best aspect of the monitoring was that it helped them to reach their objectives. However, a number of the agencies commented on the burden of detailed reporting requirements—the micromanagement. The amount of time needed for data collection and reporting was difficult for their limited staffs and, in some cases, limited skills. NGOs also worried that the time frame for projects did not permit time for the most important objectives, such as behavioral change, to be reached.

Sustainability of Supported NGOs

One of the major concerns of some of the NGOs visited was their viability as agencies once FFS funding was over. They did not know if they would be able to retain furniture, computers and other materials once projects were completed. This concern appeared most acute in newer agencies that had no other significant source of support for their infrastructure or activities. Other agencies with additional funding were concerned but looking ahead to continuing projects and collaborating with other institutions, but without any support or information from FFS. This issue undermines these agencies and their staff in an important way. FFS needs to provide clear guidelines for the future as well as to begin to address these concerns with information and efforts to help these agencies obtain other sources of support.

Documentation Center

The FFS Center has been functioning since April 1999, and was said to have 15–20 users a week as well as some calls and requests via electronic mail. Staff members recognized the need for promotion to increase demand. They did not discuss strategies to support and educate users. In this regard, there is an urgent need to have Documentation Center staff trained to assist users in research. These Centers will not reach their full potential if they

remain simply as repositories of information. By refining the role of the Documentation Center in this way, Center staff would have the opportunity to educate users. There are existing models in the region that should be considered and reviewed for guidance in this endeavor. As well, networking appears to be focused upon disaster relief coordinated by Costa Rica, rather than other HIV/AIDS documentation centers in the region. Since they are providing technical assistance to other Centers (Comunidad San Pedro Sula), it would be important for these contacts to be made to strengthen their skills and maintain updated materials of relevance to Honduras and the region.

The Effect of the Reallocation of Funds Due to Hurricane Mitch

One of the common themes at FFS and during the NGO visits was the interruption of activities not only because of the hurricane and the ensuing disaster, but also because of the reallocation of funds. Activities and materials planned had to be discontinued, which created a bad image (mala imagen) for them (according to FFS) as well as resentment from NGOs, some of whom contributed their own financing. Not being able to reprogram 1998 for 1999 was also reported to have been a problem for them. This situation was especially frustrating for the IHSS recipients because, due to a clerical error, 1999 activities were placed in the 1998 budget column and thus funds planned for 1999 were lost as well.

BEHAVIORAL CHANGE COMMUNICATION

Information, Education and Communication (IEC) Materials and Strategies

While there was not time to review individual materials from the youth campaign or those directed at other groups, this area also appears to reflect a lack of creativity and cultural/subcultural appropriateness. In a brief review of plans and materials earlier this year, Shedlin observed that materials were overly conservative, lacked mention of crucial issues, such as anal sex and bisexual MSM behavior, and were geared to educated audiences, that is, the language level and quantity of words versus illustrations was high. FFS staff had little time to discuss materials, but made it clear that while some advances had been achieved, additional materials were needed for sex workers and youth.

Much attention and resources appear to have been directed at youth for the “Identificate” campaign (T-shirts, hats, and buttons) but little to high-risk behavior groups. The need for appropriate sex worker materials is clear. However, in existing materials, sex workers are still addressed only as sex workers and not as women of reproductive age or in their role as mothers and wives. Only one pamphlet that cursorily mentioned illicit drugs was available and only for sex workers. Most NGOs have not been able to produce their own materials and where they have been produced, such as at Liga in San Pedro Sula, their creative learning/prevention games have not been produced nor shared with other programs through FFS efforts. An NGO targeting gay men as well as MSM activity generally has presented many iterations of material directed at gay and MSM communities that reportedly have been rejected by FFS with little appropriate technical

assistance or apparent understanding of communication within these communities. The current version of FFS' booklet is very conservative and therefore does not effectively reach individuals engaging in high-risk MSM behavior. NGOs maintain that they have to accept FFS' changes because FFS is printing the materials. Other agencies also mentioned restrictions on the development of their materials, specifically the inclusion of anal sex.

Equally problematic is the continuing reliance on an approach to materials as complementary to activities and the lack of expertise that would develop materials as part of an integrated learning and dissemination strategy using an experiential approach. Liga has developed games that use materials developed in a learning strategy, but no other examples of strategies were observed. While there are existing materials for an English language/health education teaching strategy, and such a strategy was suggested to a receptive FFS in 1996, no such strategy was developed for the unique Gringuera population with whom CEDEPS works, for whom learning English is a much higher priority than HIV.

Clearly, decision-making about the role and responsibility for the design and development of materials needs attention, especially for high-risk behavior groups. It might be more cost-effective for NGOs working with similar groups to develop materials together and coordinate dissemination strategies than the current situation for high-risk behavior groups, similar to the strategy used for youth-focused materials. Technical assistance is needed for FFS and NGO staff, not only in the design and elaboration of materials, but in developing content and illustrations as well as utilization strategies upon which they are based.

Supplies of prevention and educational materials were low or nonexistent in most of the agencies visited. This was especially obvious at STI reference centers (UMIETS), where there were few posters of any kind, no videotapes in the waiting room, and no materials for clients to take with them. Condoms were being supplied by Dutch donors. Since most reported the fluidity of their clients and the changing populations, having materials on hand for new clients is important.

Counseling

Staff-identified NGO weaknesses included counseling. The need for a more technical approach, better crisis intervention skills and counseling within the prevention process was noted. Another problem was the stigma attached to counseling in general in Honduras. Staff members are working with the university to develop needed criteria for counseling evaluation. (This is a crucial area and these criteria should be carefully evaluated.) Staff also discussed directions that would be useful for the future, including the possibility of the department of psychology approving a rotation for psychology students at FFS. This would be of mutual benefit and probably an extremely cost-beneficial symbiosis.

Many materials are available from Counseling, Testing, Referral and Partner Notification (CTRPN) projects funded by the CDC as well as numerous agencies and PWA groups in the United States. While all issues and guidelines may not be relevant for the Honduran epidemic and populations, these should be made available and used with cultural appropriateness in mind. “Notification registry” was mentioned briefly without an opportunity to explore this important issue. This needs to be followed up, given legal and confidentiality issues and in light of the new law.

While the reviewers did not have the opportunity to assess counseling, based on FFS and NGO staff comments regarding counseling content and the understanding of counseling, the reviewers have serious concerns regarding the need for indepth counseling technical assistance.

STI CONTROL

National Guidelines and Norms

The Honduras Policy for STI/HIV Control and the Honduras Strategic Plan for AIDS Control are well-designed attempts to develop a three-pronged approach to HIV prevention, combining behavioral change communication, STI control and social marketing of condoms.

The STI prevention and control component supported by USAID/Honduras is based upon the implementation of an effective STI diagnosis and treatment system using syndromic approach in government health centers with doctors (CESAMO). Activities under this component include training in syndromic management and counseling, printing of national STI guidelines, counseling guidelines, educational materials, condom distribution through health services, and supervision, monitoring and evaluation.

The national STI syndromic management guidelines were developed in 1997 under the sponsorship of AIDSCAP. The guidelines include the syndromic management of urethral discharge, genital ulcers, vaginal discharge, lower abdominal pain, and inguinal bubo. Flow charts with and without rapid laboratory testing are included. However, there is no distinction of type of services that would apply to the different types of flow charts.

The evaluation team was told that counseling guidelines were in preparation; however, no draft was provided.

Training

A 5–day STI management course has been set up for health care providers of the Ministry of Health. A methodological guideline has been developed for the training. The course includes lectures, small group discussions, role plays, and case studies about STI transmission, control and syndromic approaches, prevention education and behavioral change (including counseling, treatment compliance, condom use and partner notification), monitoring, supervision, evaluation, surveillance, and a post-test evaluation.

The training course is not followed by field experience and continuing supportive supervision.

There is no global analysis of knowledge gained, changes in attitudes and perceived competency, or participant feedback or evaluation of the trainers by participants. Only process indicators of the training have been evaluated (number of courses). Outcome indicators, such as the number of clients being managed appropriately or the number of contacts brought for treatment, are not included.

By August 1999, health personnel from 103 health centers of 5 health regions had been trained in syndromic management (table 1). However, only 30 out of the 103 trained health centers are currently using the syndromic approach.

Table 1: Health Centers Trained in Syndromic Management

Region	Type of Health Center	No. of Health Centers Trained	No. of Health Centers Using Syndromic Approach	Percent
Metropolitan Region	CESAMO	18	18	100
	CESAR	1	1	100
Region No. 2	CESAMO	22	3	14
	CESAR	9	-	-
	HOSPITAL	7	-	-
Region No. 3	CESAMO	13	3	23
	CESAR	-	-	-
	HOSPITAL	1	-	-
Region No. 4	CESAMO	10	-	-
	HOSPITAL	2	1	50
Region No. 6	CESAMO	14	1	7
	HOSPITAL	6	3	50

Source: Dr. Urquía report

STI Services

The implementation of model STI clinics and reference laboratories has not been appropriately and adequately accomplished.

The Ministry of Health in Honduras currently offers STI clinical services in five regions of the country (Region Metropolitana and Regions 2, 3, 4, and 6). The evaluation team had the opportunity to visit the STI reference center (UMIETS) in Tegucigalpa, Comayagua, La Ceiba, and San Pedro Sula and one health center (CESAMO) in Tegucigalpa.

Persons from the general population with STI symptoms attend the health centers (either UMIETS or CESAMO) for syndromic diagnosis and treatment. All patients receive prevention education and behavioral change (including counseling, treatment compliance, condom use, and partner notification). STI services have been integrated appropriately into the public health system in functional terms because it has been combined into a

whole series of operations to bring together otherwise independent administrative functions and mental attitudes with proper provision of health. However, the lack of appropriate infrastructure for the counseling sessions could preclude adequate prevention education and behavioral change. Most of the counselors are not exclusively dedicated to the counseling service; they stop their usual work and look for an available office to provide the counseling. Furthermore, counseling services belong to the Mental Health Division of the MOH, making monitoring and supervision of the services more difficult.

Sex workers attend the UMIETS for routine periodic examination as required to obtain a health certificate. No information was available to assess trends in the number of women who have attended over time. No standardized flow charts are used for medical and laboratory services. FSWs attend the clinics every two weeks for gynecological examination with speculum. Specimen collection for laboratory diagnosis is taken at each of these visits on symptomatic women. These include rapid and delayed diagnostic testing. Rapid diagnostic testing includes Gram stain of an endocervical swab specimen (ordered by the physician only when there is cervical pus and available only in the Las Cruzitas UMIETS); wet mount examination of vaginal secretions for bacterial vaginosis (clue cells), yeast and trichomoniasis; and rapid plasma reagin (RPR) card test for syphilis (during the first visit). Delayed diagnostic testing available within one week following specimen collection includes cervical *N. gonorrhoeae* cultures and HIV ELISA. No pH determination of the vagina, whiff test or diagnosis of *C. trachomatis cervicitis* is available. It was clear that most of the time endocervical samples were not taken appropriately.

A big concern was the personnel training, infrastructure and biosafety of the laboratories at both the UMIETS and the national levels. Lack of adequate equipment, supplies, and backup power was common. In La Ceiba UMIETS, no laboratory technician was available and the equipment was not used for several months.

Attendance at the UMIETS may be stigmatizing, particularly for women other than FSWs. Also, the amount of human and economic resources required make these clinics impractical methods of service provision for the general population. A major thrust of the project should be towards providing access to acceptable and effective routine STI care through general health care services in the public, private and informal sectors. The model STI prevention and care package, using syndromic management, implemented by the project, should be strengthened in the public health sector and expanded to the private and informal sectors.

It is important to recognize that in Latin America, as in other developing settings, an important sector of the market in STI care is captured by the private or informal sector. STI case management should be improved as far as possible at these sources of care. Provision of treatment guidelines, training, availability of information on effective drugs, and information on condom provision and use for these sources of care will need to be addressed in the future.

Prevention of STIs cannot be achieved solely by the provision of care to those individuals who come on their own to health facilities. It will be important to identify and provide treatment to infected individuals who do not spontaneously seek health care. One approach to strengthening the project is the promotion of appropriate health care-seeking behavior. Developing and strengthening the provision of STI care needs to be accompanied by the education of potential service users on the availability and advantages of the services. This should take into account the reasons why many individuals fail to seek early treatment. A local understanding of the reasons for lack of appropriate health care-seeking behavior should be explored by the project.

Treatments

Presumptive treatments are prescribed for genital ulcers (*T. pallidum* and *H. ducreyi* if there are not vesicular lesions), vaginal infection (bacterial vaginosis, based upon vaginal discharge characteristics and clue cells, trichomoniasis, and vulvovaginal candidiasis), cervicitis (*N. gonorrhoeae* and *C. trachomatis* based on the presence of pus seen at the os), and latent syphilis if RPR results and treatment history suggest it. Women with positive gonococcal cultures are treated in their next follow-up visit. Drugs used for treatment include: Benzathine penicillin G, 3 doses of 2.4 million IU for syphilis; Metronidazole, 2 g single dose for bacterial vaginosis or trichomoniasis; Clotrimazole, 500 mg vaginal tablet, single dose for vulvovaginal candidiasis; Spectinomycin, 2g IM, single dose for gonococcal infection; and, Doxycycline 100 mg, twice a day for 7 days for chlamydial infection.

Few problems have been observed in the treatment regimens. Supervised treatments are given for syphilis (first shot), bacterial vaginosis, trichomoniasis and gonococcal infection. However, therapy for bacterial vaginosis and trichomoniasis sometimes is not directly observed because of alcohol consumption. Therapy for gonococcal infection uses IM dose of an expensive drug. The therapy for chlamydial infection is taken home by women because multiple doses are prescribed; this regimen could lead to slow or no decrease of the prevalence of this disease if the patients do not complete the therapy.

The Ministry of Health provides STI medications at no cost. Many of the health care providers interviewed had concerns regarding the sustainability of the program as many more patients could seek STI diagnosis and treatment through MOH services when STI services become more accessible and acceptable. The establishment of rotating funds for STI drugs is a strategy that could assure sustainability of the STI clinics. The USAID Mission in Bolivia has implemented this strategy and is an excellent example to follow.

Referral System

Current UMIETS would serve as reference/referral centers. Where routine STI care is provided by the general health services, there will be a proportion of patients, probably between 5–10 percent, who will require referral for specialist care. Decentralization of

these referral services to all regions in Honduras and establishment of a referral system is another important output for the future.

A big gap in the current program is the referral system between the NGOs and STI services. Most of the NGOs have trained peer educators to provide information, face-to-face education, and condom distribution. However, there is not a unique system of referral to MOH services. A few NGOs have developed formats to refer patients to the clinics but there is no monitorization of the system. A standardized methodology for referral is necessary.

Monitoring and Supervision

Although each clinic provides the regional and national levels with a monthly report that provides information about the level of utilization, it does not allow monitoring of implementation (adequacy of supplies, performance of service providers) by comparing actual progress to expenditures. Instead, this process focuses only on information about patterns in the frequency and distribution of diseases. Methods to monitor supplies are being tested; this information would ensure that work is progressing as planned and anticipated or would detect problems in the implementation of activities.

The next steps for the management and supervision of these clinics/laboratories are to define and use key indicators for monitoring and evaluating the progress of the program, other than the current ones.

A supervising system to enable health providers to provide feedback, discuss problems and receive support has not been appropriately implemented. A national supervision team has been formed but the supervision guide is still in development and the number of supervisions completed thus far is relatively small.

CONDOM SOCIAL MARKETING

Condom Demand, Behavior and Use

Recent national surveys and samples of high-risk subpopulations conducted by the Honduras Ministry of Health between 1996 and 1999 clearly show that Honduras does not have a condom use culture, either for family planning or HIV/AIDS prevention. Key survey findings related to this evaluation are summarized below.

Condom Use for Family Planning

The total fertility rate (TFR) is very high in Honduras, at about 3.5 in urban areas and 6.3 in the countryside. Half of the women in union (WIU) report current contraceptive use, but sterilization (18 percent), pills (10 percent), and intrauterine devices (IUDs) (9 percent) are preferred; only 3 percent use condoms. Despite almost universal knowledge of condoms, only 18 percent of WIU had ever used a condom for family planning.

Reasons for non-use of condoms varied but lack of knowledge of condoms, the cost of the product and difficult access to condoms were insignificant.¹

Virtually all men (95 percent) know about condoms but only 11 percent are current users. Knowledge of a source of supply does not appear to be a constraint because about 85 percent of men in urban areas and 70 percent in rural areas know where to obtain condoms. Most (77 percent) of the male condom users obtain them in the private sector (pharmacies, 48 percent) and the balance (23 percent) obtain them from the public sector. It is interesting to note that even a third (33 percent) of low-income men who use condoms buy them in pharmacies, and 12 percent of high-income men obtain condoms for free from the public sector. Across all income levels, men who use condoms report that they get them from friends (low income [28 percent], middle income [17 percent] and high income [16 percent]), which suggests that condoms may not always be accessible in those places and at those times when they are needed for protection against HIV and other STIs.²

Of those men who had used condoms in the past but were not current users, several reasons were reported for non-use: most (72 percent) reported that they were using other family planning methods, were not sexually active or only had one partner. Only 1.5 percent reported that condoms were inconvenient to obtain; cost was not an issue. Even in rural areas, only 2.4 percent of the men who were not using condoms reported difficulty in obtaining them. And, among the men in the national survey who use condoms and buy them, only 16 percent believe that they are expensive.³

Condom Use for HIV/STI Prevention

Respondents in several small studies by the Honduran Ministry of Health between 1996 and 1998 reported a high level of knowledge of AIDS and its sexual transmission, but there was mixed knowledge of the value of condom use to avoid infection. Several of the smaller studies among high-risk groups suggested that risky sexual behavior was not uncommon; that men are having unprotected sex with high-risk partners, their own wives and/or other regular partners; and, that consistent condom use was limited. Unfortunately, these smaller studies did not provide any information to explain why condom use was low.

Relatively few Honduran women in the general population know that HIV infection can be avoided by using condoms (urban—43 percent, rural—24 percent), but two thirds of

¹ *Honduras, Encuesta Nacional de Epidemiología y Salud Familiar, Informe Final*, Ministerio de Salud, Tegucigalpa, Noviembre, 1996.

² *Honduras, Encuesta Nacional de Salud Masculin, Informe Final*, Ministerio de Salud, Tegucigalpa, Diciembre 1996.

³ *Estudio Sero-epidemiológica de Sifilis, Hepatitis B y VIH en Hombres que Tienen Relaciones con Otros Hombres de la Ciudades de Tegucigalpa y San Pedro Sula*, Ministerio de Salud, Tegucigalpa, Mayo 1999 (b).

women, aged 15–44, who knew about condoms and had sexual experience reported that they would use a condom if their partner requested it.⁴

Men also have limited knowledge—only two thirds of urban men and half of rural men knew that condoms could be used to avoid HIV infection. The data also suggest that condom use by men may be low because most (89 percent) of the men with sexual experience believed they were at little or no personal risk of getting AIDS. Most men (81 percent) who knew about condoms said they would use them if their partner asked them to use one.⁵

Risky sexual practices are not uncommon in Honduras; in a national sample, 43 percent of all men with sexual experience reported that they had had sex with a prostitute.⁶ Only 62 percent of male sex workers always used a condom with a new partner, despite the fact that virtually all knew about HIV/AIDS, believed that they were at risk of getting AIDS, knew that HIV could be transmitted by sex, and know that HIV infection can be avoided by using a condom.⁷ Most (91 percent) respondents in a survey of urban truck drivers did not use condoms with their regular partner despite the fact that nearly one in five (18 percent) reported sex with a sex worker and 40 percent of those sex worker contacts were without condoms. These data imply an overlap of unprotected sex from sex workers to wives and regular partners. Of concern is that 18 percent of those truck drivers who had sex in the 6 months prior to the survey reported anal intercourse with women, an extraordinarily risky behavior that provides a pathway for the HIV virus.⁸

A Ministry of Health study of street-based sex workers in five cities in the spring of 1998 found a 10 percent HIV rate overall, while 15 percent tested positive for syphilis and 37 percent tested positive for one or more STIs other than syphilis. Virtually all sex workers (99 percent) knew about AIDS and most sex workers (80 percent) reported using condoms. However, only 28 percent of sex workers always used condoms with known clients or regular partners and 27 percent did not use a condom in their last sexual encounter. Risky sex was not uncommon as 11 percent reported they engaged in anal intercourse.⁹

There were similar findings in a study of night watchmen in Tegucigalpa and San Pedro Sula. Nearly all had heard of HIV/AIDS (Tegucigalpa—94 percent, San Pedro Sula—98 percent). Most knew that HIV can be transmitted by sex (Tegucigalpa—87 percent, San Pedro Sula—96 percent) and that it can be avoided by using a condom (Tegucigalpa—60 percent, San Pedro Sula—85 percent). However, condom use was low. Only 3 percent always used a condom with their regular partner and only a fourth (26 percent) always used a condom with a sex worker. Risky sexual practices were not uncommon. In the 6

⁴ Ministerio de Salud, Noviembre 1996.

⁵ Ministerio de Salud, Diciembre 1996.

⁶ Ibid.

⁷ Ministerio de Salud, Mayo 1999 (b).

⁸ Ministerio de Salud, Mayo 1999 (a).

⁹ Ministerio de Salud, Mayo 1999 (d).

months before the survey, 18–20 percent reported having sex with a sex worker; among those night watchmen who reported having sex in the past 6 months, 17 percent had anal sex with women and 11 percent had anal sex with other men.¹⁰

A 1997 study of sex workers in Central America, including 300 sex workers in bordellos, bars, cantinas, taverns, and on the street in San Pedro Sula, found that Honduran sex workers reported the highest condom use among sex workers in Central America. In fact, virtually all (97 percent) of the Honduran sex workers had a condom with them at the time of the interview. However, only 41 percent knew how to properly use a condom and a third (37 percent) of the Honduran sex workers said that they did not always use condoms with their clients. Although no sex workers reported anal intercourse without a condom, 82 percent did accept that practice. The reason for non-use of condoms was not economic because most Honduran sex workers said that condoms were not expensive and most (87 percent) thought they were inexpensive (*barratos*).¹¹

Branded product advertising alone will not lead to increased use of condoms for HIV/AIDS prevention in Honduras. Basic behavior change communication is required to create a condom use culture. Since condom use for family planning is marginal, there should be little concern that condoms will be stigmatized as an AIDS product and suffer negative impact on their acceptability for contraception. Knowledge of condoms, price and accessibility were not reported as constraints to use; both men and women reported that they would use a condom if their partner were to ask which suggests that information, education and communication (IEC) efforts could be effective. There is a need for more effective education and information in Honduras about the necessity of using condoms for dual protection, reduced risky sex, consistent condom use with high-risk (sex workers and men) non-regular partners, the effectiveness of condoms for preventing HIV and STI infection, and proper condom use. The institutions developing these messages need to also include the high-risk persons in the program.

Condom Price and Accessibility

A June–July 1999 study by a commercial marketing firm in Honduras looked at condom availability in four cities (table 2): Tegucigalpa, San Pedro Sula, Choluteca, and Puerto Cortes for the Pan-American Social Marketing Organization (PASMO). Within those cities, the study sampled 1,640 locations that might sell condoms, grouped into three types of retail sales points: traditional (pharmacies, convenience stores, supermarkets, and gasolineras (convenience stores attached to stations that sell gasoline); clinics (public, NGO and private); and, nontraditional sales points (discotheques, night clubs, motels, bars and cantinas, bordellos usually attached to bars, and massage parlors).¹²

¹⁰ Ministerio de Salud, Mayo 1999 (e).

¹¹ Johnny Madrigal-Pana, *El Condom y los Trabajadores Comerciales del Sexo: Encuesta en America Central*, Instituto Latinoamericano de Prevencion y Educacion en Salud (ILPES), San Jose, Costa Rica, Mayo 1998.

¹² Jorge Martin Frech, *Report de Resultados Finales del Estudio Chequeo de Distribucion—Condomes—Honduras, Mercaplan, San Pedro Sula, Honduras, July 1999.*

Table 2: Condom Distribution in Urban Honduras, 1999
(Percentages)

	Total	Pharmacy	Convenience Store	Super-Market	Gasolinera	Clinic	Night Club	Motel	Bar	Bordello
Sell Condoms	28.3	95.2	21.2	57.9	55.3	7.5	0.0	13.7	1.3	17.0
Reason for not selling										
No demand	40.7	15.4	47.0	46.9	32.4	37.8	40.7	20.8	51.1	15.9
Distributor never visited	26.4	0.0	36.1	40.6	29.4	6.1	29.6	15.0	32.6	6.8
No market	13.4	15.4	0.0	0.0	14.7	17.3	18.5	36.3	4.2	59.1
Closing Time										
5–9 p.m.	73.7	92.8	85.5	95.5	4.8	62.5	0.0	2.8	33.3	11.1
10 p.m. to 1 a.m.	6.9	2.3	8.1	4.5	16.7	0.0	0.0	16.7	33.3	44.4
Open 24 hours	13.8	1.2	3.2	0.0	78.6	25.0	0.0	66.7	0.0	0.0

Source: Jorge Martin Frech, July 1999.

Nearly all of the pharmacies (95 percent) sold condoms, as did many of the supermarkets (58 percent) and gasolineras (55 percent). Most people in Honduras who buy condoms purchase them in pharmacies (see table 3) where the PASMO study reports a good selection and distribution of prices: 11 percent of condom sales in pharmacies are at less than 7.10 Lps., 19 percent sell at 7.11–14.20 Lps; 36 percent sell at 14.21–21.30 Lps; 18 percent sell at 21.3–28.40 Lps., and 15 percent sell for more than 28.4 Lps.

Table 3: Source of Supply for Women in Union, Aged 15–44, Who Use Modern Contraceptives by Method
(Percentages)

	Sterilize	Pill	IUD	Condom	Injectable	TOTAL
PUBLIC	34.8	19.1	59.0	31.5	1.4	34.8
Hospital MSP	26.7	1.0	10.4	5.4	1.4	14.6
CESAMO	0.0	11.4	28.9	18.1	0.0	10.3
CESAR	0.0	5.8	1.2	5.9	0.0	2.1
Hospital IHSS	8.1	0.9	18.5	2.1	0.0	7.8
PRIVATE	64.5	80.5	40.9	62.5	95.6	64.4
Pharmacy	0.0	30.5	0.0	47.2	63.0	13.0
MD/Clinic	16.4	1.6	16.3	0.4	27.8	11.8
ASHONPLAFA Clinic	48.1	1.8	24.4	0.5	4.8	26.8
ASHONPLAFA Puesto	0.0	39.9	0.0	5.6	0.0	10.2
Other (groceries, etc.)	0.0	6.7	0.2	8.8	0.0	2.6
UNKNOWN	0.7	0.5	0.2	6.0	3.0	0.9
TOTAL	800	491	404	150	43	1,896

Source: Ministerio de Salud, Noviembre 1996

The PASMO study argues that pharmacies and supermarkets close early (between 5–9 p.m.) and do not provide access to condoms when persons at risk need them. Although gasolineras are open 24 hours a day, one must be relatively well off to buy condoms there because most customers would be expected to arrive by car and they tend to sell the more

expensive brands. The PASMO study further argues that most of the places where casual sex is likely to occur (night clubs, bars, motels, and bordellos) operate when more traditional retail outlets are closed or do not sell condoms and that there is a need for an aggressive social marketing program in those locations. However, conflicting information was provided from at least one commercial private sector distributor who promotes condoms in nightclubs, bars, motels and discotheques. Moreover, the MOH reports that it provides free condoms to motels and club owners. In addition, if the primary sexual encounters of club, bar and motel customers are with sex workers, the studies cited suggest that sex workers appear to have condoms, report that they use them (at least with new customers), and get them at their place of work.

It is believed that much of the casual or nonregular partner sex in Honduras is not commercial but transactional, in which men meet women, sometimes in bars and clubs, and provide them with gifts in exchange for sex. In any case, a better understanding of when and where people have sex and under what conditions they might need condoms is needed before assumptions are made about the populations and situations to be targeted by programs. A study of sexual behavior in Honduras would be very useful for determining the level of need for a condom social marketing program in bars, clubs and bordellos, when more traditional retail outlets are closed.

Table 4: Commercial Sex Workers in Honduras and Central America
(Percentages)

	Honduras	Central America
CONDOM USE		
Ever had vaginal sex without using a condom in past 12 months	37.3	57.9
Ever had anal sex without using a condom in past 12 months	0	7.7
Ever experienced ejaculation in the mouth without using a condom in past 12 months	1.0	6.4
Always use a condom with client	89.9	66.1
Always use a condom with current regular partner	22.4	21.0
Spontaneously mentioned reason to use condom with client:		
Prevent STIs	86.0	89.1
Prevent AIDS	98.7	73.9
Hygiene	1.7	12.8
Prevent pregnancy	45.2	31.5
CONDOM SUPPLY		
Place of work (motel, bordello)	40.7	21.6
NGO	32.0	27.1
Bar/discotheque	21.2	5.8
Health center	3.4	13.0
Private pharmacy	2.0	23.7
Other	0.7	8.8
BARRIERS TO CONDOM USE		
Never felt embarrassed to buy	76.7	73.8
Condoms are expensive	1.7	17.4
Percentage of sex workers carrying a condom	96.7	60.2
Knowledge of correct use	41.0	29.6

Source: Madrigal-Pana, 1998.

The Condom Market

In an estimated total annual market of 9.4 million condoms, the primary supplier is the public sector (MOH), which will distribute 5.6 million free condoms (60 percent of the total), in 1999 through 1,050 health posts. (See table 5, which is based on interviews conducted for this evaluation in September 1999.)

Table 5: The Honduras Condom Market, 1999

	USAID Donation In 1999	Purpose	1999 Sales/ Distribution	Percent	Condoms in Stock (end 1999)
PUBLIC SECTOR					
MOH No Logo; no cost	0	Free distribution in 1,050 health posts	300,000 ¹	3.2	0
MOH No Logo; no cost	5,282,000	Free distribution in 1,050 health posts	5,282,000 ²	56.5	0
Subtotal	5,282,000		5,582,000	59.7	0
NGO SOCIAL MARKETING					
FFS No Logo; no cost	1,000,000	Free distribution in 950 NGO outlets	1,504,000 ³	16.1	0
FFS Lovers Plus; no cost	1,002,240	Free distribution in 950 NGO outlets	1,002,240	10.7	0
ASHONPLAFA No Logo; 0.85 Lps. each	504,000	Sold in 1,640 community-based outlets	330,000 ⁴	3.5	164,000
ASHONPLAFA Guardian; 2.83 Lps. each	1,002,000	Sold in retail outlets (6)	496,000 ⁵	5.3	506,000
Subtotal	3,508,240		3,332,240	35.7	670,000
PRIVATE SECTOR					
DUREX (5 brands); 10–11 Lps. each		Commercial sale	180,000	1.9	
ANSEL (7 brands); 4.5–5.5 Lps. each		Commercial sale	100,000	1.1	
ASHONPLAFA Piel; 7 Lps. each		Commercial sale	112,000 ⁷	1.2	
Other Private Sector (11) brands; 5–10 Lps. each		Commercial sale	40,000 ⁸	0.4	
Subtotal			432,000	4.6	
TOTAL CONDOM MARKET			9,346,240	100.0	

¹ Purchased by the Ministry of Health using United Nations Population Fund (UNFPA) resources.

² Includes 504,000 donated by USAID for Family Planning and 4,778,000 for AIDS.

³ Includes 504,000 donated by USAID in FY 1998.

⁴ Estimate based on sales of 165,296 between January and June 1999.

⁵ Estimate based on sales of 248,000 between January and June 1999.

⁶ There are an estimated 450–600 pharmacies in Honduras where condoms are sold.

⁷ Estimate based on sales of 56,000 between January and June 1999.

⁸ Estimate: majority is at the higher end of the price range.

The private social sector (NGOs), dominated by ASHONPLAFA and FFS, will distribute and sell another 3.3 million subsidized condoms in 1999 (36 percent of the total) through nearly 3,000 outlets, ranging from small NGO community-based nontraditional locations to large pharmacies. Finally, the private commercial sector will sell an estimated 432,000 condoms (4–5 percent of the total market), mostly through pharmacies, supermarkets and

gasolineras in 1999. It is striking to note that all but 732,000 of the estimated 9.3 million condoms sold in 1999 were donated by USAID or by a USAID–affiliated program (e.g., 1,002,240 Lovers Plus condoms were donated to FFS by the USAID–sponsored PASMO).

Condom Brands and Prices

In 1998, there were only 7 or 8 condom brands on the market in Honduras, but there were 24 by late 1999. However, there are not 24 separate companies selling condoms. In fact, five major condom distributors were identified in Honduras and several of them have multiple branded products. For example, Solis Distribution Company represents the London International Group and distributes four of its Durex brand condoms (Tropical, Extrafuerte, Confort, and Sensitivo); and Rivera y Compania represents the American condom manufacturer, Ansel, and distributes seven of its brands (Nuda, Prime, Rough Rider, Stimula, Sultan, Erotica, and Bareback). These condoms sell at a broad range of prices, providing the consumer who wants to use this product with many options, ranging from 2.8 Lps. per unit to 10.7 Lps. per unit.

Table 6: Condom Brands and Prices, July 1999
(Source: ASHONPLAFA, September 1999)

BRAND	Retail Price (Lps.)	Unit Price (Lps.)	Unit Price (US \$)	Premium (Lps.)
Tropical (Durex)	32.00	10.7	.75	2
Extrafuerte (Durex)	32.00	10.7	.75	2
Confort (Durex)	32.00	10.7	.75	2
Sensitivo (Durex)	32.00	10.7	.75	2
Preventor Dotted	27.67	9.2	.64	10
SICO	26.00	8.7	.61	3
Piel (ASHONPLAFA)	20.00	6.7	.47	2
Rough Rider (Ansel)	18.05	6.0	.42	2
Masculan	18.00	6.0	.42	3
Preventor	16.00	5.3	.37	10
Preventor Fibra Vegetal	16.00	5.3	.37	10
Control	16.00	5.3	.37	-
Control Sento	31.10	5.2	.36	-
Control Forte	31.10	5.2	.36	-
Control Fantasy	31.10	5.2	.36	-
Control Nature	31.10	5.2	.36	-
Nuda (Ansel)	15.29	5.1	.36	1
Stimula (Ansel)	14.55	4.9	.34	2
Bareback (Ansel)	14.00	4.7	.33	2
Prime (Ansel)	13.50	4.5	.31	2
Erotica (Ansel)	13.46	4.5	.31	2
Sultan (Ansel)	12.00	4.0	.29	1
Jontex Anatomico	3.50	3.5	.24	-
Guardian	8.50	2.8	.19	2

Premium Payments by Distributors

In addition to listing retail prices for condom brands on the market in Honduras, table 6 also includes data on premiums that distributors pay to the retailer for each package sold.

For example, the distributor of Preventer condoms pays a 10 Lps. premium for all three brands. Because the standard markup at the retail level is 25–33 percent, the retailer might buy the condoms from the distributor for 12 Lps. and sell them for 16 Lps. If a 10 Lps. premium is added, the retailer makes 14 Lps. on the sale of each package. However, if a distributor sells a Preventer condom package to a retailer for 12 Lps. and returns a 10 Lps. premium to gain market share, the distributor only makes 2 Lps. per package. This is clearly not a sustainable practice. The evaluation team observed an example of the impact of premiums during a visit to a large pharmacy in central Tegucigalpa. The pharmacy was selling Durex at 32 Lps./3, Preventer at 28.5 Lps./3, and Guardian at 8.5 Lps./3. When asked which condom was the best product, the sales lady recommended Preventer, which provides a 10 Lps. premium compared with the 2 Lps. premium offered by Guardian and Durex. In fact, ASHONPLAFA's Guardian condom, manufactured in the United States and provided by USAID, was the best value.

Findings on Major Condom Suppliers

Interviews were held with representatives of the five largest condom suppliers, which provide virtually all of the condoms in Honduras (table 4), including the public sector (Ministry of Health), the private social sector (ASHONPLAFA and FFS), and the private commercial sector (the Solis and the Rivera y Compania distribution companies and ASHONPLAFA). Key findings are summarized below.

The Public Sector

Ministry of Health

The Ministry of Health received 5,282,000 No Logo condoms from USAID in 1999 and purchased another 300,000 using UNFPA funds. These condoms are distributed for free in 1,050 health posts throughout Honduras. Ministry of Health officials made the following observations:

- IEC and advertising campaigns on the use of condoms for STI/HIV prevention must be increased.
- Studies are needed on the willingness to pay and current prices.
- Health Center hours should be expanded to increase accessibility; in most clinics, condoms are not dispensed after 2 p.m.
- The need to spend 2–3 hours at many clinics to be examined and obtain a prescription in order to get condoms should be reduced or eliminated. The four HIV/AIDS posts where condoms can be obtained in 5 minutes could serve as a model.
- The MOH should reinvigorate its program to distribute condoms to sex motels and night clubs.
- The MOH believes that there is a need for a new social marketed condom brand for HIV/AIDS. MOH wanted PASMO to bring its VIVE condom program to Honduras and would support the registration of the VIVE condom.

The MOH did not understand why USAID would not approve the launch of the PASMO program in Honduras.

- The MOH would like to introduce quality controls on condom imports to Honduras and strengthen the registration requirements. Virtually no condom brands are now registered in Honduras. The law only requires that a new brand be registered with the Ministry of Economics, which only involves a brand name search. There are no laws that require condoms to be registered with the Ministry of Health and there are no quality control requirements or quality tests.

The Private Sector (NGOs)

ASHONPLAFA

ASHONPLAFA, the Honduras International Planned Parenthood Federation (IPPF) affiliate, received 504,000 No Logo condoms from USAID in 1999, which they sell for 0.85 Lps. each through 1,640 rural community-based outlets serviced by 19 ASHONPLAFA representatives who visit the rural areas. ASHONPLAFA also received 1,002,000 condoms from USAID, which it packages and markets under the brand Guardian and which sell (retail) for 8.50 Lps./3-pack or 2.83 Lps. each. In addition to its subsidized, social marketing products, ASHONPLAFA also purchases, packages and markets its commercial Piel brand condoms, which sell for 7 Lps. each. ASHONPLAFA markets its branded products through five private sector distributors, mostly to pharmacies. ASHONPLAFA also employs two full-time sales persons on staff.

ASHONPLAFA's condom sales dropped in 1999 as competition developed from USAID-donated condoms distributed for free by FFS and competition increased from the commercial sector (see table 7). ASHONPLAFA's sales of Piel condoms can be expected to continue to decline as long as the commercial sector is providing premiums to retailers to gain market share. ASHONPLAFA's sales of Guardian condoms will also continue to decline as long as FFS is receiving and distributing free branded condoms, especially high-image packages, such as Lovers Plus. The ASHONPLAFA No Logo donated by USAID and sold at 0.85 Lps. each, also suffered a setback in 1999. Sales of this product cannot be expected to increase as long as the Ministry of Health and FFS are distributing the same No Logo condoms for free.

It appears that ASHONPLAFA is devoting a great deal of time and effort to the condom business, which is an insignificant family planning method in Honduras. But ASHONPLAFA will fight to protect its condom business as long as USAID continues to give it free or subsidized commodities and maintains its sustainability requirements. The sale of USAID-donated condoms is a cash source with little real expense beyond the opportunity cost of management. Therefore, despite declining sales, it is realistic to expect that ASHONPLAFA will continue to invest significant energy to arrest the slide of its share of the condom market. For example, if PASMO brought the VIVE condom to

Honduras, ASHONPLAFA would probably reduce the price of its Guardian brand. ASHONPLAFA is now experiencing sales loss from its commercial brand Piel due to cutthroat competition from Preventer and is preparing to reintroduce its inactive brand Protektor to compete. ASHONPLAFA plans to launch Protektor at 16 Lps./3-pack (i.e., the same price as Preventer) and plans to match the 10 Lps. premium that the Preventer distributor gives to pharmacies for each package they sell.

Table 7: ASHONPLAFA Condom Sales, 1998–1999

PRODUCT	1998 Sales	1999 Sales 1/1–6/30/99	Estimated Sales 1999	Change 1998–1999
No Logo for social marketing community-based program; 0.85 Lps. each	372,000	165,296	330,000	- 11 %
Guardian social marketing commercial outlets distribution; 2.83 Lps. each	866,016	248,000	496,000	- 43 %
Piel commercial; not provided by USAID; 6.7 Lps. each	280,944	56,000	112,000	- 60 %

Source: ASHONPLAFA, September 1999

What is needed in Honduras is greater use of condoms for HIV/AIDS prevention. However, ASHONPLAFA is reluctant to provide condom promotion services, believing that serving MSM and sex workers in its facilities is inconsistent with its mission of providing “family planning in family friendly clinics.”

Fundacion Fomento en Salud (FFS)

FFS is a USAID–supported umbrella organization working with 14 NGOs that distribute free condoms in 975 places in 4 cities: Comayagua, San Pedro Sula, Tegucigalpa, and La Ceiba. In 1999, FFS will distribute more than 2.5 million free condoms in Honduras, including 1.5 million No Logo condoms provided by USAID, and 1 million Lovers Plus condoms, donated by the Population Services International (PSI) PASMO program. FFS’ costs are paid by USAID and FFS in turn supports NGOs, which distribute these free condoms and literature in brothels, bars, universities, NGO offices, mercados, beauty shops, and factories in association with the Honduran Social Security Administration.

FFS reports needing continued operations funding from USAID, free condoms, and funds to hire full-time staff for its NGO associates so they can begin to systematically visit the distribution points they service. FFS is in the process of registering Lovers Plus in Honduras and wants USAID to continue to provide them for free to FFS because Lovers Plus is the condom of choice among sex workers and is perceived to be a higher quality and less greasy product than ASHONPLAFA’s Guardian condom. FFS would also like to work with PASMO on the VIVE condom regional brand because it believes that PASMO would provide them with free condoms, as well as funds and technical assistance for marketing, advertising, and NGO development and resources to help FFS build its own organization. However, FFS does not appear to actively reach out to high-

risk groups in Honduras, such as MSM, and does not appear to have the capacity to manage a national HIV/AIDS condom social marketing program.

The Private Commercial Sector

The commercial sector in Honduras is small (annual sales are estimated at 430,000 units) and is currently either saturated or only growing very slowly. Three distributors dominate the commercial condom market: Solis, Rivera y Compania, and ASHONPLAFA (see table 4). The commercial condom market in Honduras is in turmoil and 24 brands are competing to become established. Distributors are offering cutthroat premiums to capture market share; for example, Preventer, a Belgian condom, is being sold at 16 Lps./3 with a 10 Lps. premium. This cannot continue. Some brands will drop out of the market in the coming year and the price of the surviving condom brands in the commercial sector will most likely increase. Between January 1998 and January 1999, there was a 3.9 percent devaluation, and a further 5.4 percent devaluation between January 1999 and October 1999. Retail condom prices will also increase if currency devaluation continues because all condoms are imported.

SOLIS Distribution Company

Solis is a consumer marketing company distributing 2,000 products, including the Durex line of four condom brands, in pharmacies, supermarkets and gasolineras. Solis also promotes Durex condoms in straight and gay nightclubs, bars and (sex) motels but it does not believe there is a primary market in those locations. The owners will not sell Durex condoms because the profit margins are too narrow in comparison with Guardian condoms, which they buy at 8.5 Lps/3 and sell for 20 Lps. each. The owners also receive free condoms from the MOH and sell them.

Durex is a high-quality and high-price product that sells for 30–32 Lps/3 to a middle- and upper-class market. The marketing message is safety and the best quality product. Solis is not interested in launching a low-price condom at this time because the return is higher on a higher priced product and it needs to support a total team, which includes display men, promoters, salesmen, professional marketing staff, consultants and professional full-time management.

Durex was introduced in March 1997; sales are small but growing and are now about 15,000 per month. Sales are increasing because Solis salesmen have been taught how to sell condoms without embarrassment. Solis also believes that the growing awareness of AIDS in Honduras is helping to increase the market for condoms.

Solis believes that a new low-cost condom could be successfully introduced in the commercial private sector and targeted to HIV/AIDS if it were properly marketed and if it were not challenged by a good quality, highly subsidized product, such as the FFS Lovers Plus condom or the ASHONPLAFA Guardian condom. In fact, Solis would be interested in working with USAID on this project, and subject to the approval of the

London International Group, would be willing to do this pro bono if they could cover their costs.

Rivera y Compania Distribution Company

Rivera y Compania, a national company distributing drugs and other consumer products, also distributes seven Ansel mid-range condoms that retail from 14–18 Lps/3-pack and is selling about 100,000 condoms annually. Its market is primarily in pharmacies (450–600) and a few supermarkets which are visited by a team of 14 full-time salesmen who visit all of the sales points each week. The market has grown in the past three years and continues to grow slowly.

Rivera y Compania believes that the commercial private sector could sell a lower price condom for HIV/AIDS if there were proper promotion. It would be interested in working with PASMO on the VIVE condom and believes that it could be successful if it came on the market with a sufficient premium.

USAID's Regional HIV/AIDS Condom Social Marketing Program

In response to the HIV/AIDS epidemic, USAID/G-CAP supports a seven-year (FY 1997–2003) regional social marketing program with Population Services International (PSI) to increase the accessibility of affordable condoms throughout Central America. PSI's implementing organization, PASMO, markets and sells the subsidized, high-quality VIVE brand condom and also develops parallel behavior change communications programs to increase demand for condoms and their correct use. The PASMO program works through importing and distribution agreements with commercial partners in each country and supports them by advertising VIVE condoms; it also produces IEC messages to promote safe and effective condom use. PASMO also links NGOs with commercial distributors to ensure that persons at high risk of HIV infection (sex workers and their clients, truckers, MSM) in high-risk locations (truck stops, bars, night clubs, bordellos, on the street) have access to good quality, affordable condoms. The costs for the PASMO program in each country are born completely by the USAID regional project, including management, promotion, IEC, commodities, and technical assistance and training, as needed, to local partners.

Discussion

The objective of a condom social marketing program is to increase condom use by increasing the target market consumers' demand for the product and by increasing the consumer's access to a good quality product at an affordable price.

However, there is relatively little demand for condoms in Honduras, either for family planning or for HIV/AIDS prevention, but the constraints do not appear to be price, access or product quality. Good-quality condoms are available across a broad price range (from no cost to 32 Lps./3-pack). People trade time for money and up to a third of poor

people buy condoms in pharmacies, presumably to avoid waiting in public health clinics for up to 3 hours to get them for free. There are reports of up to 3,000 condom outlets around Honduras, including public health posts, NGO community-based outlets, and private commercial sector sales points, including pharmacies, supermarkets, and convenience stores. It would be a good idea to take a sample of the outlets, especially the health posts and NGO sales points, to confirm that good quality and affordable condoms are actually in place. Condoms are also sold in nontraditional outlets, including motels, bars and nightclubs, although there is some evidence suggesting a need to make condoms more available and more affordable in these locations. A preliminary step would be to undertake a study of sexual behavior in Honduras, especially addressing the questions of casual transactional sex and the crossover between high-risk sex and regular partners in the general population. Finally, since virtually all the condoms sold or distributed in Honduras are manufactured in Europe and the United States, there should be limited issues of product quality. However, condom quality could be affected by improper logistics management from the point of import to the point of sale, and this question should be investigated.

Knowledge of condoms' effectiveness for AIDS prevention and increased condom use are issues that need to be addressed and which cannot be resolved by a condom social marketing program that is limited to selling a subsidized, branded product. In an environment where risky sex is not uncommon, education and behavior change interventions are needed if consistent and proper condom use for HIV/AIDS and STI prevention is to become the norm. The most effective way to address these issues is to develop a mutually supporting targeted condom marketing and behavior change program, supported by a broadly focused IEC program.

Since there is limited demand for condoms for family planning and those needs appear to be met, the key goal of a USAID condom program in Honduras should be to meet the critical HIV/AIDS public health issue. To do so requires an implementing agency that understands and is prepared to resolve problems and is willing to reach out to and embrace the populations at risk. The implementing agency must also have the internal capacity, experience and leadership needed to carry out a successful HIV/AIDS program. Neither FFS nor ASHONPLAFA currently meet these criteria.

A final question is the issue of sustainability. In 1999, all but 732,000 of the 9.3 million condoms sold in Honduras were provided for free by USAID or by a USAID program. If current program levels continue, the MOH will need 5.3 million condoms in the year 2000, and the USAID-funded NGOs, FFS and ASHONPLAFA, will need a net of 2.7 million condoms (see table 4). However, USAID/Honduras currently projects that it will only have sufficient FY 2000 funds to purchase 5 million condoms, leaving a gap of 3 million condoms per year. It seems that the current annual level of USAID condom donations is not sustainable. Therefore, USAID needs to make some choices about the continued level of commodity support that it will provide to its partners and how to best target its condom donations for contraception and HIV/AIDS prevention.

In Honduras, where the overall contraceptive prevalence rate for condoms is 2 percent and the HIV/AIDS prevalence is the highest in Central America, a primary goal of the Mission's condom donations should be public health rather than family planning. As the Mission decides which partners to continue to support with donated condoms, it should also consider the impacts that conflicting sustainability objectives can have on implementing agencies. For example, the 2.5 million free condoms distributed by FFS in 1999 appear to have captured a portion of ASHONPLAFA's market share. Declining condom sales threaten ASHONPLAFA's sustainability objectives by decreasing cash income and by requiring increased management time and resources that might be better devoted to ASHONPLAFA's primary business, which is family planning. Although a full-service, family planning service provider must have condoms available, it is estimated that ASHONPLAFA's condom business could neither significantly affect the TFR in Honduras nor contribute much to the financial viability of the NGO. It is estimated that at current sales levels, annual income from donated condom sales would be less than \$75,000, and this profit would have a much lower net amount if all associated management, sales and personnel costs were allocated to the condom component of ASHONPLAFA's business.

Establishment of a Condom Social Marketing Program in Honduras that Targets HIV/AIDS

It is necessary to establish a condom social marketing program in Honduras. ASHONPLAFA's primary objective is to provide family planning services in "family friendly clinics" and it does not want to address or work with the issues and groups related to HIV/AIDS. The needed HIV/AIDS social marketing program could be operated by ASHONPLAFA if it were to expand its vision and commitment to include HIV/AIDS, but this shift is not likely. Finally, if USAID continues to donate condoms to ASHONPLAFA to be marketed as its Guardian brand at 8.50 Lps./3, or provides free branded condoms to FFS (e.g., Lovers Plus), it will not be possible to develop a sustainable HIV/AIDS condom social marketing program. If USAID/Honduras continues to support ASHONPLAFA's Guardian brand condom with donated commodities, the Mission's HIV/AIDS program should remain essentially as it is, with enhanced IEC and behavior change programming.

Working Together to Increase Access to Condoms in Honduras

In general, there appears to be adequate access to condoms in Honduras, especially for family planning. There is contradictory evidence for the need to increase access to condoms for HIV/AIDS prevention in nontraditional outlets frequented by high-risk groups and at times when the primary supply locations (MOH clinics, pharmacies, supermarkets) are closed at night. However, if an HIV/AIDS condom social marketing program is developed, it should include a component that reaches nontraditional outlets.

If ASHONPLAFA continues to focus on family planning, it is not obvious how it would work with other partners to increase access to condoms for HIV/AIDS. However, both the

Ministry of Health and the partner selected to implement an HIV/AIDS program should work closely with FFS and its NGO clients to increase access to condoms in high-risk places and with high-risk clients. Those NGOs could provide a parallel distribution mechanism and opportunities for behavior change programming that would reach markets that the Ministry of Health and the HIV/AIDS condom social marketing agency might not be able to reach directly.

Availability of Condoms to High-Risk Groups

High-quality condoms appear to be generally available in Honduras, with a broad choice of brands and prices, in multiple outlets. Condom availability and the quality of the condoms in public and NGO distribution points should be verified by a retail audit.

But the key issue in Honduras is not primarily that of access. The more fundamental need is for information, education, and behavior change that will lead to the consistent use of condoms, especially in high-risk acts and with high-risk partners.

Availability of Condoms through the Commercial Sector

Representatives of the two largest private commercial sector condom distributors in Honduras were both interested in working with USAID to introduce a moderately priced public health condom. The advantages are that a commercial private sector partner would have the professional knowledge and experience, management capacity, marketing and sales staff, distribution networks in place, and other resources needed to successfully promote a condom in a professional way.

The suggested approach would be for USAID to assist a commercial private sector partner to develop a sustainable market for a condom brand that could survive on its own after USAID support is terminated. In the beginning, USAID would probably need to provide the condoms and funds for marketing and advertising, and would also need to support an IEC and behavior change program to develop a condom use culture, especially in relation to high-risk sex.

An effective linkage could be made with FFS and its NGO associates to reach selected subpopulations and to support behavior change activities if FFS were to agree to broaden its network to be more inclusive of high-risk partners.

To assure that the end goal of a viable commercial product is achieved, the condom would need to be priced at 6–8 Lps./3-pack, which should be well received by the public if it were perceived to be a quality product. Finally, it will be virtually impossible to develop a viable relationship with a commercial private sector partner if USAID continues to provide free condoms that ASHONPLAFA and FFS can sell or distribute as branded products, such as Lovers Plus or Guardian condoms.

SURVEILLANCE AND RESEARCH

HIV Reporting System

A new HIV case reporting system has been implemented. The new system includes a new data collection format and a new database file. There is an integrated interface that would allow records to be entered in each regional office, data transfer to the national level and creation of analysis reports. However, hardware is not available in all regions to implement this ambitious program.

There has been an increase in the number of AIDS cases every year for the past five years (with the exception of 1996). However, the delay of the report makes it impossible to characterize 1999. The number of reported HIV asymptomatic infections is very low and this reflects the lack of HIV voluntary counseling and testing services available in the country.

Surveillance

Honduras has already implemented what UNAIDS has recommended as “second generation HIV surveillance.” In addition to prevalence data, considerable demographic and behavioral information has been collected. The number of sentinel sites as well as the number of populations screened has been increased. Excellent descriptions of the cross-sectional surveys have been written under the supervision of the CDC. The trip reports provide an excellent summary of the activities and recommendations.

The effect of Hurricane Mitch on data collection, blood samples storage and transport, and questionnaires lost has not been evaluated. However, the number of sites and sample size could guarantee the information estimates. Furthermore, what is most important in sentinel surveillance is not a single point prevalence but trends and future studies will help to improve understanding of this effect.

Despite the fact that Honduras has the best sentinel surveillance system in the region, integration of Honduras to a regional surveillance system would facilitate understanding the epidemic. A PASCA initiative has been proposed to develop this system. This multicenter approach aims to establish a system that provides decision-makers with accurate and reliable information about the epidemic among FSWs and MSM and to update this information on an annual basis. The information would be suitable for making informed decisions about setting priorities for resource allocation and designing targeted interventions. The study expects to contribute the formation and strengthening of a Central American cadre of experts who will ensure continuous surveillance into the future. This activity has been designed to be a collaborative effort between PASCA; the Ministries of Health of Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama; the Center for AIDS and STDs at the University of Washington; UNAIDS; the Pan American Health Organization (PAHO); CDC; and, several local NGOs.

Operational Research and Evaluation Plan

Despite the efforts in the second generation sentinel surveillance, there is an obvious lack of information available to understand behaviors in different populations, sexual networks, epidemiological bridges between populations, migration, health seeking behaviors, quality of STI services, and availability and quality of condoms. Design and implementation of research that addresses these topics should be important outputs for the future USAID project in Honduras. Technical assistance for behavior studies will be needed to assure integration of quantitative and qualitative research.

Also urgently needed is the development of an evaluation plan that identifies not only process indicators but also outputs, intermediate outcomes, and impact indicators. The evaluation plan should describe indicator definitions, data sources, purposes, and limitations of each indicator.

POLICY DIALOGUE

USAID/Honduras has four internal partners supporting policy dialogue activities in the country: FFS, the MOH, PASCA and the Implementing AIDS Prevention and Care (IMPACT) Project. The Ministry of Health has traditionally played a strong, centralizing role in STI/HIV prevention activities in Honduras.

FFS measures its progress in policy dialogue using the following indicators:

- Increased number of public speaking engagements, lectures, and workshops with public and private sector stakeholders, including nonprofit organizations, employers, the press, the military, church groups, schools, training centers, and universities;
- Number of quality research activities undertaken and disseminated;
- Increased understanding and commitment among GOH officials and legislators on the importance of STI/HIV prevention and control (progress is measured using PASCA's AIDS Policy Environment Score [APES]); and,
- Number of positive HIV/AIDS policy changes (progress is measured using PASCA's legal regulatory matrix which tracks specific changes in laws, norms and standards in each country).

The MOH indicators focus on information and systems to inform the policy dialogue process. A central action for the MOH was the development of a national strategic plan.

FFS coordinates with PASCA's local policy liaison for joint program activities and technical assistance. PASCA has provided support to the MOH as well as to FFS to support the development of new epidemiologic projections, to update the socioeconomic impact study, and to support activities which led to the passing of the AIDS law in Honduras and the presentation of the MOH's national strategic plan.

Honduras has made significant progress in two key areas of policy dialogue during 1999. The MOH presented its national strategic plan in August 1999 and the AIDS law, which has been pending for over a year, was passed on September 9, 1999.

The development of the national strategic plan took more than 18 months, was delayed by Hurricane Mitch, and then had to be redesigned to incorporate the needs to address the situation of large shelters as a new focal point for high-risk transmission. The process included a cross-section of representatives from the MOH, IHSS, Sanidad Militar, donors working in health, as well as NGOs considered to be leaders in the field. There was also representation from the Ministry of Education and Labor. It does not appear to have involved HIV-positive persons, youth, private sector leaders, or others in its development.

The AIDS law was passed due to leadership from the Saud Soloman. UNFPA worked with policy leaders through its programming. PASCA, FFS and the MOH developed and implemented a strategy of small forums between key legislators, HIV/AIDS experts and HIV-positive persons, which led to the passage of the law with the full support of the president of the Congress. The policy change matrix below highlights the areas where Honduras has made progress and areas for further action.

USAID/Honduras is using APES to measure change in the AIDS policy environment in Honduras. PASCA developed APES to measure the degree to which the policy environment in a particular country supports efforts to prevent the spread of HIV/STIs, provide quality care for people with AIDS, ensure the rights of people with AIDS, and ameliorate the negative impacts of AIDS on individuals, families, communities, and society. APES is designed to reflect both the current level of support as well as the changes that take place over a one- to three- year period as a result of policy activities. The score is intended to evaluate changes in the policy environment over time. Results of a midterm assessment (1998) of APES in five Central American countries are compared with baseline results obtained in 1996. Table 8 shows the results for USAID's five Central American countries, as measured in 1998 (source: *ibid.* p.9)???

Table 8: AIDS Policy Environment Score by Country and Dimension, 1998

	Policy Support	Policy Formulation	Organi- zation	Resources	Evaluation and Research	Legal and Regulatory	Program Components	Total
El Salvador	34.2	52.8	45.9	44.7	51.6	45.3	53.4	46.3
Panama	45.9	65.2	61.2	47.4	57.2	54.6	62.0	56.1
Guatemala	43.0	56.7	51.8	37.9	56.1	48.4	49.4	49.2
Nicaragua	33.7	54.1	51.1	44.3	47.3	45.0	52.6	46.2
Honduras	51.1	72.7	68.6	65.3	65.6	62.9	50.1	61.2

Source: PASCA, 1999.

As can be expected, Honduras had the highest scores and the least variation between categories. It is important to note that while Honduras has the most resources, research,

policy support, and policy formulation in the region, it has a low score in program components. The program components section of APES looks for components such as proactive monitoring for accurate reporting by the media, functioning social marketing and logistics systems for condoms and STI drugs, universal blood screening, infection control guidelines for health workers, national treatment guidelines for STIs, prevention programs focused on high-risk transmitters, confidential counseling and testing programs on demand, family life education for youth, and a functional HIV/AIDS surveillance system. Several of these components have been difficult to implement in Honduras, and some have been impossible, without a law and regulations to give the national program the authority to develop them.

The following table summarizes policy changes in Honduras between 1997 and September 1999. The 1996 information is the baseline, accumulated amount to date.

Table 9: HIV/AIDS Policy Change Monitoring Matrix, September 1999 Update, PASCA

Year	Legislation	Implementing Rules and Regulations	Executive Orders	Ministerial Decrees	Directives and Guidelines	Professional Practice Standards	National Action Plans	Total
1996	1	1	1	2	2	0	0	7
1997	1	1	0	1	2	0	0	5
1998	0	1	0	0	0	0	0	1
1999	1	0	0	0	0	0	1	2
2000								2

Source: PASCA, 1999. Positive policy changes are defined as policy actions that favor the overall environment for HIV/AIDS prevention programs and/or as the removal of adverse actions (i.e., barriers). This matrix registers the number of policy changes during the reporting period. The attached narrative describes the nature and significance of the policy movement for each country.

SELECTED SUPPORT DOCUMENTS

Two support documents, the electronic mail of September 16 from UNAIDS regarding the Honduran epidemic, and the management report by Mario Ganusa regarding the sustainability (sostenibilidad) of FFS, point out the lack of sufficient or adequate response in Honduras to a serious epidemic and in particular, specific areas needing immediate attention, both at the national level and at FFS specifically. The ONUSIDA memo identifies garifuna and mobile populations (sailors and fishermen were given as examples; sex workers traveling with truckers across borders could be added to the mobile population category) as high-prevalence populations. Neither has had serious attention, and FFS has only begun to address complex garifuna needs and issues with limited efforts. The lack of organization of sexual minorities and PWAs was mentioned as well. These are clearly not strengths of FFS, and given the models available in other countries for these activities, FFS could use its organizing authority to sponsor and support such development at the community and policy levels. The issue of human rights for PWAs was not even addressed in the interviews. The document identifies condom promotion and government commitment as lacking and points out the need to act on the new law without further delay.

The management report is disturbing, and some of the concerns were obvious to the evaluation team as well. Aside from the management and administrative issues which were not examined in any depth, the call for a strategic plan and a more egalitarian and participatory organization appear to be crucial issues.

It is suggested that both these documents be considered in the development of recommendations and future organizational, policy and program planning for FFS.

III. RECOMMENDATIONS

OVERALL STRATEGY

1. In general, the private sector-focused Center mechanism envisioned by USAID/Honduras is a sound one, and the Mission should not drastically alter course midstream. This is recommended because the goals of USAID/Honduras in the area of HIV/AIDS could be attained effectively through FFS if the recommendations proposed to FFS are followed.
2. Individuals with multiple sexual partners are particularly vulnerable to acquiring STIs and thereafter transmitting infection to additional sexual partners. The members of such core groups are likely to play an undue role in the maintenance of high rates of STIs and it is expedient to target STI services and prevention activities at them. The epidemiological data support the fact that sex workers, men who have sex with men, and garifunas are the most affected populations.
3. Honduras has already reached the level of a generalized epidemic, although there are important regional differences in HIV prevalence in specific groups. USAID/Honduras should continue intervention activities through the Ministry of Health and NGOs in the current geographic areas.
4. The design, implementation, and evaluation of HIV/AIDS intervention activities should continue to apply crosscutting issues, such as gender, youth, community ownership, sustainability, and local capacity.
5. The program working with the Ministry of Health to develop the general availability of HIV testing and counseling and to develop and promote effective strategies for providing basic care to people living with HIV/AIDS should be expanded. Legal and human rights are needed but would require additional funds. New interventions appropriate to different stages of the epidemic require more funding, not reallocation of current funds.
6. The design and implementation of an evaluation plan is urgently needed.
7. USAID/Honduras should investigate avenues for integrating HIV with other health and education issues, particularly since HIV is the leading cause of death of women of reproductive age in Honduras. Also, of the strategic objectives of USAID/Honduras, three are HIV-related, yet the programmatic aspects of the Mission's portfolio treat HIV as completely separate from maternal health and education issues.
8. USAID/Honduras' bilateral program supports a separation between prevention and care. However, at this point in the epidemic, there is a demonstrated need to integrate these issues.

9. PASCA is a regional USAID–funded resource that could provide technical assistance concerning the integration of HIV into non–HIV NGO activities.

COORDINATION AND FFS

Coordination is a core reason for USAID support to FFS, but FFS seems not to have been able to fulfill this role effectively. This coordination needs to be coordination of the NGOs that receive FFS direct support, coordination of NGOs supported by FFS with other NGOs working in HIV, and, coordination between FFS and the MOH's STI/AIDS/tuberculosis (TB) program. Because FFS–supported NGOs sometimes have other donor support, there needs to be encouragement by FFS of information sharing of non–FFS funded activities, as well as gathering of information regarding the HIV activities of Honduran NGOs that do not receive FFS funding.

Regarding coordination related to the NGOs, FFS' role should be that of ensuring facilitation of interagency communication and collaboration, including sharing information regarding HIV activities and programs (from NGO to NGO, from NGO to MOH, and from MOH to NGO) and the dissemination of lessons learned. As a goal should be to build sustainable networks, as much as sustainable NGOs, FFS needs to cultivate its identity as a partner in this coordinating role, rather than simply a source of funding and administration. Regarding coordination between FFS and the MOH, the partner relationship is no less important.

1. FFS, with the active involvement of USAID/Honduras, should create an advisory group composed of representatives of international health/development and philanthropic organizations that do not receive FFS funding. This group should include a representative from the MOH STI/AIDS/TB program. The executive director of FFS should also be a member of this group and should have the same status as the other members. This group could have a revolving chairmanship (perhaps annually) for which the MOH and FFS representatives would not be eligible. It could help FFS set general policy as well as guide the organization in expanding its funding base and sustainability. The members of the advisory group should be individuals who understand, or can be educated about the complexities of the epidemic and the need to reach specific high-risk behavior groups. It would not be useful to have individuals on the advisory group who reject safe sex messages, cannot accept the promotion of condoms, and/or are uncomfortable discussing the needs of sex workers, MSM, or any other high-risk behavior group. USAID/Honduras could be a consultative or ex officio (non-voting) member of this body.
2. FFS should form a coordinating body made up of representatives from the NGOs that are funded by FFS. This group could meet periodically and would serve the purpose of institutionalizing coordination among the NGOs. Representation from the MOH's STI/AIDS/TB program and USAID/Honduras should be invited as observers to attend these meetings.

These two recommendations include activities that require FFS staff commitment of time and energy; this should be reflected in work plans. However, these activities do not require much in the way of monetary resources to accomplish. The highest level of resources envisioned would be the resources required to bring together the FFS NGO representatives for the coordinating group meetings. Advisory group representatives should receive no compensation. Good staff support from FFS and well-planned meeting agendas should be provided. Any funding for these additional FFS-centered activities should come from the funds that FFS presently budgets for its core activities, and not from the already very limited funding that is allocated to the NGOs for HIV programming.

3. USAID/Honduras should view the establishment and functioning of the above groups as indicators of progress for FFS.
4. USAID/Honduras needs to take an active role in the development of a joint planning process between FFS and the MOH.
5. USAID/Honduras needs to take an active role in donor coordination.

FFS AND THE NGOs

Technical Assistance

The technical assistance provided by FFS to the NGOs is viewed as very good in the areas in which it is provided. However, there is a need for FFS to expand its technical assistance into new areas of focus, as listed above. Furthermore, FFS needs to incorporate technical assistance and sensitivity training in all the areas of concern regarding high-risk acts (anal, oral, MSM, sex workers, etc.) into its work with all the FFS-funded NGOs, and not just those that focus on specific communities. To accomplish this, it is clear that FFS, itself, needs to receive sensitivity training in some of the taboo areas, especially regarding anal sex generally, as well as MSM. The need for an integrated approach, expressed by the government and NGOs alike, should guide new thinking about the provision of information and services (in other words, activities of the NGOs should go beyond HIV to include information and services that would reduce the stigma of messages and services and better serve the complex needs of the target audience).

1. FFS should engage a consultant (for a limited time) who specializes in the area of MSM to conduct sensitivity training and program analysis and planning with the FFS staff.
2. FFS should engage a consultant (for a limited time) who brings expertise in the area of building programs that take an integrated approach.

3. Technical assistance is needed for FFS and NGO staffs for the development of strategies for using BCC and IEC materials optimally so that such materials can be used in campaigns to truly educate and change behavior (i.e., IEC does not connote simply informative brochures). This will entail a reconceptualization accompanied by technical assistance to FFS so that FFS can move to the next stage of its activities.

Administrative Assistance

The administrative assistance provided by FFS to the NGOs is viewed as excellent. However, some NGOs perceive the need for additional written guidelines. There is clearly no assistance being offered to the NGOs in the area of expanding their individual funding bases, which is essential to building sustainable NGOs.

1. As part of its assistance work plan, FFS should begin to routinely provide all NGOs with technical assistance regarding expanding the NGOs' funding base (assistance with proposal writing, identifying other donors, other kinds of fundraising or income-generating activities).

Focusing on the Epidemic

FFS has a fairly good mix of NGOs that it supports. However, FFS supports a number of NGOs that focus exclusively on youth, while supporting few NGOs that focus on the highest risk behavior groups. For instance, FFS only supports one MSM-specific organization. This, in itself, would not be a weakness if FFS were providing training and encouragement to the other FFS NGOs in the area of MSM, so that they could routinely provide information and services as appropriate. For example, there is an NGO in Comayagua that provides services to sex workers. This NGO noted that there is definitely identifiable MSM activity in Comayagua, and that there is a group of transvestites performing as sex workers. However, no organization is dealing with this high-risk group in Comayagua. The FFS-supported sex workers NGO could, with technical assistance and encouragement, effectively begin to deliver services to this group, alongside its already established areas of work.

1. FFS should consider either realigning its network of NGOs by cutting out some of the NGOs that do not reach the highest risk behavior groups and supporting more that do, or FFS should provide assistance in reaching the highest risk behavior groups, adding to its already existing network.
2. If FFS decides to realign its network of NGOs, it is recommended that FFS consider including a non-HIV specific NGO that focuses on women's issues so as to begin integrating HIV efforts into the non-HIV NGO service community.

Participation of Affected Populations in FFS' Work

While the FFS staff appears to be sensitive to the needs of the affected populations, as large as it is, it does not include anyone who has intimate, first-hand knowledge of the high-risk behavior groups that it is imperative to reach. Additionally, although the epidemic is still highly concentrated in San Pedro Sula, FFS staff is based entirely in Tegucigalpa, and its support to NGOs is not focused on San Pedro Sula. Regarding the FFS staff, although it might be difficult for FFS to identify an openly HIV-positive person who also is qualified to provide HIV/AIDS technical assistance (or a sex workers who would be qualified), FFS could recruit a qualified gay-identified man. This person would not only bring needed diversity and experience to the staff but, if this person were housed in the offices of one of FFS' San Pedro Sula NGOs, it would have the added benefit of establishing FFS presence there.

1. FFS should hire someone from the affected community as a staff member. This person should work out of one of the FFS-supported NGOs in San Pedro Sula and travel to Tegucigalpa to work in the FFS offices at least once a week. This recommendation, if followed by hiring a gay-identified man, has the added benefit of addressing the weaknesses enumerated above. In addition, if FFS hires a gay-identified man under this recommendation, that staff person should be housed in an FFS-supported HIV NGO in San Pedro Sula other than the FFS-supported gay NGO. This allows for the needed outreach and sensitivity on MSM issues to the non-MSM HIV NGOs.
2. If FFS, either now or in the future, decides to realign the network of NGOs that it funds, it should absolutely focus on funding additional NGOs in the San Pedro Sula area.

STI SERVICES

1. It is necessary to strengthen the implementation of model STI prevention and care packages at public health services and expand to the private and informal sectors, including pharmacies. As more partnerships develop in the future between the public and private sectors for STI prevention and control, sharing successful training methods and components will become more important to keep up with the challenge of training more trainers with potentially fewer resources.
2. STI care and prevention services for MSM need to be strengthened. The STI/HIV prevention project has been working with this population only in San Pedro Sula to empower and build self-esteem. While these are especially important in the early stages of group development, the focus now should be on promoting STI services and behavior change (condom use, partner reduction) to reduce the transmission of HIV and STIs. Priorities and targets should be established in these areas and MSM outreach workers should be evaluated on behavior change results (i.e., STI services

utilization rates, condom use, HIV testing and counseling). This component should be expanded to other cities of the project.

3. The current syndromic management course should be evaluated by including a global analysis of knowledge gained, changes in attitudes and perceived competency, feedback and/or evaluation of the trainers by the participants, and outcome indicators, such as the number of clients being managed appropriately or the number of contacts brought for treatment.
4. STI management guidelines should be revised to include STI management for female sex workers and congenital syphilis. Changing the current therapy for gonococcal infection to a single oral dose drug will lead to saving money. In addition, changing the current therapy for chlamydial infection to a single oral dose should be explored which would possibly be a better, more cost-effective intervention than the current 7-day course of Doxycycline because of lack of compliance by patients.
5. The effectiveness of project outreach staff (peer educators) could be vastly improved and expanded if a standardized referral system to STI services is established. This will allow monitoring of fieldwork of peer educators.
6. The promotion of appropriate health care-seeking behavior in the target populations needs to be established.
7. Monitoring, supervision and evaluation are critical to the success of the STI control program. Strengthened data collection with improved training on filling out forms and development of software for data entry and global analysis will address trends, weaknesses, and strengths of the program and should be used to improve the quality of STI services.

CONDOM SOCIAL MARKETING

1. USAID/Honduras should review its sustainability objectives for HIV/AIDS (FFS) and its family planning (ASHONPLAFA) programs and assess how different sustainability requirements for one may negatively affect the sustainability of the other. For example, donations of 2.5 million free condoms to FFS appear to have led to a decline in ASHONPLAFA's condom sales in 1999.
2. USAID should work with PASMO and a Honduran commercial sector distribution company to build a sustainable market for a moderately priced condom.
3. Because ASHONPLAFA's Guardian condom has good market recognition and brand equity and contributes to ASHONPLAFA's revenues, USAID/Honduras may wish to consider easing the transition by donating condoms to help ASHONPLAFA relaunch an upgraded Guardian condom at 16 Lps./3 to compete with Preventer, rather than introduce the Protektor brand, as ASHONPLAFA currently plans.

4. USAID/Honduras should only donate No Logo condoms to the Ministry of Health and NGO partners to provide a safety net for the lowest income clients in need of condoms for family planning and HV/AIDS prevention.
5. An IEC and behavior change program should be developed to promote a condom use culture for HIV/AIDS/STI prevention, parallel with the branded product promotion.

SURVEILLANCE AND RESEARCH

1. The second-generation surveillance system of HIV needs to be strengthened through the institutionalization of this activity at the MOH. In other countries, more than one year is usually needed to establish this process because of the high turnover of health personnel. Public treasury money should be devoted to this activity after technology transfer has been completed. Instead of expanding sites and populations, the surveillance system should concentrate on the current ones. There is no evidence that Hepatitis B surveillance improves or is a surrogate marker for HIV/STI information but it greatly increases the costs.
2. Integration of the current Honduras surveillance system to a regional surveillance system proposed by PASCA would allow improved characterization of the epidemic, considering migration patterns in the region.
3. Future outputs of the USAID/Honduras program should include operational research in areas such as:
 - **STI services:** validation of the current flow charts for syndromic management and assessment of quality, availability, and demand for STI prevention and management services;
 - **Behaviors:** sexual networks, epidemiological bridges between population, migration, and health-seeking behaviors of high-risk behaviors/vulnerable populations targeted by the program; and,
 - **Condom social marketing:** retail audit of NGO and MOH distribution points to assess the availability and quality of condoms in place; a sexual behavior study, especially of non-sex workers, transactional and other casual, noncommercial activities; indepth market assessment for the introduction of an HIV/AIDS prevention condom; and, assessment of condom logistics and distribution in Honduras, from import to point of sale to determine the quality of the condoms available to the retail customer.

POLICY DIALOGUE

A targeted policy dialogue strategy should be designed to disseminate the plan and the law to multisectoral audiences, including big business, human rights sector, women's sector, and other programs.

1. A policy dialogue strategy for the dissemination of information about the plan and law using existing regional mechanisms should be designed (i.e. DDHH).
2. Focused efforts are needed to strengthen the medical, organizational and human rights situation of HIV-positive persons and those affected by HIV.
3. Honduras' HIV/AIDS sector needs to develop skills in the art of alliances that extend beyond the concept of coordination. Honduras has regional and intrasectoral rivalries, which prevent systematic planning and implementation. Both the law and the strategic plan offer extraordinary opportunities to teach networking, establish partnerships and collaboration skills while focusing on these concrete tasks of developing the regulations and the interventions to support the plan. PASCA can provide the technical assistance for this effort, both through its local policy person and outsiders, if invited. Coordination is minimal interaction between various actors, whereas the concept of alliances (alianzas) means to strategically work together towards a goal.
4. USAID needs to ensure that the policy dialogue technical assistance provided to FFS, both by PASCA and IMPACT, moves FFS toward a coherent plan and does not create overlap or repetition.
5. Alliances are needed with human rights actions and support to sexual minorities in Honduras.
6. Both the strategic plan and the law provide an excellent opportunity for the MOH to meet with donors, NGO representatives, HIV-positive persons, UNAIDS team members, and Chamber of Commerce members to form a multisectoral committee to meet twice a year to monitor the law and/or the plan.
7. Policy dialogue needs to systematically incorporate sectors working on the crosscutting themes, which are well represented in the strategic plan, and help them integrate HIV/STI into their activities. The sectors include human rights, domestic violence, community participation, education, and business.
8. An advocacy agenda needs to be established and then a strategy developed, in particular for HIV-positive persons.
9. The movement of the epidemic argues strongly for a systematic link between prevention activities with women at risk and access to HIV/STI treatment. The policy

agenda should look for logical partners, places (Chamber of Commerce, factories [maquilas], albergues) and policy strategies which could curb the epidemic, such as mobile clinics visiting the maquila and providing reproductive health services, including HIV/STI treatment; a law requiring the maquilas to provide this to their employees twice a year; school-based clinics (or clinics close to schools which are linked to them); regular checkups for older children, which includes assessment of HIV/STI risk; proactive action in the albergues; and, access to condoms and STI services.

APPENDICES

A: PROJECT RESULTS FRAMEWORK

B: SCOPE OF WORK

C: PERSONS CONTACTED

D: DOCUMENTS REVIEWED

E: REFERENCES

APPENDIX A
PROJECT RESULTS FRAMEWORK

APPENDIX A

PROJECT RESULTS FRAMEWORK

FFS RESULTS FRAMEWORK

IR 3.3.1.1.1. Center provides subgrants, administrative and technical assistance and training to NGOS.

- a. Mechanisms in place for review and approval of NGO subgrant proposals.
- b. Number of subgrants provided to NGOs and managed by the Center.
- c. Number of person days of technical assistance/training provided by the Center. (¿PASCA?)
- d. Improved capacity of NGOS to generate non–U.S. government funds for STI/HIV prevention, counseling and family support programs. (¿PASCA?)

IR3.3.1.1.2. NGOs provide STI/HIV prevention and counseling services.

- a. Increased number of NGOS provides condoms to young adults, sex workers and other target groups.
- b. Increased number of NGOs provides effective counseling for target groups and community-specific behavioral change communication information and materials.
- c. Increased number of NGOs provides information and pre- and post-test HIV counseling
- d. Percent of NGOs that uses a systematic approach to project design and monitoring. (Using PASCA's instruments)

IR3.3.1.1.3. NGOs and public sector are sharing information and best practices effectively.

- a. Mechanisms in place for information sharing and coordination among all NGOs involved in STI/HIV prevention, counseling and care.
- b. Number of NGOs that are members of a national HIV/AIDS prevention network. (PASCA)

IR3.3.1.1.4. National behavioral change communication (BCC) program in place.

- a. BCC materials developed and disseminated, focusing on behavior change among teenagers and young adults.
- b. Increased access to and use of BCC materials by nonprofit organizations, employers, the military, church groups, schools and universities, and other stakeholders.

- c. Increased proportion of non–U.S. government funds used for production and national dissemination of project developed BCC print, television and radio materials.

IR3.3.1.1.5. Effective STI/HIV advocacy and policy dialogue are implemented.

- a. Increased number of public speaking engagements, lectures, and workshops with public and private sector stakeholders, including nonprofit organizations, employers, the press, the military, church groups, schools, training centers, and universities.
- b. Number of quality research activities undertaken and disseminated.
- c. Increased understanding and commitment among GOH officials and legislators on the importance of STI/HIV prevention and control. (PASCA)
- d. Number of positive HIV/AIDS policy changes (PASCA)

MINISTRY OF HEALTH RESULTS FRAMEWORK

IR3.3.1.2. Strengthened public sector STI/HIV programs and policies.

IR3.3.1.2.1. Improved STI/HIV surveillance and reporting.

- a. Sentinel surveillance for HIV and syphilis among pregnant women in Tegucigalpa (6 clinics) and San Pedro Sula (9) and initial prevalence surveys to determine the prevalence and necessity for continued sentinel surveillance in Comayagua, Siguatepeques, Puerto Cortes, and La Ceiba.
- b. Revised HIV case reporting system in place.

IR3.3.1.2.2. Adoption and expansion of public sector STI/HIV prevention programs and practices.

- a. Increased MOH purchase of condoms with national funds for the National AIDS Prevention Program.
- b. Increased condom availability in MOH and IHSS clinics.
- c. Health providers (including pharmacists) trained in syndromic management of STIs.
- d. IHSS campaign in place to increase AIDS awareness and AIDS prevention practices among persons in the workplace.
- e. National BCC campaign planned and executed in coordination with the NGO Center for AIDS Awareness and Prevention.
- f. UMIETS functioning effectively in Tegucigalpa, Comayagua, San Pedro Sula, and La Ceiba; new UMIETS established in 1998 in SR de Copan, Puerto Cortes, Choluteca, and, in 1999, in Tela, Danli, Juicalpa and Puerto Lempira.
- g. Sufficient funding for antibiotics and supplies required for implementing the syndromic approach.

IR3.3.1.2.3. Improved quality and effectiveness of STI/HIV counseling and care.

- a. Norms and protocols for HIV counseling and care in place.
- b. Physicians, nurses and other public health personnel trained to provide effective HIV counseling and care.

IR3.3.1.2.4. Effective STI/HIV policy dialogue and coordination.

- a. Feasibility studies of new and low-cost technologies for the detection of STIs and HIV in clinic and outreach sites conducted.
- b. Increased percentage of men and women of reproductive age spontaneously citing two or more correct ways to prevent HIV transmission.

Increased percentage of sexually active males with a realistic perception of their personal risk in contracting HIV.

APPENDIX B
SCOPE OF WORK

APPENDIX B

SCOPE OF WORK

AIDS/STD Prevention and Control Project USAID Grant No: 522-0216

PROPOSED EVALUATION QUESTIONS

BEHAVIORAL CHANGE COMMUNICATION STRATEGY

1. Does a joint MOH-FFS BCC strategy exist? If not, why not?
2. Are the IEC materials developed and used by the MOH, FFS and the NGOs appropriate for the target populations? Are they compatible/complimentary? Are they having any impact? Is there a IEC coordination mechanism? Are strategies, approaches, and materials developed by one NGO shared across all NGOs?
3. What type of technical assistance does the MOH, FFS and the NGOs need to improve their BCC strategies and materials? What does FFS need to do to help the NGOs to improve their materials? What are the technical assistance needs in developing an effective national BCC strategy?
4. Both the MOH and FFS conducted campaigns in 1998 and 1999. Were the campaigns appropriately designed for the target populations? Did they have any impact? Should there be a follow-on campaign?
6. To what extent are the materials and messages created by the MOH and FFS successful in increasing perception of risk of HIV infection among target groups and decreasing their high-risk sexual behavior?

FFS AND THE NGOS

1. How can FFS further become a key resource for its clients, the NGOs, including those who do not receive funds from FFS? In reality, the NGOs are FFS' clients. Now after more than a year of experience, how can FFS adjust to better serve their clients? What are FFS' staffing needs to better serve the clients?
2. How can the relationship between FFS and the NGOs be characterized? What is the degree of satisfaction that the NGOs have with the technical assistance provided by FFS? How effective are the supervisory visits that FFS makes to the NGOs? To what extent have the NGOs been strengthened administratively and technically? What are the current needs of the NGOs, both technically and administratively, that are not being met? Do these needs include sustainability?
3. To what degree have the NGOs benefited from the technical and administrative assistance they have received from FFS? Do all have sound, operational financial/accounting systems? Are they capable of developing IEC materials and interventions that are appropriate for their target populations? Do they feel that the

training they have received is adequate to help them address the needs of their target populations?

4. The administrative costs of FFS are relatively high. Since FFS, in part, can be considered as a pass-through mechanism of funds to the NGOs, is their current staffing level and administrative costs justified?

5. Does a mechanism exist to determine when NGOs no longer require FFS assistance?

6. What are the pros and cons of placing an FFS staff person on the North Coast?

7. Since sub-grants were awarded to the NGOs, do the NGOs have greater knowledge of and better working relationships with their target populations? (Almost none of the NGOs were directly involved with their target populations prior to receiving grants. Thus, most of them got into the “business” because of availability of funds).

8. To what extent have the NGOs been successful in increasing the perception of risk of HIV infection among their target populations and decreasing their high-risk sexual behavior?

OVERALL STRATEGY

1. In the earlier stages of the epidemic in Honduras, it was appropriate to concentrate on high risk groups, i.e., sex workers, men who have sex with men, and the Garifuna. The epidemic in Honduras is now approaching a “generalized” stage, especially in the Northern part of the country. Thus, have we exhausted all we can from the traditional approach? Should the program have a new strategy that deals with the reality that the epidemic is now becoming “generalized?” What new areas should the project address as the epidemic moves beyond the special target audiences?

2. Asked in another way, is the current model an effective and efficient strategy for preventing HIV/AIDS transmission in Honduras? Should the project reassess its geographic focus and emphasis on core transmitters, or should it stick with these groups while other agencies support strategies more directed towards the general population? Where is USAID’s competitive strength to contribute to this area?

3. Could more be accomplished with the resources that we have? What interventions would the evaluation team recommend?

4. How could existing primary prevention programs be enhanced?

5. Given the limited availability of funds, in the medium term, which groups should the national program focus on? Adolescents? Young adults? Commercial sex workers? Men who have sex with men? Middle-class urban males? Young women? Should more effort be put into prevention efforts on the north coast? Where can we get the biggest bang for the buck?

6. At this point, what is the importance and the need for a BCC strategy that focuses on the general population?

7. Is too much attention being placed on distributing and promoting the use of condoms, at the expense of other interventions?

8. Should FFS be working with fewer NGOs? If so, how many, and which groups should they focus on? Should the NGOs, who generally have a localized focus, have a national focus?

9. Given limited funding, should USAID support a single intervention? If so, what would that intervention be? Would all NGOs treating HIV prevention nationally with a targeted intervention be an effective approach to curbing the epidemic?
10. Some view that HIV/AIDS prevention efforts should be integrated into the mainstream of general development work, since there is evidence that it impacts the major development benchmarks such as, school enrollments, employment, life expectancy, poverty, and per capita income. Thus, should an integrated reproductive health approach replace the current “free-standing” HIV/AIDS prevention approach?
11. Should USAID support the provision of basic medical and social services to HIV-infected individuals, including the treatment of STDs, opportunistic infections, and TB?
12. Should USAID support C-sections in order to reduce vertical transmission?
13. Should USAID support assistance to families and communities to care for children and orphans who are affected by the epidemic?
14. Should USAID support assistance to HIV+ persons in the community in order to reduce transmission?
15. What is the status of the existing program to absorb additional funding?

COORDINATION/SOUNDESS OF APPROACH

1. Does Honduras have a strategic direction for the effective control and prevention of STDs and HIV/AIDS?
2. How do FFS’ work plans relate to the National Plan? How do the MOH’s work plans relate to the National Plan?
3. Who should be overlooking the entire process to insure that there is a coherent approach to addressing the epidemic? Should this be a private sector responsibility, a public sector responsibility, or a joint responsibility?
4. What should be the characteristics of the organization(s) responsible for coordination?
5. Since FFS exists to serve the NGOs, one would think that the NGOs should be part of the Board of Directors of FFS. Also, the MOH, the IHSS, and people living with HIV/AIDS. This would give voice to these groups regarding the actions carried out by FFS, which is supposedly working on their behalf. Would this be a good idea?
6. How can the host country infrastructure be strengthened to better provide preventive services?
7. Does a mechanism exist for routine coordination of donors and the MOH? If not, why not?
8. To what extent are the NGOs coordinating with the MOH and with each other in the health regions where they work?

DATA

1. To what extent does qualitative and quantitative information exist to assess progress and improve the effectiveness of activities and interventions? Are these data being used for these purposes? What programmatic decisions have been made based upon existing data?
2. What data gaps exist?

3. Are the findings of studies being used to develop curricula for in-school youth?
4. Do the new proposed studies reflect a programmatic need for data?
5. What studies would the evaluation team recommend for the medium term?
6. What are the obstacles to the opportune collection, dissemination, and use of sentinel information? How can these be overcome?
7. What progress has been made in reducing under reporting of HIV+ cases?

POLICY DIALOGUE

1. What progress has FFS and the MOH made in the area of policy dialogue?
2. To what degree has the project been effective in involving other sectors and agencies (of government)?
3. What has been the involvement of the other sectors to date and what efforts should be made to strengthen this involvement?
4. Are the MOH and FFS willing and capable of interacting with private sector organizations, including religious groups? What more could be done to garner the support and commitment of the private sector in prevention activities.
5. What further efforts are necessary in the policy dialogue area?

STD TREATMENT

1. To what extent is the syndromic approach to STDs being implemented in MOH and IHSS health clinics and hospitals? How many clinics/hospitals have received training in this approach? Is there an adequate supply of appropriate drugs on hand in each clinic?
2. What obstacles still exist for the delivery of STD diagnosis and treatment services to the target populations (sex workers, MSM, Garifuna, young adults)? How can these obstacles be overcome?

CONDOM SOCIAL MARKETING

1. Given ASHONPLAFA's (the family planning association) social marketing program, is it necessary to establish an HIV/AIDS condom social marketing program in the country?
2. How can the MOH, FFS, the NGOs, and ASHONPLAFA work together to increase access to condoms in the country, particularly in non-traditional settings and in the night?

APPENDIX C
PERSONS CONTACTED

APPENDIX C

PERSONS CONTACTED

USAID

Dr. Richard Montieth
Dr. John Rogash
Dr. Angel Coca, USAID/Honduras

MINISTRY OF HEALTH

STD/AIDS Control Program, National Level Team

Dr. Jeremias Soto, Director
Dr. Rosalinda Hernandez, Epidemiology Unit
Ilsa Madrid, Consultora OPS
Bertha Alvarez, Education Unit
Rudy Molinero, PETSIDA
Mirian Carpio, Counseling and Self-Support Groups
Marco Urquia, STD Division, Medical Care and Impact Reduction Unit

Instituto Nacional de Laboratorios de Salud

Mrs. Suyapa Mendoza
Mrs. Rita Meza

Instituto Nacional del Torax

Mrs. Fidelina Euceda

Regional Level

Dr. Carlos Bennaton G, Director of Health District #3
Dr. Victor Manuel Borjas, Regional Chief of STD/AIDS and TB, Region#3

UMIETS

Las Cruzitas staff, Tegucigalpa
CESAMO Los Pinos staff, Tegucigalpa
UMIETS La Ceiba staff, La Ceiba
UMIETS Comayagua staff, Comayagua
UMIETS San Pedro de Sula staff, San Pedro Sula

IHSS

Dr. Irma Zacapa
Dr. Patricia Turcios
Dra. Ada Rivera, IHSS/DN

NGOs

FUNDACION FOMENTO EN SALUD

Dr. Jorge Higuero, Director FFS
Dr. Mayte Paredes, Coordinator FFS

ASHONPLAFA

Mr. Carlos Morlacchi, Executive Director

ALTERNATIVAS Y OPORTUNIDADES

Dr. Lisette Coello
Mrs. Noemi Rodriguez
Mr. Nelson Pavon

PRODIM

Dr. Javier Calix

ITCC

Mrs. Clementina Garcia

GAVIOTA

Mrs. Martha Carias

DUARI

Mrs. Melida Quevedo

COCSIDA

Mrs. Fanny Galeano

COMUNIDAD GAY SAMPEDRANA

Lic. Dereck Guzman Raickov, Executive Director

LIGA DE LACTANCIA MATERNA

Dra. Ingrid Carol Lopez

FRATERNIDAD SAMPEDRANA DE LUCHA CONTRA EL SIDA

Dr. Carlos Lopez, Fraternidad Sampedrana de Lucha Contra el SIDA

INDESEC

Ing. Rodolfo Quiroz, Director

CEDEPS

Dra. Reyna Andara

COMVIDA

Lic. Andino and staff

PASCA

Xiomara Bu

UNAIDS

Dr. Jairo Palacios

UNFPA

Patricia Rivera

UNDP

Rocio Tabora

PASMO

Ms. Francoise Armand, PASMO Marketing Manager, Population Services International

CONDOM SOCIAL MARKETING

Mr. Carlos Hernandez, Sales and Marketing Manager, Solis Distribution Company

Mr. Augusto Cesar Lopez, Solis Distribution Company

Mr. Gerardo Augusto Flores Ortega, Manager, Rivera y Compania Distribution Company

Mr. Ricardo Reyes, Director, Contraceptive Social Marketing Program

APPENDIX D
DOCUMENTS REVIEWED

APPENDIX D

DOCUMENTS REVIEWED

USAID grant, project papers and amendments

Annual work plans and quarterly reports

Honduras National Plan for Surveillance and Prevention of AIDS/HIV (1995–1997)

Relevant project research and operational documents

- Medical Chart for Female Sex Workers
- Medical Chart for General Population Patients
- STD Management Course Curricula
- STD Management Course Evaluation
- Syndromic Management Course Curricula
- Statistical Laboratory Results Form

PASCA's AIDS Policy Environment Score, Technical Report, 1998

PASCA's Legal Monitoring Matrix, June 1999

Relevant background documents on Honduras' political, economic and health situation

Copies of training/educational manuals and videotapes

Samples of IEC materials

Relevant newspaper articles and other press coverage

APPENDIX E
REFERENCES

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