Health Assistance and COVID-19 Emergency Response in Honduras (HACER)

FY20 Semi-Annual Report

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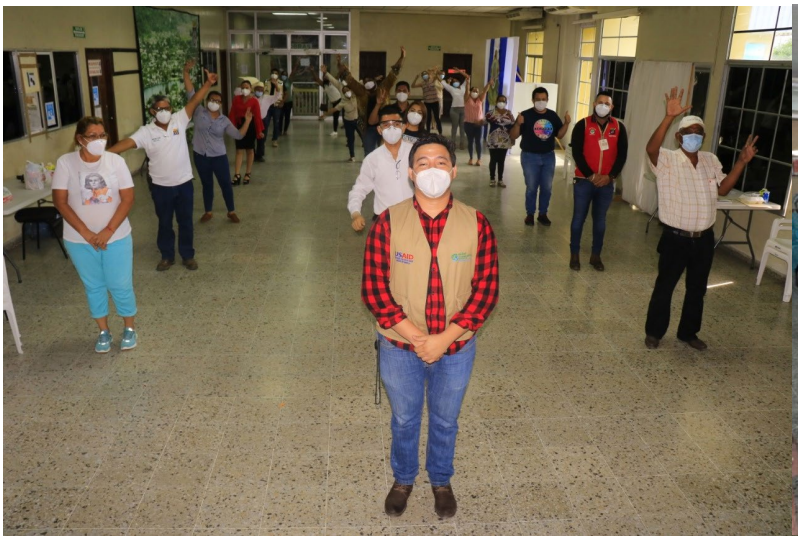
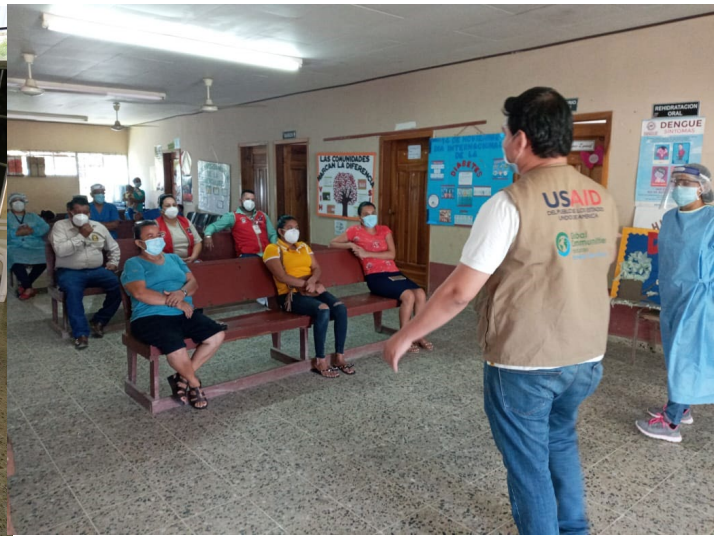
Global Communities
Honduras



Community Volunteer Training Puerto Cortés



Community Meeting and Dialogue Sessions, Chameleoncito, Puerto Cortés

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Abbreviations

AAP	Accountability to Affected Population	HACER	Health Assistance and COVID-19 Emergency Response
CODEM	Municipal Emergency Committee	M&E	Monitoring and Evaluation
CODEL	Local Emergency Committee	MoU	Memorandum of Understanding
CMDS	Community Meeting and Dialogue Sessions	NFI	Non Food Item
DBM	Dead Body Management	PPE	Personal Protective Equipment
ERR	Municipal Rapid Response Team	RCCE	Risk Communication and Community Engagement
FBM	Feedback Mechanism	SESAL	The Department of Health- Honduras
FGD	Focus Group Discussion	WASH	Water and Sanitation and Hygiene

Program Overview

Global Communities (GC) is implementing the six-month, $700,000 Health Assistance and COVID-19 Emergency Response (HACER) program to support USAID's priorities for COVID-19 preparedness and response in Honduras. HACER is mitigating the public health consequences and humanitarian impacts of the COVID-19 pandemic across the municipalities of Puerto Cortés and Villanueva in the department of Cortés, while providing limited Risk Communications and Community Engagement (RCCE) in the Dry Corridor. The HACER program will achieve this goal by meeting the following objectives:

Objective 1: Improved the capacity of municipalities to prevent and respond to COVID-18, through improved health education, disease surveillance, contact tracing, and Dead Body Management (DBM)

Objective 2: Improving hygiene practices in target municipalities through hygiene promotion activities and targeted provision of Water, Sanitation, and Hygiene Non Food Items (WASH NFIs)

COVID 19 Update

According to the Government of Honduras, as of the end of September, there are 78,788 confirmed COVID-19 cases and 2,399 deaths in Honduras. The department of Cortés still has the highest number of confirmed cases and deaths, with 30% of Honduras' confirmed cases. As of end of September, Villanueva and Puerto Cortés, GC's municipalities of intervention in Cortés, represent two of three municipalities with the highest number of cases, with 1,681 and 1,919 cases respectively.

In the municipalities of La Esperanza and Intibucá in the Dry Corridor, there are 71 and 191 cases respectively. Though the number of cases in the department of Intibucá remains much lower than in Cortés, Intibucá has a much higher positivity rate, with 1.8 times as many positive cases as negative ones, translating to a 65% positivity rate. Given the much lower municipal response capacity in the Dry Corridor, GC has increased its activities in the department of Intibucá (more details in the *Challenges, Lessons Learned, and Project Adjustments* section below).

Table 1 Epidemiological situation (As of end of September)

Cases	Honduras Total	Department of Cortés		Department of Intibucá	
		Villanueva	Puerto Cortés	La Esperanza	Intibucá
Total confirmed Cases	78,788	1,681	2,111	71	191
Active cases	32,308	1,196	1,134	18	77
Deaths	2,399	62	35	0	3
Incident rate per 10,000 inhabitantes	203	94	155	54	32
Case fatality Rate x 100	3.04	3.7	1.7	0	1.6

Source: Secretaría de Salud Report- Honduras-September 2020

Over the last few weeks the government has lifted the *confinimiento* (stay at home orders) and many activities have resumed, including the reopening of restaurants and hotels, increase in tourism, and people returning to work, many by public transportation. As has been the case in other countries, the number of cases are likely to increase as the country reopens.

Key Program Achievements

Indicators

During the first three months of program implementation, HACER has supported 17,091 unique beneficiaries. The tables below provide the number of people reached by sector/objective and by indicator.

Table 2. Overall Beneficiary Table

Sector/objective	Beneficiaries			Status
	Target	Reached reporting period	Reached Cumulative	
Health objective	40,000	17,091	17,091	Ongoing
WASH objective	40,000	17,091	17,091	Ongoing

Table 3. Indicator performance tracking table

Sub sector	Indicator	Target		Reached					
		Original	Adjusted (based on baseline results)	Reporting period			Cumulative		
				Female	Male	Total	Female	Male	Total

Health									
PHEIC and Pandemics	Number of health care staff trained	44	44	52	25	77	52	25	77
PHEIC and Pandemics	Number of people reached through risk communication activities by channel	40,000	40,000	9,132	7,959	17,091	9,132	7,959	17,091[1]
PHEIC and Pandemics	Percentage of the target population that can recall 2 or more protective measures	80%	90%	N/A	N/A	N/A	N/A	N/A	N/A
PHEIC and Pandemics	(Custom) Number of local stakeholders supported by HACER to participate in extending the reach of COVID-19 risk communication, community engagement and response activities	194	194	74	53	127	74	53	127
WASH									
Hygiene Promotion	Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double	10,000	10,000	9,132	7,959	17,091	9,132	7,959	17,091
Hygiene Promotion	Percentage of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands	80%	70%	N/A	N/A	N/A	N/A	N/A	N/A
Hygiene Promotion	Percentage of households targeted by the hygiene promotion program with soap and water at a designated handwashing location.	80%	98%	N/A	N/A	N/A	N/A	N/A	N/A
WASH NFI	Total number of people receiving WASH NFIs assistance through all modalities (without double-counting)	13,988	13,988	0	0	0	0	0	0
WASH NFI	Percentage of households reporting satisfaction with the contents of WASH-NFIs received through direct distribution (i.e. kits) or vouchers	80%	80%	N/A	N/A	N/A	N/A	N/A	N/A
WASH NFI	Percentage of households reporting satisfaction with the quality of the NFIs received through direct distribution (i.e. kits) or vouchers	80%	80%	N/A	N/A	N/A	N/A	N/A	N/A

Objective 1: Health

Through HACER, GC works closely with municipalities to improve their COVID-19 response by providing the municipal rapid response teams (ERRs) with logistical support and trainings. GC also works closely with neighborhoods with high numbers of COVID-19 cases to 1) better link them to the municipal response by identifying and training community health volunteers, 2) identify problems and solutions specific to the community through Community Meeting and Dialogue Sessions (CMDS), 3) increase access to hygiene products by distributing hygiene and disinfectant kits to households visited by ERRs (usually households with a suspected COVID-19 case) and vulnerable households, and 4) increase risk communication activities.

Start-up: During this reporting period, GC hired HACER project staff, including Health Officers in each municipality, a Project Coordinator, a Communication and Reporting Officer, and an M&E Officer. GC provided new HACER staff with a technical and administrative induction on July 16th, 2020 and protection training that covered four half days between the 6th and the 14th of August.

Coordination and response plans: GC signed Memorandums of Understanding (MoUs) with the Municipal Emergency Committees (CODEM) in La Esperanza, Intibucá, Villanueva, and Puerto Cortés. The municipalities are hosting GC staff in their offices and have designated warehousing space for the handwashing kits and disinfection kits. GC also signed an MoU with COMPIRONIL, the civil society organization coordinating the response

[1] Cumulative number of beneficiaries was mistakenly reported as 14,934 in the September report

to COVID-19 in the municipalities of La Esperanza and Intibucá. GC Health Officers held work sessions with Cortés' Regional Health Department and with CODEM in both Villanueva and Puerto Cortés through an online platform in July. The sessions enabled GC to get a better understanding of the transmission dynamics of COVID 19 specific to each municipality and support the development of a detailed operational plan for both Villanueva and Puerto Cortés. The development of the operational plans for La Esperanza and Intibucá took place at the beginning of August in close collaboration with CODEM and the Regional Health Department. GC continues to coordinate with CODEM to discuss the mobilization of medical personnel and community health volunteers.

Logistical support: GC leased seven vehicles for the municipal ERRs; the vehicles were operational in early august. GC also finalized the procurement of PPE for the ERRs and community health volunteers on September 28th. The PPE will be handed over to the ERRs during the next reporting period. See the *Procurement and Logistics* section below for more information.

Neighborhood selection: GC completed a mapping of all local stakeholders and their responses, including municipal health establishments, local civil society organizations (e.g. administrative water boards), other aid organizations, and relevant private sector actors. GC used information provided by CODEM, epidemiologic information (including the current number of cases), and the distance and vulnerability of each neighborhood, to select communities in each municipality that GC would work closely with, including for the CMDS component, the community health volunteers, and the provision of the WASH NFI kits. The communities selected are outlined in the table below.

Department	***Municipality***	***Communities***
Cortés	Villanueva	La victoria, Gracias a Dios, 21 de Abril, Tres Reyes, Barrio Las Flores, Barrio Las Lomas, Barrio Jose Cecilio del Valle, Barrio Martin Fajardo, Guacamaya, Jesús de Nazaret, Martinez, El Milagros, Apadrinados. *Note: these 13 communities fall under four sectors.*
Cortés	Puerto Cortes	Baracoa, Calan, Chameleconcito, Barrio Buenos Aires
Intibucá	La Esperanza	Santa Anita, Arenales de Chogola
Intibucá	Intibucá	Llano de la Virgen, Sata Catarina

Community Meeting and Dialogue Sessions: In targeted neighborhoods, GC organized CMDS to improve the population's access to information, identify problems and solutions, and promote the implementation of community actions to improve surveillance and prevention. The selection of CMDS participants varies by neighborhood; it is based on each communities' structure and key local actors. CMDS participants usually include representatives from community-based organizations (Water Boards, *partonatos*, other organized groups), the local emergency committee (CODEL), religious establishments, local health establishments, parent committees, and any other major community organization. The frequency of CMDS varies by neighborhood and depends on the issues being discussed and addressed; on average they take place every two weeks. During the sessions, participants discuss the COVID-19 situation in the municipality, review the data from the local health establishment(s), evaluate the current response, and discuss proposed adjustments and new courses of actions.

Ana María Medina is a youth from the community of Arenales-Chogola, in the municipality of La Esperanza. She is participating in the CMDS in her community.

"I am happy to participate in the community dialogue sessions in my capacity as president of the community's board of trustees, since, through these sessions, we make known how our community is organized and the way in which we are working. It also helps us to strengthen and improve communication with community-based organizations. The participants are informed of the COVID-19 situation in our community, we analyze the information provided to us, we commit to defining a plan, and work closely with health personnel in community activities for the prevention and control of COVID-19."

GC began CMDS in the selected neighborhoods in September. Each community (12 in total) has so far held one session and initial sessions focused on

analyzing why COVID-19 is spreading in each community and providing key risk communication messages to CMDS participants.

CMDS with truckers: GC is working with the Puerto Cortés Port Authorities to organize CMDS with truckers. With the *confinimiento* lifting, the Port Authorities are first focusing on ensuring things go smoothly as things reopen.

Community health volunteers: In Villanueva, GC was already working closely with the network of community health volunteers managed by Villanueva's health services for the Zika response under the USAID-funded *Nuestra Salud* program. Under HACER, GC is working with the municipal health services in Villanueva to reorient volunteers to support the COVID-19 response. GC provided them with training and supported their integration into the Rapid Response Teams (ERR). GC is also piloting the activation of the community volunteer network to support the response in Puerto Cortés, La Esperanza, and Intibucá, based on the Villanueva model. The model is being piloted in the same neighborhoods selected for the CMDS given that they have been identified as priority communities by the municipalities, based on high rates of infection and low access to medical services. GC presented the Villanueva model to CODEM's medical management team in all three municipalities. Following positive response from CODEM, GC worked closely with local health services to select and train the community health volunteers.

Volunteers were chosen from lists developed/kept by the local health establishments of people that support health initiatives in their communities; these people are often already recognized as health leaders in their community and have previously supported other health initiatives (e.g. vaccination campaigns, distribution of mosquito nets). The health volunteers are selected in close collaboration with the local health establishments, community leaders, and municipalities.

Doña Zelfa Areli Domínguez Gonzalez has supported health initiatives in her community of Santa Catarian, in the municipality of Intibucá for over eight years. She is now a community health volunteer under the HACER project.

"The HACER program has allowed us, the leaders of the community, to meet and talk again after months of confinement in our homes. With the training they gave giving us, I feel more confident supporting the community under the supervision of the local health center staff and HACER staff. In home visits, I am better able to direct prevention messages and advise how to avoid COVID-19 infection. We accompany the rapid response teams (ERRs) and soon I will be proud to support the delivery of hygiene kits and continue to provide prevention messaging to benefit the families in my community"

GC conducted trainings for 26 community health volunteers in Villanueva, 16 in Puerto Cortés, 8 in La Esperanza, and 13 in Intibucá. Trainings included contact tracing, disease surveillance, infection prevention and control (IPC), risk communication, hygiene promotion, kit distribution protocols, and working with the ERRs. Volunteers received stipends of 250 Honduran Lempira (equivalent to about $10.25) on days they support ERRs or conduct activities within the community. The stipend amount is in line with what other actors provide and national standards, $10.25 in urban areas and $8.20 in rural (GC operates in urban areas where caseloads are higher). In Honduras, community health volunteers only receive stipends for certain activities (e.g. sensitization campaigns, kit distribution).

During this reporting period, in addition to supporting ERRs with household visits to facilitate their access to their community, community health volunteers conducted risk communication activities in the community and supported the local health establishments to provide services in the community. During the next reporting period, they will also support the distribution of the hygiene and disinfectant kits.

***Surveillance of COVID-19 in the community*:** During this reporting period, twelve ERRs (2 in La Esperanza, 2 in Intibucá, 4 in Villanueva, and 4 in Puerto Cortes) visited 17,091 people (9,132 women and 7,959 men, of which 761 (4.4%) tested positive for COVID-19. In addition to the household visits, ERRs have carried out information campaigns in public spaces, set up containment areas, and medical brigades.

Dead Body Management (DBM) Training: In the proposal GC indicated that we could provide dead body management trainings to ERRs and other key personal, if needed. In early July, SESAL and PAHO trained medical

and paramedial personnel of national hospitals, municipal triage centers, funeral homes, and other key units (fire department, red cross) in DBM. CODEM also provided information on what to do when a household member dies in the home to households . With this in mind, GC is not providing further DBM training under HACER. GC has included it as a topic of discussion in the CMDS.

Risk communication: GC coordinated closely with Cortés' Regional Health Department as well as the Municipal Communication Manager in La Esperanza, to select and create risk communication material and define mechanisms to promote 1) health messaging and 2) good hygiene and disinfection practices. The KAP survey that GC conducted also provide valuable information about the most effective communication channels and ways to tailor messaging to targeted communities. GC follows WHO guidance as a basis for communication materials and activities. GC finalized the communication plan is divided into three sections, each targeting a different key audience, with distinct objectives and intervention methods. It can be summarized as follows:

KEY AUDIENCES	OBJECTIVES	INTERVENTION METHODS
Departmental, municipal ,and local authorities	Advocacy	Bilateral and multilateral coordination meetings, supported by presentations
Community leaders, community volunteers, and other organizations	Active participation, community involvement	Interpersonal communication, CMDS. Support of written material or presentations.
Households	Behavior changes, promoting unified messages	Mass media, interpersonal and digital communication media. Written and audiovisual material.

Objective 2: Water, Sanitation and Hygiene (WASH)

Hygiene promotion

The ERRs provided hygiene promotion to the 17,091 people they visited. Topics included critical moments for handwashing, handwashing techniques, among others.

WASH NFIs

During this reporting period, GC procured hygiene and disinfection kits. Procurement of the kits was delayed, initially due to the need to go through a second RFQ process for the procurement of soap bars and subsequently due to problems in identifying locally or regionally manufactured PPE- see *Procurement and Logistics* section below. The supplier will now deliver the kits to the warehouses on October 5th and 6th and distributions will begin at the end of October. GC finalized its Standard Operating for Procedure (SOP) for the distribution of the kits; distributions will take place door-to-door over six weeks. The kits will be distributed by community health volunteers in the neighborhoods identified as particularly vulnerable and targeted for the CMDS. Beneficiaries will include:

- Households visited by ERRs
- Vulnerable households identified in collaboration with the CMDS. Criteria varies by community but usually includes:
    - Household with an family members in high risk categories (e.g. elderly family member or someone with a pre-existing condition)
    - Low income and low or no access to hygiene items
    - Household headed by single mothers
    - Households with no or limited access to water and/or basic sanitation facilities

GC is working closely with the community (CMDS members, health facilities, etc.) to identify beneficiaries meeting the criteria. During distributions community volunteers also provide key risk communication messaging to beneficiaries and inform them of the feedback mechanism (FBM) set up by GC (see below). Risk communication material and information on the FBM is also included in the kits.

Accountability to Affected Populations (AAP)

During this reporting period, GC developed an SOP for its Feedback Mechanism (FBM). The M&E Officer received training on GC's FBM and chosen platform, Podio. Members of GC's Syria team shared best practices and lessons

learned from the FBM used for their OFDA projects. GC set up the feedback phone number and email. No feedback has been received so far but GC anticipates that we will receive feedback following the distribution of the kits.

Information on the FBM is included in the hygiene and disinfection kits and volunteers provide information to beneficiaries on the FBM during distributions. GC Health Officers have also communicated information on the FBM during CMDS and meetings with CODEM and the community. Posters on the FBM have been placed in relevant public spaces.

Monitoring, Evaluation and Reporting

***Baseline survey*:** GC's baseline survey aims to inform GC's approach and gather baseline data to measure the impact of HACER activities. The survey also included a KAP assessment on COVID-19 understanding in targeted communities that enabled GC to better tailor its RCCE activities. GC hired a consultant to conduct the baseline survey. GC trained five supervisors and ten enumerators in data collection standards and methodology. Enumerators conducted the interviews in person, ensuring that appropriate precautionary measures were taken (e.g. interviewing one household member at a safe distance). A total of 391 households were interviewed across all four municipalities of intervention between the 24th and 28th of August. The consultant reviewed and cleaned the data and GC put together the baseline report. The report included key recommendations that have helped inform program adjustments highlighted in the *Challenges, Lessons Learned, and Program Adjustment section* below. Results from the KAP component were also shared with municipalities and other stakeholders to better inform COVID-19 response. The baseline report is available in Annex A.

***Gender Equality and Social Inclusion Assessment*:** GC also conducted a gender and social inclusion assessment to ensure that the program sufficiently addresses the needs of vulnerable individuals. The assessment is available in Annex B. GC will also be conducting informal Focus Group Discussion (FGDs) in November as part of the CMDS to better understand challenges to mainstreaming gender equality and social inclusion in the communities COVID-19 response

Post distribution Monitoring: GC has developed the PDM questionnaire and will conduct PDM two months after the kit distribution (this allows enough time for the households to use the kits). Given that the distributions were delayed, GC will be requesting a No Cost Extension (NCE) to be able to conduct PDMs and final KAP survey two months after distribution. However, if an NCE is not approved, GC will conduct PDMs two to three weeks after the end of the distribution.

Private Sector FGDs: GC had initially planned to conduct FGDs with private sector actors in Puerto Cortés to better understand the barriers faced by companies in implementing COVID-19 preventative measures. However, following discussions with CODEM, GC has prioritized the expansion of the community health volunteers in Villanueva and La Esperanza instead. GC is still working with Puerto Cortés Port Authorities to organize the CMDS with the truckers given that they have been identified as one of the most at risk industries.

Procurement and Logistics

Vehicle leases: GC leased seven pick-up vehicles, three in the municipality of Puerto Cortés, three in Villanueva, and one in La Esperanza. The vehicles leased are a Japanese make, leased from Honduran suppliers. Given that these are short term leases of less than 180 days, they are not subject to US manufacturing requirements.

Kit procurement: GC experienced delays in the procurement of the hygiene and disinfectant kits. While GC was able to procure most of the items for the hygiene kits in August, GC received only one offer for the soap bars included in the handwashing kits. GC determined this offer unreasonable given that the cost per soap bar was significantly above market price. GC therefore launched a second Request for Quotations and identified a supplier able to provide the soap at a reasonable cost. Furthermore, given that PPE is included in the kits, GC experienced delays due to the difficulties in identifying locally or regionally manufactured PPE (see below).

PPE: GC was not able to identify some locally or regionally manufactured PPE items (including masks). Given USAID's PPE guidance, GC is not currently able to procure PPE for non-staff members than isn't locally or regionally

manufactured; this includes PPE for ERRs and beneficiaries. Given that 1) PPE for the ERRs is critical for their safety and 2) the PPE distributed to beneficiaries are part of the handwashing/disinfectant kits, GC has submitted a request to the Agreement Officer to allow GC to purchase PPE manufactured outside the region. The request was approved in October.

Challenges, Lessons Learned, and Program Adjustments

PPE procurement: See above in *Procurement and Logistics section*.

Movement restrictions: Although virtual communication has facilitated coordination with municipalities and start-up activities, the movement restrictions imposed by the GoH often made community mobilization challenging, particularly when it comes to training the community health volunteers and conducting the CMDS. GC coordinated with CODEM to enable exemptions from travel restrictions in cases where in-person trainings and CMDS can be held safely.

Program adjustments: As indicated above, GC has adjusted its activities to respond to baseline findings and the epidemiological situation and response capacity in the municipalities of intervention. These changes remain within the scope and objectives outlined in the initial proposal. Specifically, GC expanded its activities in the department of Intibucá based on baseline findings and changing needs. GC is

- Including the municipalities of La Esperanza in the handwashing and disinfection kit distribution (we originally only planned this activity in Puerto Cortes and Villanueva). This is based on results from the baseline survey that indicated difficulties accessing those items in the department of Intibucá. Only 16% of the kits will be distributed in the department of Intibucá and the remaining 84% will be distributed in the department of Cortes.
- Expanding the community volunteer component to the municipalities of La Esperanza and Intibucá. This is due to much lower municipal capacity in the Dry Corridor and a resulting need to increase community involvement/response.
- In the Dry Corridor, focusing on two municipalities in one department instead of the initial three municipalities in three departments included in the proposal. This enables us to provide a more comprehensive response in targeted municipalities.

Furthermore, GC is expanding our beneficiaries for the handwashing/disinfection kits from only including households visited by the ERRs to also including vulnerable households in neighborhoods with high number of cases.