EVALUATION OF THE USAID/HONDURAS PRIVATE SECTOR POPULATION II PROJECT (522-0369)

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

TABLE OF CONTENTS

ANNEXES

APPENDICIES

ABBREVIATIONS

AHLACMA	Associacion Hondurena de Lactancia Materna
USAID/W	USAID/Washington
AIDS	acquired immunodeficiency syndrome
ASHONPLAFA	Associacion Honduerna de Planificacion de la Familia (Honduras)
AVSC	Association for Voluntary Surgical Contraception
CDIE	Center for Development Information and Evaluation (PPC,AID)
CESAMO	a MOH center with one or more physicians and nurses who offer curative and primary health care
CESAR	a MOH center with one or more auxiliary nurses who provide primary health care and a limited range of curative services and medications
CPI	consumer price index
CPR	contraceptive prevalence rate
CPS	contraceptive prevalence survey
CPTs	contraceptive procurement tables
CSP	Community Services Program
CYP	couple years of protection
EFHS	Epidemiology and Family Health Survey
FP	family planning
FPMD	Family Planning Management Development Project
GNP	gross national product
HMO	health maintenance organization
IHSS	Instituto Hondureno de Seguridad
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	intrauterine device
MANDOFER	a pharmaceutical company with which ASHONPLAFA has a contract for the SMP
MCP	Medical Clinical Program
MIS	management information systems
MOE	Ministry of Education
MOH	Ministry of Health
NGO	non-governmental organization
PC	The Population Council
PEC	Programa de Educacion Comunitaria
PIO/T	project implementation order/technician (technical services)
PLAN	Foster Parents Plan International
POPTECH	Population Technical Assistance Project

PSP II	Private Sector Population II Project
PVO	private voluntary organization
SAC	Clinic Administration System
SDP	service delivery point
SECPLAN	Ministry of Planning
SIES	Sistemas Integrado de Estadisticas de Servicio
SMP	Social Marketing Program
SOMARC	Social Marketing for Change Project
SOW	scope of work
STD	sexually transmitted disease
TA	technical assistance
TFR	total fertility rate
TV	television
USAID	United States Agency for International Development
VSC	voluntary surgical contraception
WRA	women of reproductive age

EXECUTIVE SUMMARY

USAID/Honduras contracted the Population Technical Assistance Project (POPTECH) to conduct the final evaluation of the Honduras Private Sector Population II project (522-0369). The purpose of the evaluation was to assess whether the project achieved its purpose, to examine the roles of the Associacion Hondurena de Planificacion de la Familia (ASHONPLAFA) and different project participants, to evaluate project performance, and to identify major lessons learned and needed adjustments to strategies, methodologies and indicators for the implementation of the follow-on project. A four person team was in Honduras for a month, concluding their visit on November 17, 1994.

At project outset in 1989, Honduras had a population growth rate of 3.1 percent per year, high infant and maternal mortality rates and a population expanding faster than the coverage growth of the national social service and employment infrastructures. The project goal was to reduce the national total fertility rate (TFR) from 5.6 in 1987 to 4.7 in 1995: to reduce the TFR for rural women from 6.9 to 5.8 and the TFR for urban women from 3.8 to 3. The specific purpose was "to contribute half of the increase in contraceptive prevalence from 41 percent in 1987 to 50 percent in 1994." The project contributed directly to strategic objective number 3 of the current USAID Action Plan, which is to improve family health. The project worked toward this objective by helping couples to plan their families, which is critical to reducing both infant and maternal mortality rates, and by assisting directly in prevention of acquired immunodeficiency syndrome (AIDS) through expanded promotion and distribution of condoms (Honduras reports the highest number of AIDS cases in Central America).

ASHONPLAFA, the principal project participant, has provided family planning services at 1,963 rural and urban distribution points and medical services at six ASHONPLAFA clinics and seven private clinics in all geographic areas of the country, despite strong criticism from the Catholic Church. In addition, through a contract with one of Honduras' largest pharmaceutical distributors, it has provided contraceptives to over 600 pharmacies and stores throughout Honduras. The association has achieved 82.5 percent of the couple years of protection (CYP) targets set up in the original project logframe and later amendments.[1] The ASHONPLAFA Medical Clinical Program (MCP) achieved 83.8 percent of the targets, the Community Services Program (CSP) 81.3 percent and Social Marketing Program (SMP) 78.2 percent. CYP in 1993 was 19 percent higher than it was in 1991.

ASHONPLAFA has devoted considerable institutional effort to cost recovery and income generation: it has steadily increased prices, significantly increased client volume, significantly increased revenues in Honduran lempira, and has improved the execution of its budget. In 1994 the level of self-sufficiency is projected to be 27 percent, having steadily increased from 21 percent in 1990, to which level it had dropped from 28 percent the year before. Although levels of self-sufficiency increased significantly in five of the six regional offices, they fell in Tegucigalpa, the largest office. In 1989 the Tegucigalpa Regional Office incurred 36 percent of total regional costs and was 108 percent self-sufficient for direct costs; in 1994 it incurred 47 percent of the direct regional costs and was only 37 percent self-sufficient. Continuing institutional needs include cost control, pricing strategies based on costs and a sliding fee scale, and generation of income in addition to program service charges.

[1] Based upon nine months of MCP and SMP 1994 data; only six months of CSP.

The administrative reorganization of ASHONPLAFA has increased delegation of authority from the central office and has given the regional offices increased latitude to plan and manage their programs. Despite this advance, several problems noted at the project's mid-term still existed at the project's end. The financial accounting and other management information systems (MIS) were not in use in all of the regions, did not provide cost accounting information, and did not provide regional and mid-level staff members with data about the programs so that corrective measures could be taken. Clinic underutilization is also a problem.

The major conclusions of this evaluation are as follows:

1) The team projects that ASHONPLAFA will achieve about 88 percent of the 1989-1994 CYP targets. Despite this underachievement, in light of clinic underutilization, the team believes that targets, particularly MCP targets, should be set much higher under the new project.

2) Continued efforts are needed to develop a regional organization with appropriate delegation of function, an operating management information systems (MIS) that can assist staff at all levels in management and planning, a self-supporting social marketing program and the ability to budget effectively.

3) Donors need to agree on a strategy for ASHONPLAFA that includes concrete objectives for the next five-year period.

4) Quality of medical services requires additional attention. In some instances, training and sterile procedures were found in need of improvement. A quality control reporting and supervision system needs to be installed so that ASHONPLAFA's good reputation for medical service delivery is maintained.

5) During the next five years, the IEC component needs to be strengthened by developing a new marketing and advertising plan for social marketing, as well as an information and education strategy for the other service programs. There should be spot checks on particular media efforts to see if messages are received and understood by target audiences. Regions need to have some control of the IEC budget for local efforts.

6) Efforts with other private voluntary organizations (PVOs) were somewhat successful in increasing knowledge and use of family planning, but operations research is needed to more fully understand rural demand for family planning.

7) Indicators under the new project should include functional outputs, service, and service utilization outputs.

Lessons Learned:

8) When a project has potentially conflicting objectives (expanding geographic coverage and cost- recovery), clear guidance must given as to which objective should receive greater emphasis.

9) Changing the structure and management policies of an institution is a long process that requires clear, agreed-upon steps as well as understanding and patience on the parts of the members of the organization and USAID.

10) Donors and grantees should establish agreed-upon plans and objectives for shifting financial responsibility to the grantee.

11) To measure impact, as was desired in this evaluation, population-based data is necessary. USAID should attempt to carry out demographic and health surveys in time frames which would support bilateral population projects.

SUMMARY OF RECOMMENDATIONS

In conjunction with ASHONPLAFA, USAID should:

1) Set targets for self-financing, including targets for mid-point and end-point self-financing.

2) Provide social marketing technical assistance (TA) to train the current program director, revise and update the marketing plan and develop strategic market niches for the CSP and SMP.

3) Provide TA to help the IEC program develop materials for the illiterate and barely-literate and to evaluate the program.

4) Provide TA and local-cost support to improve personnel management through development of a job classification scheme, a remuneration system, a training needs assessment and a training program.

5) Provide MIS technical assistance.

USAID should:

6) Provide support to Foster Parents Plan (PLAN) for training and referral for family planning and for small, applied research projects on rural demand for family planning.

ASHONPLAFA should:

7) Develop strategies for increasing revenues, including greater utilization of clinics. The possibility of contracts with health maintenance organizations (HMOs) and other private insurers to reimburse ASHONPLAFA for affiliate family planning services should be contemplated during the follow-on project design.

8) Increase CYP outputs, productivity and utilization through better promotion of services; expansion of the morning shifts for voluntary surgical contraception (VSC) services; inclusion of new contraceptives currently not provided, (such as NORPLANT® and the injectables); expansion of laboratories that provide tests for fertility, sexually transmitted diseases (STDs) and reproductive health problems; improvement in cost-recovery mechanisms; and possible development of mobile clinics, nurse-staffed mini-clinics and intrauterine device (IUD) insertion services in rural areas.

9) Institutionalize sliding fee scale.

10) Remedy problems noted in quality of care (insufficient counseling, control of HIV infection and training of providers).

11) Seek a yearly target rate of CYP growth that significantly exceeds the rate of growth in the number of women of reproductive age.

Finally, ASHONPLAFA and USAID should design the new project, and monitor and evaluate its functional outputs, service, and service utilization output indicators.

1 BACKGROUND

1.1 Demographic Data

Data from the Ministry of Planning (SECPLAN 1988) indicate that when the Private Sector Population II project (PSP II) was initiated Honduras had a population of 4.4 million with a crude birth rate of 38 per 1,000 and a crude death rate of 7 per 1,000, which resulted in a natural rate of increase of 3 percent per year. In 1994, SECPLAN projected a population of 5.5 million with a crude birth rate 34 per 1,000 and a crude death rate of 6.4 per 1,000, which brings the natural rate of increase to 2.8 percent per year.

According to the Epidemiology and Health Survey (EFHS), the 1987 contraceptive prevalence rate (CPR) was 41 percent, while the 1991 CPR was 47 percent. In 1991, 50 percent of women surveyed did not desire their last child. In 1987, traditional methods accounted for 7.4 percent of method use, while these methods accounted for 11.7 percent in 1991. Growth in the use of modern methods over this period was a modest 1.8 percent. These rates are based on "women in union" (i.e., married women), which leaves out roughly 40 percent of fertile-aged women, including adolescents and single women, many of whom are said to be sexually active. (One third of all families are headed by a woman.) The 1987 EFHS reported that urban areas made greater use of contraceptives than rural populations, suggesting the need to increase efforts to reach the rural population with family planning information and services. This is particularly important given the fact that over half of the population resides in rural areas where fertility remains high.

1.2 Socioeconomic Background

The Central Bank projects that Honduras' per capita gross national product (GNP) in 1994 was $615, making Honduras second poorest among all Latin American nations. The country experienced favorable economic growth in the early years of the project, but its high level of international debt, combined with two years of drought, has forced the government to retrench, illustrated by the reduction of social spending in the health sector. Over the project lifespan inflation has severely affected the poorest segment of the population (the lempira exchange at the beginning of this project was L 2/US$1 and now is L 9/US$1). A 1993 Inter-American Development Bank analysis indicates that the poorest 20 percent of the population receive 2.7 percent of the national income while the wealthiest 20 percent receive 63.5 percent. Sixty-six percent of families live below the poverty level. Other indicators of underdevelopment include low levels of education (an average of two years), high levels of illiteracy (32 percent), high levels of teenage pregnancy (50 per 1000), and high levels of inability to gain access to health services (36 percent).

1.3 National Climate for Family Planning

For the last 30 years there have been at least limited family planning services in Honduras. In 1963, ASHONPLAFA opened its first clinic in an Ministry of Health (MOH) hospital and gradually expanded its work with support from the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), the Pathfinder Fund, Associacion for Voluntary Surgical Contraception (AVSC) and other organizations. USAID provided support for substantial expansion into a six-region national program with the PSP I project in 1985. The MOH has provided limited

family planning services since 1976, when a program was initiated with USAID assistance. Until recently, there has been slow growth in family planning activities.

In 1990, the MOH officially incorporated a "reproductive risk approach" into its infant and maternal health programs. Provision of family planning services to women at reproductive risk (i.e., women under 18 or over 35 years of age, women of high parity and women who are at risk of becoming pregnant within two years of their most recent delivery/pregnancy) is one component of the reproductive Risk Approach. Consequently, the MOH has recently begun to increase provision of family planning services through its existing service delivery network. The government has allowed private organizations to expand their family planning programs with few restrictions, and there are no restraints on the import or sale of contraceptives by pharmaceutical companies.

The Catholic Church, however, has opposed family planning over the years and mounted an organized opposition, including opposition to an initiative for a national population policy. The Church, together with a local pro-life organization, successfully halted discussion of this initiative and formed part of the Honduran delegation to the 1994 International Conference on Population and Development where it tried to block the final plan of action. Only recently have Hondurans increased their use of contraceptives in the face of the Church crusade against modern methods. The 1991 EFHS showed that over 70 percent of family planning acceptors were Catholics.

1.4 Project Background and Evolution

PSP II was originally authorized for July 1989 to June 1995 and has now been extended through March 1996. The level of USAID/Honduras funding is US$16 million, with an anticipated US$2.1 million from other donors and US$7.1 million from the host country, i.e., from ASHONPLAFA and other private voluntary organizations (PVOs). The first phase of the project, PSP I (522-0286 - 1985-1989), was designed to assist ASHONPLAFA in expanding family planning information and services throughout the country. The project was based on evidence that a large unmet demand for family planning services existed and that the private sector, of which ASHONPLAFA was the most important provider, would be the most efficient provider of those services. PSP I contributed to an increase in contraceptive prevalence from 34.9 percent in 1984 to 40.6 percent in 1987, as documented by the 1987 EFHS. As this project was concluding, it became evident, however, that although ASHONPLAFA was making gains, problems remained related to its organizational structure and low coverage of target populations in some areas of the country. Rural coverage was particularly a problem.

Until 1985 ASHONPLAFA had been a small organization, but in a relatively short period of time (the duration of PSP I) it expanded operations throughout Honduras, including construction and opening of regional offices in San Pedro Sula and Choluteca. Construction was begun on two additional clinics, La Ceiba and Juticalpa, which opened in 1990. Partially because of the rapidity of this growth, ASHONPLAFA was unprepared to manage this larger and more complex organization. Even though decentralization was a primary component of PSP I, practices were still too centralized and authoritarian; the need for decentralization and delegation of authority was evident. Additionally, as ASHONPLAFA grew, its dependence on outside funding also increased.

PSP II was designed to address these problems, to support the development of a more efficient and effective ASHONPLAFA, and to increase efforts to reach underserved rural populations, including support to PVOs working on outreach to those rural populations.

1.5 Project Goal and Purpose

The goal of this project is to reduce the national total fertility rate (TFR) from 5.6 in 1987 to 4.7 in 1995; to reduce the TFR for rural women from 6.9 to 5.8; and the TFR for urban women from 3.8 to 3. The specific purpose of the project was "to contribute half of the increase in contraceptive prevalence (percentage of couples in union of reproductive age using modern family planning methods) from 41 percent in 1987 to 50 percent in 1994." Verifiable indicators specified in the logframe were that “of couples in union (i.e., married couples), 40 percent in rural areas and 65 percent in urban areas are using a modern contraceptive, of which 50 percent will be doing so as a result of this program.” The means of verification for both TFR and CPR indicated in the logframe were the Contraceptive Surveys (CPS) of 1991-1992 and 1993-1994.

1.6 This Evaluation

The Population Technical Assistance Project (POPTECH) was contracted to conduct the final project evaluation with the purpose of assessing whether the project achieved its purpose, examining the roles of ASHONPLAFA and different project participants, and evaluating project performance. In addition, the final evaluation was to identify major lessons learned and needed adjustments to strategies, methodologies and indicators for the implementation of the follow-on project.

The four-person team arrived in-country on October 9, 1994. The evaluation methodology consisted of document reviews, personal interviews with ASHONPLAFA, Foster Parents Plan International (PLAN) and Population Council staff, participant observations, observation of VSC procedures, and interviews with a wide range of stakeholders in all regions (for more information on the methodology, please see Appendix B). During their first week in Honduras, team members collected and reviewed documents and participated in briefings with USAID and ASHONPLAFA officials. During the second week, the team held further interviews with ASHONPLAFA, PLAN and Population Council staff; traveled to the other five ASHONPLAFA regional offices; visited pharmacies and community service distributors in those areas; and reviewed USAID files and procedures. During week three the team continued its review, held meetings with other project implementing units, and delivered a preliminary briefing to USAID population staff. During the fourth week the team wrote this report. On November 10 - 11, team members briefed USAID and ASHONPLAFA. The team departed Honduras on November 12 and the project chief of party left on Nov. 18, 1994.

2 OVERALL PROJECT PERFORMANCE AND DESIGN

2.1 Project Impact

What impact has ASHONPLAFA had on increasing contraceptive prevalence in Honduras?

Strict attribution of impact is difficult because the time frames of this project (June 1989 to 1994) and national reproductive health surveys (1987 and 1991) do not overlap and because the CPS scheduled for 1994 has been delayed. The data available, however, do indicate ASHONPLAFA has contributed to increased CPR. The CPS of 1991-1992 indicated that since 1987 the TFR had fallen to 5.1 nationwide and to 6.4 for rural women and 3.8 for urban women. Modern method CPR rose slightly from 32.9 percent in 1987 to 34.7 percent in 1991. According to the 1991 EFHS, ASHONPLAFA provided 60 percent of family planning services to those who were using modern contraception at the time of the survey. ASHONPLAFA has provided 1,162,320 couple years of protection (CYP) over the life of the project. ASHONPLAFA growth of CYP averaged 8 percent a year while the growth rate of women of reproductive age (WRA) was 4.0 percent a year. Real assessment of the impact will have to wait until completion of the 1995 CPS.

2.2 Effectiveness

In terms of cost effectiveness, how does this impact compare to the $14.9 million investment?

The team applied the IPPF and ASHONPLAFA method of dividing the yearly total expenditures in dollars by the year-end CYP to come up with an annual cost per CYP (see Table 1). The $11.49 per CYP figure compares favorably to two studies[2], one that shows costs per CYP in five African countries ranging from US$6 to US$33 in 1989 and the second showing the cost per CYP in developing countries ranging from US$11 to US$26 in 1985. Honduras is probably on the low side because of its heavy reliance on clinical methods to provide protection.

TABLE 1

COST PER CYP, 1989 - 1993 (US DOLLARS)					
	1989	1990	1991	1992	1993
Expend	1,350,768	2,088,062	2,212,774	2,814,221	2,817,466
CYP	89,978	205,781	207,908	233,121	245,279
Cost/ CYP	$15.01	10.15	10.64	12.07	11.49

[2] The two studies were: P. Senanayske and R. Kleiman, "Family Planning Meeting Challenges: Promoting Choices" 1989, discusses costs per CYP in five African Countries and P. Bulatoa's "Expenditures on Population Programs in Developing Regions: Current Levels and Future Requirements" 1985 World Bank Working Paper #679.

On a scale from one to ten, where would ASHONPLAFA rate in terms of effectiveness?

On a scale of one to ten, the team rated ASHONPLAFA's overall project performance as a six, with a considerable range across various program areas. The team's average scores for each area were: Community Service Program - eight; Social Marketing Program - five; Medical Clinical Program - seven; overall quality of care - six (method choice -- seven, client information - six, provider/client relations - five); ASHONPLAFA administration and management - five; and regionalization effort - six. The widest divergence of opinion related to "method choice" and the least to "social marketing and medical clinical programs."

How did the project contribute to the Mission's action plan objectives -- specifically to improve family health?

It is evident that this project is integral to the achievement of objective number 3 of the 1995-1996 USAID Action Plan, which is to improve family health. The project contributes to this objective by increasing the percentage of Hondurans who practice family planning; assisting child survival by increasing the time between each birth; and assisting in the fight against acquired immunodeficiency syndrome (AIDS). How much contraceptive prevalence increased during the project period is unknown; however, the continued increase in voluntary sterilization and the expansion seen by both ASHONPLAFA and the MOH in the number of temporary method acceptors suggest that next year's CPS will show increases in both long- and short-term method use. The TFR decline indicates that more women are spacing their children, thus protecting their health and their children's. In addition, commercial sales of condoms are rising, which indicates that consumers are quite aware of the HIV/AIDS threat in Honduras.

Did ASHONPLAFA and USAID respond to the recommendations made in the mid-term project evaluation?

In November, USAID/HRD reported to USAID/ODP that all of the recommendations from the mid-term evaluation had been implemented except for the agreement on USAID-supported personnel costs and fringe benefits, which should be implemented. It reported that ASHONPLAFA's revenue-raising efforts improved as a result of better pricing, expanded demand and increased outside support. ASHONPLAFA is now focusing on cost accounting so that prices better reflect the cost of services (this was still an area of weakness at the end of the project). Increased technical assistance for fundraising and local-cost support has been provided to improve program cost-recovery and is ongoing. Technical assistance in computer networking and development of the management information systems (MIS) will continue through the end of project. Simplifying the Community Services Program (CSP) reporting system has been made part of the MIS technical assistance (TA) and will also continue through end of project. Recommendations to improve the personnel department and also to develop competency and performance evaluation systems are being implemented by both IPPF and the Family Planning Management Development Project (FPMD) and will continue through the end of project. Technical assistance to review the quality and safety of medical services is still pending.

What economic, social and political factors facilitated or impeded project performance? Have the approaches taken by ASHONPLAFA been viable and suitable for wider use?

A number of factors impede the expansion of modern family planning in Honduras, in general, and through this project specifically. The low level of education for women (of the 4,157 women

surveyed in the 1991 Epidemiology Health Survey (EFHS), only 2,238 had better than a second grade education); the high unemployment levels of both men and women; and *machismo* (which has affected acceptance of vasectomies) all slow demand for family planning. Fierce opposition from the Catholic Church and the political left has probably dampened demand in general and probably accounts for the rise in traditional methods relative to modern methods. Additionally, specific to this project, ASHONPLAFA's private sector collaborators in the project - NGOs such as PLAN International, CARE and Save the Children - were all inexperienced in family planning. Each of them, as a result of policy decisions at the international headquarters level, were just entering the field in 1991.

On the other hand, an important facilitating factor is the potential demand for contraception (unmet need). The 1987 CPS estimated this demand as 15.8 percent of all WRA. Seventy-four percent of those classified as having unmet needs were from rural areas. The role of the collaborating PVOs is critical to reaching these women.

ASHONPLAFA's approaches to several of these factors have been viable and suitable for wider use. ASHONPLAFA has steadfastly met the Church's opposition to family planning through IEC campaigns and direct dialogue. It has collaborated well with the PVOs serving rural communities. ASHONPLAFA's approach to dealing with the economic hardship most Hondurans are facing, however, has not been as successful; the sliding fee scale which was a condition of Amendment 14 in 1993 has not been developed.

Conclusions

In the absence of population-based data it is impossible to attribute impact to this project. However, inasmuch as the average ASHONPLAFA growth of CYP has exceeded the growth of WRA by 4.0 percent, ASHONPLAFA has contributed to increased contraceptive prevalence. It has done so at a cost which compares favorably with costs identified in two international studies. ASHONPLAFA is responding to the recommendations of the mid-term evaluation although important actions recommended in that evaluation and in project amendments related to finance and sustainability remain incomplete at this time, namely, those related to cost accounting and a sliding fee scale.

2.3 Project Achievements and Progress Indicators

Did the project achieve its goal, purpose and outputs as stated in the logframe, project paper, and other implementing documents in the following areas: extension of family planning services and activities to rural areas, cost recovery and revenue generation, IEC, medical clinical activities, community services and social marketing? If not, what were the principal constraints?

2.3.1 Expansion to Rural Areas

The project did not fully achieve its planned outputs related to extension of rural family planning services. The project was to expand rural services through the addition of 295 CSP distributors in rural areas and through referral in rural areas to ASHONPLAFA, the MOH and other service providers. ASHONPLAFA has added 235 rural distributors to its network; however, while some of these distributors are in rural regions, such as Gracias a Dios, others are in the

marginal barrios of cities such as Tegucigalpa, where the population is composed mostly of rural migrants. Distributors serving this population have been classified as rural, even though the distance to urban services is short. ASHONPLAFA did not add the planned number (295) of service delivery points (SDPs) due to travel distance, accessibility and cost factors.

Although they had a slow start-up, PVOs are making referrals and providing support so that rural women and men can receive services. Foster Parents Plan International (PLAN), working in 348 rural communities, has reported that, as a result of PLAN referrals, 1,780 rural men and women received VSC, including 751 within the last six months. The Population Council assisted PVOs (including Save the Children and CARE) to train their field staff and volunteers and to become more active in family planning. Save the Children, working in two rural regions, reported that the number of contraceptive users increased over the life of the project. CARE, working in 90 communities in three rural regions where CPR was reported to be 5 percent, has trained health personnel and provided family planning IEC

2.3.2 Cost-Recovery and Revenue Generation

The only cost recovery objective in the Project Paper was that the Social Marketing for Change Project (SMP) become self-sufficient by the end of the project. This output was not achieved. In addition, USAID mandated in the cooperative agreement that the following conditions be met: 1) a pricing strategy be developed to carry out periodic revisions based on personal income and adjustments made accordingly (completed); 2) an incentive program be developed for the Community Services element to increase user numbers (completed); and, 3) that ASHONPLAFA implement a more complete strategy for self-sufficiency. This strategy is not yet completed.

2.3.3 Information, Education and Communication (IEC)

There were six outputs for IEC and five outputs for the old training department. In the IEC element four were achieved: 1) 50 percent of education and promotional efforts would be aimed at the rural population; 2) a strategy would be developed for adolescents; 3) a strategy would be developed to define actions for communication activities supporting service delivery; and 4) a strategy would be developed to coordinate these communication activities. The other two outputs were partially achieved: 1) 25 percent of promotional activities would be directed at men to increase acceptance of male methods; and 2) an advertising agency would be assisted so that it can produce radio and television (TV) spots, maintain billboards, and develop newspaper advertising and press releases.

All five outputs have been achieved: 1) 310 new CSM distributors would be oriented; 2) all distributors would be oriented on CSM/SMP linkup; 3) two new promoters and one new supervisor would be trained and put on the job; 4) a pharmacist employee training program would be in place; and 5) training would be provided for private voluntary organization (PVO) personnel.

2.3.4 Medical Clinical Program

Medical Clinical Program (MCP) outputs through the end of 1994 were expected to be: 66,374 VSC procedures, 12,000 acceptors of temporary methods, 81,589 cytological examinations and 59,000 other laboratory examinations; and 14,000 intrauterine device (IUD) insertions in 1993 and 1994. ASHONPLAFA data indicate that by September 1994 the following had been achieved: 55,376

VSC (83 percent of the target); 10,223 acceptors of temporary methods (85 percent); 136,576 cytologies (167 percent); 72,512 other laboratory tests (123 percent) and 9,445 IUD insertions (67 percent of the target) for 1993-1994.[3]

Clinical facilities remain underutilized. There is ample room for growth in the years to come, particularly in better promotion of the services, meeting the needs of adolescents, expanding morning shifts for VSC and inclusion of new contraceptives (such as NORPLANT® and the injectables). New strategies for service delivery, such as mobile clinics, nurse-staffed mini-clinics and IUD insertion in rural areas, should also be considered.

2.3.5 Community Services Program

The project paper calls for CSP service distributors to be increased by 310, of which 295 were to be located in rural areas. CSP added 416 new service delivery points (SDPs) to its network during 1989-1994, of which 181 were classified as urban and 235 as rural (as noted previously, some of these are in peri-urban areas). Two thirds of the total 1,963 SDPs are classified as rural. CSP has an active role in 264 of the 291 (90 percent) municipalities in Honduras. In addition to the increase in SDPs, the CSP was expected to provide services to 64,000-65,000 active users in 1994. However, ASHONPLAFA no longer keeps track of active users; the CSP services target agreed upon with USAID in June 1993 was 386,150 CYPs by the end of the project. The CSP CYP reported through June 1994 represents 81.3 percent of the target.

2.3.6 Social Marketing

Four outputs were expected to result from SMP efforts: 1) implementation of a contract between ASHONPLAFA and MANDOFER; 2) a distribution network supplying 90 percent of pharmacies and other authorized prescription drug point-of sales outlets; 3) 38,548 CYP in 1994; and 4) 100 percent of operating costs (except product cost) defrayed by project income. ASHONPLAFA achieved the first two outputs, which were process indicators. The last two outputs -- CYP and cost-recovery -- have not been achieved. The projected 1994 CYP is only 72 percent of the target. CYP targets were not achieved for a number of reasons: lack of coordinated strategic direction of the program on ASHONPLAFA's part; insufficient collaboration with MANDOFER; a poor publicity campaign, poor launch of a new commercial line; stock-outs of oral contraceptives at several points; and competition from the CSP, Instituto Hondureno de Seguridad (IHSS) and the MOH, all of which provide contraceptives for free.

ASHONPLAFA data on the level of SMP self-sufficiency (direct costs including the costs of contraceptives) indicate that the level was 35 percent during the first nine months of 1994, 58 percent in 1993 and 68 percent in 1992. To improve SMP performance under a future project, ASHONPLAFA needs to improve planning, monitoring, evaluation, information-sharing and use of data for decision-making. ASHONPLAFA should also use SOMARC technical assistance.

[3] ASHONPLAFA reports 9,445 insertions and a total of 14,073 IUDs sold, including those 9,445 and additional IUDs sold to private providers.

2.3.7 Project Indicators

To what degree were the indicators developed under the Private Sector Population II Project suitable measures of outputs, purpose and goal achievement? How can they be improved?

The indicators identified in the Project Paper for community services, social marketing, IEC, training, and monitoring and evaluation are almost exclusively *process indicators*, except for several service utilization indicators (# of active CSP users, MCP client visits and SMP CYP). Figure 1 presents potential levels of indicators for this project, including inputs, process, outputs and outcomes. Ideally, if the data are available, one would evaluate as far to the right of this conceptual framework as possible; certainly at the level of outputs.

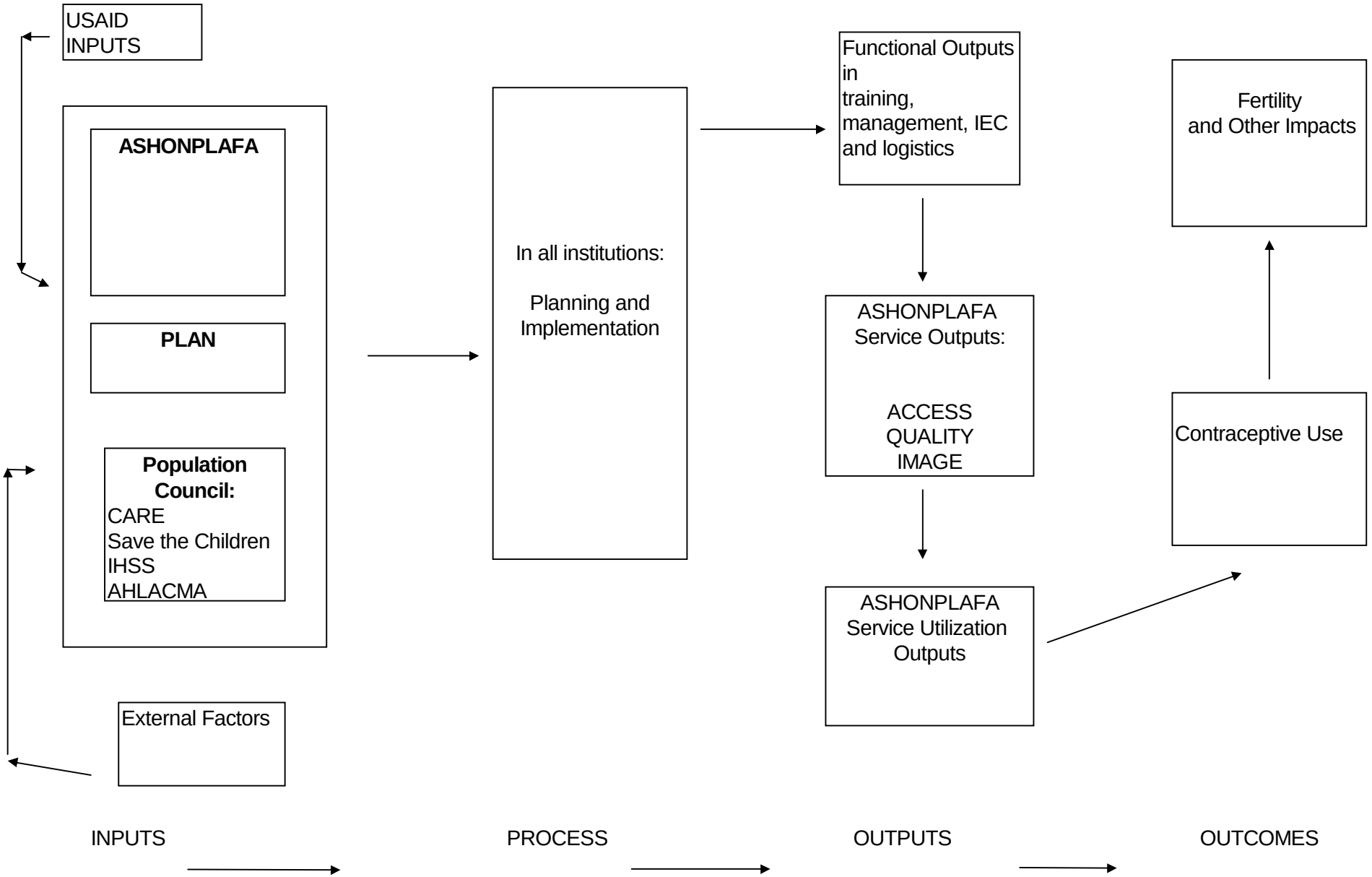
Many good output indicators exist for community services, social marketing, IEC, training, management and medical services. As Figure 1 indicates, there are *functional output indicators* for training, management, IEC and logistics; at the level of services, there are indicators of *service outputs* (access, quality and image) and for the *utilization of services* (CYP, continuation rates, etc.). A project designed with indicators at the output level would facilitate a more rigorous evaluation than one that relies primarily on process indicators. Ideally, of course, indicators of outcome, effect and impact, supported by population-based data, would also be used. See Annex 1 for illustrative indicators that might be used in a future project.

Conclusions

When assessed by process indicators (such as strategies developed or clinics added), ASHONPLAFA has achieved its stated objectives. However, when assessed by output indicators, ASHONPLAFA has generally not done as well. The Association has not met its CYP targets since 1990 and CYP growth in each of the programs has been erratic. Institutional self-sufficiency rose slightly from 1990-1994, but is lower in 1994 than in 1989,

Indicators in this project were process-oriented and imprecise. For instance, rural expansion has been understood to include expansion into peri-urban areas occupied by rural migrants. Indicators under the follow-on project should be more precise and place greater emphasis on ASHONPLAFA's achievement of functional, service, and service utilization outputs.

FIGURE 1: CONCEPTUAL FRAMEWORK OF THE PRIVATE SECTOR II POPULATION PROJECT



2.3.8 Gender

Were the activities and technologies promoted and implemented by the project among men and women in accordance with gender interests and perceived needs?

A response to this question ought to draw on studies on gender and family planning in Honduras. The first question is "how does gender influence women's and men's social, emotional and economic interests and needs in Honduras in terms of family planning?" In order to know whether ASHONPLAFA's activities and technologies were in accordance with those interests and needs, the team would need to ascertain what those interests and needs are. However, given the scarcity of Honduran family planning gender studies, the team reviewed two focus group studies which provide the basis for selection of indicators on gender differences used in this evaluation.[4] The indicators are: accessibility (days/hours of service convenient to user/gender) and quality of care (constellation of services and gender of provider).

In 1992, the Center for Development Information and Evaluation (CDIE) evaluation team, with ASHONPLAFA's assistance, conducted eight focus group sessions with urban and rural women to assess their perceptions of contraceptive access, quality and image. The team concluded that the principal concern of rural women, in terms of access, was distance to a center and the difficulty of being away from home overnight. ASHONPLAFA found that for men, the principal access issue was the day and time of clinic hours. ASHONPLAFA, working with international PVOs, has attempted to address both of these gender-related access issues. It provides a mini-van that transports women from rural communities to and from the clinics. The male clinic is open on Saturday; the day identified by men as most convenient for them.

Both women and men indicated very clearly in these focus groups that the constellation of services available at a family planning program was important. Women indicated that they preferred attending a clinic where they could obtain a full range of maternal and child health care. Men indicated that they would like a male-only clinic that can provide other services for men. ASHONPLAFA has developed services in line with these gender preferences and provides both a women's clinic (no child health) and a men's clinic.

Gender of the provider is important to both women and men; ASHONPLAFA has both male and female physicians and counselors. However, to date the only VSC counselors for the men have been female. IPPF has led both gender workshops and training for department heads and regional directors. ASHONPLAFA held 27 one-day-long workshops on sexuality and gender that were attended by almost 1,000 participants (staff and community). ASHONPLAFA intends to incorporate the collection of gender-disaggregated data at the beginning of the next project.

[4]The first, providing data on the male perspective, is a study by ASHONPLAFA and AVSC on the barriers to vasectomy in Honduras and the development of strategies to increase the demand for male VSC*, Evaluacion de las Barreras a la Vasectomia en Honduras e Implementacion de Estrategias para Incrementar la Demanda por la Anticoncepcion Quirurgica Voluntaria Masculina*, ASHONPLAFA-AVSC, March 1988. The second source of data are focus groups with rural and urban women undertaken by the CDIE team of evaluators of twenty-five years of USAID support to family planning in Honduras *USAID's Family Planning Program in Honduras*.

Conclusions

Given the limited knowledge of gender and family planning issues in Honduras and given the fact that gender, as a concept, has only quite recently been recognized as an important factor in population and development, ASHONPLAFA has done a commendable job in attempting to integrate gender considerations into its programs.

3 ASHONPLAFA MANAGEMENT

3.1 Mission

How successful are ASHONPLAFA strategic plans in the following areas: regionalization, financial self-sufficiency, definition of goals and objectives, long term planning and budgeting?

ASHONPLAFA has engaged in major planning exercises in recent years. The team reviewed two products of that planning: the *Three Year Plan 1995-1997*, mainly prepared for IPPF, and the draft *Strategic Plan 1995-2000* (*The Strategic Plan).* The following discussion is based upon an analysis of *The Strategic Plan* developed in May 1994 during a three-day workshop of intensive participative activities with senior and middle management and the regional directors. The *Strategic Plan* speaks of "beginning to experiment with a more decentralized system, using the concepts of delegation of functions to the regional centers," in one or two regions selected as demonstration sites. ASHONPLAFA believes such experimentation would provide useful information about the decentralization process, would create a favorable climate at the regional centers, and would help to delegate functions. ASHONPLAFA indicates that decentralization will strengthen the capacity of the staff and the system at the regional centers to manage their own programs, make decisions and look for new initiatives. In the *Strategic Plan*, the purpose of the Regions Division is to contribute to the administrative and operational efficacy of the regional centers through the implementation of policies, norms and procedures to reach the goals and objectives of ASHONPLAFA, through central planning and norm setting.

The *Strategic Plan* gives relatively little attention to financial self-sufficiency. The only text related to financial self sufficiency states “that financial self-sufficiency was 25.7 percent in 1993 and was to be 29.2 percent in 1994.” The two major donors in 1994 were USAID (providing 56 percent of total revenues) and IPPF (providing 12 percent). The *Strategic Plan* does not present strategies for surpassing this level of sufficiency.

Conclusions

ASHONPLAFA has produced a document which will be useful in the upcoming USAID negotiations on the new project.; however, more extensive strategic planning is necessary on financial self-sufficiency. Continued participation of the staff in the planning process, including financial planning and monitoring, will be essential to staff commitment. Follow-up and monitoring of the plans and budgets will be required.

3.2 Structure

3.2.1 Reorganization of Central Office

Since the reorganization of central ASHONPLAFA, do administrative and management policies and procedures support delegation of authority? Are these delegations of authority respected?

ASHONPLAFA is structured into six regional offices, including Tegucigalpa where the central office is located. The center in San Pedro Sula was established in 1986, Choluteca in 1988, La Ceiba in 1989, Juticalpa in 1989, and Santa Rosa de Copan in 1991. (Annex 1. Figure 1.2). A major objective of this project was to support increased delegation of authority within the central office and to the regional offices. To guide this process, in March 1993 ASHONPLAFA contracted Price Waterhouse to provide technical assistance on organizational restructuring. The purposes was to narrow the span of central supervision, promote delegation of authority to both department heads and regional personnel, and strengthen the regions. Re-organization, initiated in August 1993, was being completed in November 1994. As part of the reorganization, Price Waterhouse developed an organizational manual and job descriptions for all staff and for the board of directors.

The reorganization reduced the number of staff supervised by the executive director from ten to five (division chiefs of information and marketing, administration and finance, institutional services, regions, and the audit chief). (See Annex 1, Figure 1.3) Staff view the reduction positively; each chief manages with a fair amount of delegation from top management; however, only the executive director or his/her deputy is authorized to fire, sanction, determine salaries or to make personnel decisions. Delegation to other levels is not clear.

A result of the reorganization was the creation of a Division of Regions to coordinate and direct the six regions; most of the Regional Chiefs find this Division functional and helpful. The new organizational structure also seems to promote closer cooperation and support between the Evaluation and IEC departments and the Service Divisions (CSP, SMP and MCP)

3.2.2 Regional Offices

To what extent has decentralization improved regional managers' ability to respond innovatively to the conditions of their regions? To what extent has their response improved quality and availability of services? How can ASHONPLAFA develop goals and long-term planning strategies by region, based on the particular condition of each region?

ASHONPLAFA senior management indicates that it delegates authority to regional chiefs based on their capacity, experience and regional necessities. The box below outlines the team's perception of the degree of authority delegated, by management area.

An important achievement at the regional level is the recruitment of a group of volunteers and the election of a volunteer regional advisory board. Even with the pressures from the Catholic Church and the limited role assigned to them, these regional volunteers continue to be very active in supporting ASHONPLAFA (in some cases they even assist in service delivery). The board is a valuable resource in regional term planning; one member of each regional board represents the region at the national board meetings.

MANAGEMENT AREA	DELEGATION OF AUTHORITY
Planning	Until recently, regional offices had little opportunity for participation. Good planning depends on data; regional offices receive relatively little financial data, analyses, or comparative studies. Planning is based principally on previous performance rather than on demographic and market analysis.
Personnel:	
• recruitment hiring and firing	There is more involvement of regional staff since reorganization. However, central office has authority.
• supervision	All regional staff now report to regional director.
Finance	
• pricing	Central office establishes prices.
• purchasing	Regional limits: L. 3,000 (US$335); L. 2,000 at one time
• supplies	Determined and sent by central office. As a result, there are some problems with stock levels.
• use of regionally generated funds	Deposits are made to, and are under the control of, the central office.
• use of locally earned revolving funds	Regional offices have authority to spend these funds.
IEC strategies and messages	Central office develops these.
Monitoring and evaluation	Insufficient data at regional level to effectively monitor program and budget performance.

3.2.3 The Strategic Plan *and Decentralization*

Do current ASHONPLAFA policies and procedures and long term plans reinforce decentralization? Has the reorganization facilitated decentralization?

In September 1993 FPMD analyzed ASHONPLAFA's structure and administrative systems and concluded: "There is no clear link between the strategic objectives of the institution and the new organization being implemented; the rationale that supports the new structure seems to be almost entirely organizational. Moreover, the aspect of decentralization to the regional level is not well developed; in fact the regional centers could be subject to the same or even worse levels of centralization under the new organization. This latter is a very important point because only decentralization to the regional level will allow ASHONPLAFA to continue to develop, improving utilization of its clinical services, extending coverage and increasing revenue generation to attain some level of self-sufficiency". In response to this analysis, ASHONPLAFA engaged in the

strategic planning mentioned previously and developed the *Strategic Plan.* The Plan, however, contains only a limited discussion of the necessary next steps toward smooth decentralization.

Conclusions

The organizational manual and job descriptions were designed with the intention of decentralizing functions and strengthening the regions and have succeeded to the extent of breaking up the old vertical programs and placing supervision in the hands of the regional staff. However, the manual and job descriptions assign a limited creative role and little authority to the regions. The re-organization could facilitate decentralization, but reorganization by itself will not insure decentralization; it must be supported by clear policies of delegation of authority. Although the process has begun, it will take some time for the staff to be able to assume the responsibility that decentralization and delegation of authority implies.

Regional staff have insufficient data to plan and monitor regional performance effectively; moreover, the attitude that plans, goals and budgets should come from the central office persists to varying degrees in the regions. ASHONPLAFA could enhance the ability of regional managers to plan effectively and respond innovatively by:

- Strengthening the authority of the regional boards so they can run the activities of the region. Business people living in the regions who make decisions for their own businesses (banks, industries, farms and universities) are excellent sources of support.

- Providing planning support from the central office to insure that the regional plans are in accordance with ASHONPLAFA goals, strategies and policies, without taking away the planning capacity of the regions.

- Providing regional offices with data and training them to use data in decision making.

- Conducting meetings with all the regional directors to analyze service and financial data; enable discussion and comparison between regional offices to promote healthy competition and the exchange of lessons learned.

While strategic planning and budgeting have provided useful training opportunities for middle level staff and should improve their commitment to improved implementation in the future, additional efforts are required to link the strategic objectives of the institution and its new organization.

USAID and ASHONPLAFA don't seem to agree on an appropriate level of ASHONPLAFA regionalization. As the new project is developed, ASHONPLAFA and USAID should discuss further decentralization, and most importantly, agree on what is expected of the regional boards.

3.3 Staff and Personnel Management

How effective has the personnel management system been in contributing to achieving project objectives when considering staffing, recruitment, salaries, competency and performance evaluations, rewards and recognition, and turnover. What problems have occurred in the above areas that need resolution?

ASHONPLAFA has 253 motivated and capable personnel who contribute effectively to institutional performance. Under the reorganized ASHONPLAFA, the head of the human resources department (personnel department) reports to the chief of the Division of Finance and Administration. Routine personnel activities are efficiently handled with a computerized payroll system and clear personnel procedures are outlined in the new organizational manual and job descriptions. The competency of prospective personnel is assessed during the hiring process. At the time of the reorganization, staff competency was reanalyzed; performance evaluations take place every six months.

As the number of employees has increased, salaries have declined, so that personnel costs (salaries and fringe benefits) as a percentage of the total budget have decreased from 44 percent in 1990 to 36 percent in 1994. Until recently, remuneration levels seem to have limited ASHONPLAFA's ability to secure the best possible personnel; however, the average salary increases of 20 percent in January and July 1994 appear to have solved that problem. ASHONPLAFA salaries are now closer to Honduran salaries surveyed by Price Waterhouse and Peat Marwick, Mitchel & Co.

Staff indicate that performance is seldom used as a basis for salary determination, although limited rewards and recognition have been given for punctuality and attendance at work. By law there is a "bono vacacional" (a vacation bonus) and ASHONPLAFA also has the "Bonificación por Comisión," a bonus to compensate for the additional work when a worker replaces others. Most fringe benefits of ASHONPLAFA are determined by law; a new law imposing a 14th month of salary (two months severance pay) per year was passed and is being implemented by ASHONPLAFA.

ASHONPLAFA has two different types of workers: those whose salaries are financed by USAID and those financed by IPPF and other donors. In the case of USAID financed salaries, employees are hired as temporary employees with lower fringe benefits than those financed by other donors. The mid-term evaluation recommended that USAID and ASHONPLAFA reach a formal agreement for ASHONPLAFA to absorb personnel costs and fringe benefits. Amendment 14 of June 1993 required that ASHONPLAFA develop a plan for absorption of personnel financed with USAID funds. In 1991, USAID had been financing 62 percent of total ASHONPLAFA personnel costs; the amendment stipulated that by June 1995 ASHONPLAFA should be providing 50 percent of personnel from non-USAID sources. In March 1994 ASHONPLAFA and USAID came to a formal agreement on absorption of personnel costs; they are currently working on a fringe benefits agreement.

While ASHONPLAFA hopes to reach the targeted level of financing (50 percent) by June 1995, at this point, October 1994, USAID is financing 60 percent of ASHONPLAFA's monthly payroll. [See Annex 2, Table 2.1.] ASHONPLAFA believes it can only assume additional personnel costs if there is increased revenue from new donations and/or price increases, or if there are cost reductions. However, ASHONPLAFA was pessimistic about these alternatives due to the reduced funds from other donors (particularly from IPPF) and the difficult economic situation of Honduras.

Over the life of the project, there has been low (10 percent) staff turn-over. During reorganization, turnover went to 12 percent as some medium and high level staff left ASHONPLAFA. Some were offered better job opportunities and others did not accept the changes imposed by the new organization. 1991 was a year with a higher turnover (15 percent), when 21 employees were dismissed for various reasons and 10 left voluntarily. [See Annex 2, Table 2.4] Several problems need resolution: a job classification system, a remuneration system and greater clarity in the organization manual on delegation of authority to the Regional Chief.

Are resources such as equipment and staff being utilized at their maximum capacity? Do the appropriate staff members know how to use the various software? Does the staff have easy access to equipment?

Resources are not used to their maximum capacity. Some clinic facilities are underutilized. In most regional centers, staff use computers only as word processors; few take full advantage of the computer's capabilities. In particular, the System for Clinic Administration (SAC) has not been fully installed nor have staff been trained in its use. Training has been provided in several types of software, but sometimes the software is not available to the staff who were trained in its use. Access is not the main issue; rather the problem appears to be staff interest and capability.

Are the staff in the various programs (e.g. physicians, evaluators, counselors, etc.) receiving training that responds to their needs in a timely manner?

Training targets in the project paper were: training manual completed and in use; two new promoters and one new supervisor trained formally and on the job; and refresher training for all ASHONPLAFA personnel. ASHONPLAFA has carried out these activities. Staff training is now the responsibility of the Division of Human Resources, overseen by the recruitment and training manager. Senior and medium level staff indicate that staff training has been a motivational tool, a fringe benefit and part of the remuneration. It appears there has been little evaluation of training in terms of improved staff performance. Specific unmet training needs includes: logistics management, the clinics management system (SAC) and in the use of computers. Although ASHONPLAFA has developed training plans since 1987, with some yearly updating, the last formal training needs assessment was conducted in 1991.

Conclusions

The personnel management system has contributed to project achievement by insuring the availability of adequate personnel, based on the new job description manual. The system now allows the regions to more actively participate in the recruitment of their personnel. However, while competency and performance evaluations are carried out, they appear to have little effect on promotions or salary increases. Job classification and remuneration systems should be developed. The contribution of personnel management to delegation of authority, to regionalization or to institutional development and/or decision making capacity is limited. Given the many changes that ASHONPLAFA has undergone in recent years, ASHONPLAFA should conduct a formal training needs assessment (and continue such assessments on a periodic basis). Training should be routinely evaluated in terms of its contribution to improved staff performance.

USAID and ASHONPLAFA need to develop an action plan with clear goals, targets and monitoring, for the transfer of personnel from USAID to ASHONPLAFA funding. Although Amendment #14 was signed, USAID and ASHONPLAFA need to negotiate whether personnel support will continue through the year 2000 as the *Strategic Plan* and the IPPF Plan indicate. Under present conditions, USAID should include ASHONPLAFA personnel costs in the new project.

3.4 Finances

3.4.1 Project Expenditures

Provide a financial analysis of project expenditures as compared to the budgets in the project agreement. Provide recommendations on resource allocation among project elements, specifying future expenditures that could be reduced in the follow-on project.

ASHONPLAFA's budget in the project paper was US$14,900,000. [5] The September USAID report indicates that, to date, $13.7 million has been obligated, $9.9 million committed and $8.9 million expended. Table 2 presents the funding levels by line item as of September 30, 1994

TABLE 2

ASHONPLAFA PSP II Obligations, Commitments and Expenditures as of September 30, 1994 (000 US $)			
BUDGET ITEM	OBLIGATIONS	COMMITMENTS	EXPENDITURES
Community Services	2,506	1,783	1,583
Monitoring and Evaluation	612	394	357
Training	598	437	403
IEC	1,063	881	712
Social Marketing	715	552	509
Medical Clinical	4,079	2,951	2,751
Administration	1,879	1,435	1,168
Contraceptives	675	675	675
Technical Assistance	1,645	864	779
Total	13,771	9,972	8,939

Source: USAID Controller's Report

Only 65 percent of the total dollar budget has been expended, principally due to the devaluation of the lempira. The level of expenditure varied by line item; the SMP expenditures were the highest at 71 percent. The technical assistance line item, which could have supported institutional strengthening, was the lowest at 47 percent, perhaps because ASHONPLAFA did not realize that these TA dollars would not reduce funds available in their local cost budget and perhaps because they misunderstood USAID's focus on savings. Other factors contributing to under-utilization are explained below.

Only 84 percent of ASHONPLAFA's annual budgets funded under Cooperative Agreement 522-0369-1 were utilized during the period August 1989 to September 1994. 1990 was an exceptional year with 93 percent of the budget expended (see Table 3).

[5] The project has been extended from 1/21/95 to 3/30 96.

TABLE 3

EXPENDITURES/ PERCENT UTILIZED 8/89 - 12/94 , USAID COOPERATIVE AGREEMENT (000 LEMPIRAS)			
YEAR	**BUDGETED**	**EXPENDITURES**	**percent OF EXPENDITURES**
Aug.-Dec./89	2,695	1,603	59 percent
1990	5,245	4,901	93 percent
1991	11,644	7,855	67 percent
1992	12,483	10,177	82 percent
1993	11,561	10,728	93 percent
1994 (projected)	15,650	14,308	83 percent
TOTAL PERIOD	59,278	49,572	84 percent

Source: ASHONPLAFA Finance

Over the same five year period, expenditures exceeded the budget only in 1990 in the Medical Clinical and IEC programs. The line item with the highest percent of budget utilization was administration (95 percent); administrative expenses during the period accounted for 14 percent of project expenditures, a normal level for this type of organization. MCP utilized 86 percent of budgeted funds, which represents 27 percent of total project expenditures. CSP used 81 percent of its budget, 25 percent of the total expenditure. IEC expended 80 percent of its budget, 14 percent of the total expenditure. Other activities expended less than 80 percent of their budgets (lowest was the monitoring and evaluation line item at 58 percent); these account for less than 20 percent of total expenditures.

ASHONPLAFA staff attribute underexpenditure to the following factors:

- The planning and budgeting procedures were not as accurate as they should have been, probably due to the limited experience and training in these activities. Goals were not clear or duly monitored. Accurate cost-accounting data were not available.

- Positive promotion activities were limited as IEC used a large portion of its time, resources and efforts to defend ASHONPLAFA from attacks by the Catholic Church.

- ASHONPLAFA was confused about some USAID requests for assumption of personnel costs, expansion of services, increasing self-sufficiency, cost recovery and income generation. Various requests to reduce costs, to expend the budget and to leave undefined the fringe benefit issue created uncertainty for ASHONPLAFA's management.

- Recent changes (re-organization and staff turn-over) affected 1993 and 1994 expenditures.

- Programs were not implemented as planned due to a variety of factors including inadequate supervision and monitoring, the lack of incentives and/or commitment of the personnel to the budget, and the electricity shortage.

Conclusions

The financial analysis shows a 40 percent underexpenditure of the obligated project budget due mainly to devaluation and underexpenditure of 16 percent in the ASHONPLAFA cooperative agreement budgets. Underexpenditures resulted from confused policies and strategies and external factors such as the economic situation of the country, electricity shortages, and the attacks from the Church and religious groups. Internally, the causes were poor planning and budgeting procedures, poor financial information and lack of cost accounting. Better plans, budgets and financial information are needed, and TA and training are required.

The team is not providing recommendations on resource allocation among project elements (as requested in the SOW). Such recommendations should be based upon a thorough planning and budgeting process with ASHONPLAFA staff.

3.4.2 ASHONPLAFA Cost Recovery and Revenue Generation

To what extent were cost recovery mechanisms and revenue generating activities implemented by ASHONPLAFA?

ASHONPLAFA has undertaken or participated in several activities to recover costs and generate income. It attended a Population Council workshop on cost effectiveness[6]. In collaboration with Family Health International (FHI), ASHONPLAFA studied the Association's costs, enabling measurement of its program cost effectiveness.[7] Unfortunately, ASHONPLAFA's administrative division, which would carry out the internal development of this cost data, was not involved in the preparation of the study. ASHONPLAFA is now in the process of developing a cost accounting system, an essential component of a successful cost recovery system. While this evaluation was underway, an IPPF/WHR team worked with the administrative division to develop a classification of accounts so that an automated cost system could be put in place.

Additionally, ASHONPLAFA has steadily increased prices[8], increased clinic client volume and CSP sales and improved cost data so that central managers (although not the regional directors) have better means of understanding what the real cost of their programs are. The results are a "comeback" from 1990: at the start of the project, ASHOPLAFA generated 28 percent of its total revenues; the percentage dropped the following year, but has been rising since then. In 1994, the level is projected to be 27 percent. See Table 4.

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[6] "Analysis of Family Planning Program Cost Effectiveness" in November 1992

[7] John Bratt, Family Health International and Margarita Suazo, ASHONPLAFA: "Costs of Family Planning Services Delivered through ASHONPLAFA Programs"

[8] Table 3.9 in Annex 3 presents prices changes for various services from 1989-1994. Price increases occurred on a regular basis per USAID project conditions; nearly all were at a higher rate then the CYP deflation rate of 199% for the period.

TABLE 4

ASHONPLAFA INCOME SOURCES, 1989-1994 (000 US$)[9]					
Year	ASHONPLAFA Self-Generated	USAID	IPPF/WHR	other Donors	Total Income
1989	657 (28 percent)	1,296 (56 percent)	341 (15 percent)	25 (1 percent)	2,319
1990	476 (21 percent)	1,203 (59 percent)	412 (18 percent)	47 (2 percent)	2,038
1991	541 (24 percent)	1,360 (59 percent)	372 (16 percent)	32 (1 percent)	2,305
1992	697 (25 percent)	1,717 (60 percent)	388 (14 percent)	34 (1 percent)	2,836
1993	725 (25 percent)	1,681 (58 percent)	374 (13 percent)	102 (4 percent)	2,882
1994	792 (27 percent)	1,716 (58 percent)	399 (13 percent)	50 (2 percent)	2,957

Source: ASHONPLAFA Finance Department

In constant lempiras, the percentage of costs recovered in all six regions declined from 48 percent in 1989 to 33 percent for the first nine months of 1994, principally due to the declined level in Region 1, (Tegucigalpa) from 108 percent in 1989 to 37 percent in 1994. In San Pedro Sula, the percentage ranged over the five-year period from 33 percent in 1989 to a high of 44 percent in 1991 to 36 percent in 1994. The other four regions all increased their level of self-financing; they deserve real credit for significant advances in self-financing. See Table 5.

Using a 1989 lempira constant, how much have revenues increased since the project started?

In constant lempira, ASHONPLAFA income was 2 1/3 times higher in 1993 than it was at the start of the project. Revenues rose in all regions but most dramatically in the newer regional offices. Initial regional increases may reflect some transferring of clients from Tegucigalpa, but most of the later increases have most likely come from increased client volume.

[9] USAID totals do not include $1,339 in commodities, equipment and training.

TABLE 5

ASHONPLAFA INCOME AND EXPENSES AND PERCENTAGE OF COSTS RECOVERED BY REGION 1989 - 1994 (CONSTANT LEMPIRAS)[10]							
Year	**I**	**II**	**III**	**IV**	**V**	**V1**	**Total**
1989*							
1	819,992	304,983	143,165	375,855	261,619	393,951	2,299,565
2	888,466	100,346	27,385	50,465	12,292	15,770	1,094,724
3	108	33	19	13	5	4 percent	48 percent
	percent	percent	percent	percent	percent		
1990							
1	2,583,905	964,653	465,814	408,684	210,419	259,254	4,892,729
2	1,225,501	332,319	120,282	195,769	42,081	87,461	2,003,413
3	47	34	26	48	20	34	41 percent
	percent	percent	percent	percent	percent	percent	
1991							
1	3,947,824	1,262,289	594,885	602,036	320,510	334,441	7,061,985
2	1,715,088	550,689	173,436	319,458	139,437	150,334	3,048,442
3	43	44	29	53	43	45	43 percent
	percent	percent	percent	percent	percent	percent	
1992							
1	4,530,230	1,791,586	917,960	1,107,398	649,918	724,686	9,721,778
2	2,129,413	682,512	291,931	393,199	227,651	179,242	3,903,948
3	47	38	32	35	35	25	40 percent
	percent	percent	percent	percent	percent	percent	
1993							
1	4,356,872	2,342,691	1,025,754	1,199,834	1,300,691	664,096	10,889,938
2	2,618,425	818,621	323,048	489,499	241,922	205,873	4,697,388
3	60	35	31	40	19	31	43 percent
	percent	percent	percent	percent	percent	percent	
1994#							
1	5,537,789	2,102,931	987,441	1,286,831	1,135,259	823,061	11,873,312
2	2,030,780	751,348	292,157	429,223	250,368	178,267	3.932,143
3	37	36	30	33	22	22	33 percent
	percent	percent	percent	percent	percent	percent	

1. Expenses
2: Fees for services recovered by year
3: Fees for services / Expenses expressed as percentage
*: August - December, 1989 #: January - September, 1994

Program revenues have increased faster than the CPI but expenses have increased even more rapidly, perhaps due to increased staff and improved allotment of real costs to each program. However, it is clear that not all ASHONPLAFA central costs are ascribed to these programs: as Table 4 indicated, in 1993 ASHONPLAFA earned only 25 percent of its total US$ budget while Table 6 indicates 44 percent of the costs of services, in lempiras, was recovered.

[10] Central Office expenses are not included in the calculations

TABLE 6

LEMPIRA INCOME FOR SERVICE PROGRAMS (PERCENT OF COSTS RECOVERED) COST INCLUDES CONTRACEPTIVES (1000 LEMPIRAS)						
PROGRAM	1989 (5 months)	1990	1991	1992	1993	1994 (9 months)
SMP	740 (40 percent)	639 (96 percent)	708 (56 percent)	922 (68 percent)	1,088 (58 percent)	612 (35 percent
MCP	152 (26 percent)	547 (27 percent)	880 (25 percent)	1,329 (30 percent)	1,635 (41 percent)	1,449 (59 percent)
CSP	168 (31 percent)	487 (31 percent)	1,129 (67 percent)	1,316 (43 percent)	1,466 (41 percent)	1,464 (34 percent)
Total	1,060 (81 percent)	1,673 (39 percent)	2,717 (42 percent)	3,568 (41 percent)	4,190 (44 percent)	3,524 (33 percent)

Shortly before the team left Honduras, ASHONPLAFA provided 1994 data ascribing both direct and indirect costs to each of the service programs in each region. Unfortunately the team did not have time to fully analyze that data; however, the 1994 level of self sufficiency of each program decreased: from 35 to 27 percent for the SMP; from 34 to 18 percent for the CSP and from 59 to 26 percent for the MCP.

How can ASHONPLAFA apply better cost-recovery mechanisms and revenue generating activities in each of its programs? What actions can ASHONPLAFA take at the regional clinics to increase cost-effectiveness and cost-recovery?

While the trend is not smooth, overall, the cost-recovery trend is up for the MCP and CSP and down for the SMP.[11] The MCP should be able to be self-sufficient in five to six years, if it continues to expand mini-clinics or mobile team services, increases its other reproductive health services, and implements a sliding fee scale. The 1992 cost study indicated that the least costly family planning visits were follow-up visits and the most costly were the sterilization procedures. It also demonstrated that the busier the clinic, the less costly each CYP. Female sterilization was the least costly method per CYP provided in clinics. The limited information available on cost-recovery and cost-effectiveness suggests that demand should increase in the small clinics; cost recovery should increase in selected services; and family planning visits should increase relative to non family planning visits. See Tables 3.3, 3.4 and 3.5 in Annex 3 for increases in MCP services, including but not limited to family planning. The other clinical services (PAP smears, male and female special clinics and medicine sales) reduce clinic unit cost.

The CSP, which is attempting widespread rural penetration, will not be self-sufficient until rural demand increases substantially. Because the CSP is the most successful program in expanding the frontiers of family planning in Honduras, it is worth the cost. One of the reasons for its success to date is the system of incentives established at USAID's request early in the project.

At the mid-term evaluation the team reported that the SMP was 100 percent self-sufficient, though by 1993 it had slipped to 58 percent. The chief of the administration division felt that the earlier mid-term evaluation figures did not include the cost of contraceptives, which is now included. If the SMP

[11] Some of the fluctuations in the trends may be due to price increases or large arrivals of contraceptive supplies.

can regain its sales momentum and if ASHONPLAFA corrects the overlap of the CSP with the commercial sector, it should be self-sufficient in one or two years.

Does the ASHONPLAFA fee structure exclude potential acceptors of family planning services?

When ASHONPLAFA raised prices significantly in 1991, the increase in acceptors that year was negatively affected; however, when moderate increases were made, the program continued to grow. In the field, the team heard many stories of rural poor who could not afford the ASHONPLAFA contraceptives and were referred to the nearest MOH health post. ASHONPLAFA has not yet developed a sliding fee scale as stipulated in the project paper.

Conclusions

ASHONPLAFA has devoted considerable institutional effort to cost recovery and income generation: it has steadily increased prices, significantly increased client volume (MCP and CSP) and significantly increased lempira revenues, attended training events on cost recovery and income generation and conducted cost studies. However, perhaps due to better accounting in 1994, the percentage of costs recovered in 1993 (43 percent) and projected for 1994 (33 percent) is lower than in 1989 (48 percent).

A cost accounting system, currently under development, is critically needed to assist ASHONPLAFA in monitoring and controlling costs. All necessary support should be given to its rapid completion. Additionally, with the cost data and market data on client ability to pay, ASHONPLAFA should develop and implement a sliding fee scale as soon as possible.

3.5 Systems

3.5.1 Management Information System (MIS)

How timely are MIS reports on ASHONPLAFA indicators? How well are MIS reports disseminated? How relevant is the information in MIS reports? How is MIS information used to make decisions and solve problems?

The MIS has been a focus of comment for a number of years. The mid-term evaluation concluded that although good progress was being made in computerizing ASHONPLAFA's operations, there were several key areas in which the MIS was incomplete or in which it did not serve to provide timely and accurate data to the institution for decision making. The report noted that:

- there was no cost accounting.
- reports were insufficiently used for decision making.
- staff needed training in both the use of data for decision making and in the use of various software programs.

Since that report, there have been several MIS assessments. In September 1993, a FPMD team concluded that the MIS problems that existed at the time of the mid-term evaluation continued and that there was a great deal of information, but very little analysis and development of conclusions for decision making. The majority of the information generated was for donors or control purposes;

there was little use of it to improve productivity or reach goals. In August 1994, a FPMD/IPPF team analyzed the system and concluded that the system provided good operational control and that the modules of that system providing operational control in Tegucigalpa and San Pedro Sula needed to be expanded into to the other four regions.[12] They recommended that ASHONPLAFA's information systems (costs versus results, levels of self sufficiency, pricing, productivity of various services and quality) to support management and planning be strengthened. They noted the following:

- The outputs of the existing system and the system's users do not take advantage of the information that the system currently can deliver and the system lacks an organized means of creating executive level reports specifically to support analysis.

- The changes in the organizational structure have affected the MIS - there is now "confusion and a duplication of efforts in the recording and management of data which is reflected in the enormous quantity of forms which flow throughout the organization.[13]" There is a lack of clarity on roles and responsibilities in the management of service data: three divisions (Institutional Services, Regions and Information and Marketing) all have interests and responsibilities in the area.

- In Region I where the Clinic Administration System (SAC) has been installed, the system is operating normally and has tremendous potential; however, there are inconsistencies in the data found in the clinic and in the data sent to ASHONPLAFA's Department of Statistics.

- The development of a cost accounting system would require a modification of the classification of accounts. This should be a priority.

- Consensus exists within the institution that there is a duplication of data and collection of information which no one uses. There are 78 forms used by service personnel in the regions, including 14 in Medical Services and 23 in the Department of Sales.

- There are problems and confusion in the regions about the flow and processing of service statistics [with the Sistemas Integrado de Estadisticas de Servicio (SIES)]. No manual accompanies the SIES. There is confusion about when and how data are passed to the Divisions of Information and Marketing and to the Division of Institutional Services. The result is inconsistent data reported at the central and regional level.

The team recommended:

1. A detailed analysis of the existing systems for the collection and flow of information throughout the institution (i.e., an information audit) should be conducted. This analysis would lead to a revision and redesign of the reports and information flow in ASHONPLAFA. Additionally, they noted that a manual should be developed to accompany the SIES.

[12] DIAGNOSTICO DE LOS SISTEMAS DE ASHONPLAFA (HALLAZGOS Y CONCLUSIONES), Xavier Gonzalez-Alonso, a MIS consultant with IPPF and Kip Eckroad, Director of the MIS Department at MSH (working through the FPMD project).
[13] translated from the Spanish

2. Better use of information should be made in the planning, management, monitoring and evaluation of activities within ASHONPLAFA. Although a great deal of information exists within ASHONPLAFA, there is insufficient understanding of how to use data for decision making. The team further recommended that a workshop be conducted on management information, that technical assistance to follow-up this workshop be provided, and that thirdly, when ASHONPLAFA has experience with the development of the new systems, a system of executive information should be developed which would enable monitoring of key institutional indicators.

3. The existing computerized systems should be improved in three areas: modification of administrative and financial systems; continued installation of equipment and systems in the regions; and implementation of SIES after the redesign of the information system mentioned in point 1 above.

This team concurs with the IPPF/FPMD conclusions. The MIS has improved over the life of the project. New software has been implemented and computers are available: a Fixed Asset System and new version of the General Payroll System has been installed and the Inventory Control System was improved. Lotus 123, version 2.3 has been implemented. The modules on Permanent and Temporary Methods and on Income from the Sistema de Administración de Clínicas, Clinic Management System were installed in Region II. Training has been provided to the staff on basic computer programs such as Word-Perfect, Lotus, Net, DOS, and Clinic Management System.

Figure 2 presents ASHONPLAFA's integrated modular system, based upon TecApro software, of which these systems are a part. Some of the TecApro programs are not currently operational or are used in limited ways. For instance, a sophisticated logistic management system is in place and operational, but it is not used to determine minimum or maximum stocks, although the program is designed to keep them. Keeping minimums and maximums could help to avoid stock-out periods. Moreover, the store continues to keep inventory control cards by hand, parallel to the system.

Specific responses to points in the SOW follow on timeliness, relevance, dissemination and use of information for decision making. Currently, the data produced are relatively timely; however, in a number of cases the data are inconsistent and a reporting burden. The evaluation team also found that essential data for decision making are not available or laboriously produced. For example, the head of the SMP, when asked about targets and outputs for sales, income and CYP over the life of the Project, had to manually tally data to develop such reports. The current computerized system does not track the performance of SMP sales, income or CYP on a periodic basis.

At the time of this evaluation, IPPF consultants were providing TA on the development and implementation of a cost accounting system which they expect to be in operation by mid-year 1995. Wide use should be made of such data in the future; presently, only the division heads see financial information; very little reaches the department heads and none goes to the regions, except the budget control report.

How effectively are service statistics tracked and used?

In general, services statistics are reported and consolidated. There are serious inconsistencies in the data reported at the regional and central levels and within the central office itself. The team did not observe any example of CSP, SMP or medical services strategies developed or revised to deal with poor performance, revealed through tracking those service statistics.

Figure 2

Conclusions

At this point, there has been enough analysis; it is time to take prompt action on the IPPF/MSH recommendations. What is needed now is steadfast commitment on the part of ASHONPLAFA and IPPF and careful monitoring by USAID/Honduras to ensure that the IPPF/MSH recommendations are carried out promptly.

The inadequate use of service statistics for decision making is part of the larger problem described in the beginning of this section. It should be resolved as the larger MIS problem is resolved. When ASHONPLAFA has developed an improved MIS, it may consider graphing the service statistics of each program each month, plotting them against: 1) targets; 2) the previous year's service statistics; and 3) rate of growth of WRA.

3.5.2 Logistics

How can ASHONPLAFA improve its inventory and control of contraceptives so that scarcity and shortage can be avoided?

To determine how well ASHONPLAFA's logistics system works, three indicators from *The HANDBOOK OF INDICATOR FOR FAMILY PLANNING PROGRAM EVALUATION are useful*: frequency of stock-outs; percentage of SDPs having stock levels between their calculated minimum and maximum levels at a given point in time; and percentage of storage capacity meeting acceptable standards.

Frequency of Stock-outs. According to anecdotal information, there were several stock out periods during the project although no written reports on those periods were available. Stock-outs in Ovrette, Microgynon and Nordette affected the output of CYP in mid 1993. Other products with stock-out periods were Copper T IUDs, Guardian Condoms, Noriday, Norminest and Lo-Femenal. Several possible reasons were identified for these stock-outs:

- Errors in the development of the contraceptive procurement tables (CPTs);
- Problems related to USAID and IPPF: supply of contraceptives on time and in the required quantities; changes in the distribution systems; changes of brands and other modifications affecting the quantities required; policy changes; changes in importation procedures; transportation problems and availability of products from the supplier;
- ASHONPLAFA's inability to forecast the necessary quantities and timing of deliveries, due to the lack of an effective system of minimum and maximum stocks and a poor planning system

Percentage of SDPs having stock levels between their calculated minimum and maximum levels at a given point in time. ASHONPLAFA uses, for inventory control, a TecApro module capable of setting maximum and minimum quantities. ASHONPLAFA does not use the module to establish such levels, however, reportedly because ASHONPLAFA believes such levels would not solve what it identifies as the problem: limited quantities of donated contraceptives. ASHONPLAFA uses manually-processed inventory control cards; these provide data on stock available in specific warehouses, but not on ASHONPLAFA as a whole.

Percentage of storage capacity meeting acceptable standards. Storage of contraceptives did not meet acceptable standards in several regional offices visited. The first-expired-first-out system was not fully operational and some products near to expiration date were found. Contraceptives were stacked without clear display of expiration dates. In one regional office, power shortages limited the use of air conditioners and high temperatures resulted; nonetheless air conditioning was provided to the regional director's office.

Conclusions

The logistics system needs strengthening and revision; staff require training. Although two sets of records are kept for control purposes at the central warehouse, procedures could be simplified and effective control mechanisms established using only the computerized system. Good logistics management involves: 1) forecasting; 2) selection and procurement; 3) a management information system; and 4) distribution (with inventory control, transportation, warehousing and quality control). ASHONPLAFA should improve their capability and performance in all four areas.

4 ASHONPLAFA SERVICES

4.1 Medical and Clinical Program (MCP)

4.1.1 MCP Outputs

The MCP was ASHONPLAFA's first service delivery program and its most productive in terms of CYPs. Permanent and temporary family planning methods are provided in six regional centers and seven private clinics in cities without an ASHONPLAFA clinic. The MCP has contributed 66 percent of total ASHONPLAFA CYP outputs. Table 5 presented CYP resulting from voluntary surgical contraception (VSC) and non-permanent methods. The following Table 7 presents further data on MCP targets and outputs.

TABLE 7

MEDICAL AND CLINICAL PROGRAM TARGETS VERSUS ACHIEVEMENTS			
Outputs	Targets	Achieved 6/89-9/94	percent Accomplished
VSC - # performed	66,372	55,375	83.4 percent
Temporary methods - new acceptors	12,000	data not kept on number of new acceptors	
Temporary methods - CYP	64,447	71,595	111.1 percent
IUD insertions (1993 AND 1994)	14,000	4,512 in 1993 and 4,995 in first 9 months of 1994 = total of 9,508	68 percent
Cytological examinations	81,589	136,576	167 percent
Other laboratory examinations	59,000	72,512	123 percent
Sliding fee schedule established		not yet established	

Tables 3.1, 3.2, 3.3, 3.4 in Annex 3 show women's and men's clinic outputs, laboratory tests, and cytologies. Female sterilizations and vasectomies are displayed in Tables 3.5, 3.6, 3.7, 3.8 in Annex 3 in greater detail and Table 3.8 provides data on new acceptors and follow-up visits for temporary methods from 1989 to 1994. MCP outputs also include non CYP-producing services (cancer screening, fertility/sterility procedures, gynecological or urological consultations) which generate income, contribute to diversification of services and project an image for ASHONPLAFA beyond the family planning (FP) boundaries. The new project should include indicators for such related services.

Given the low CPR and ASHONPLAFA's leading role in the provision of FP methods in the country, the MCP has a key role to play in the years to come. Contraceptive delivery to the large proportion of non-user, high parity women; the need for expanding modern methods coverage in the rural areas; the attracting and serving of sexually active adolescents; and the need for increasing men's

participation in the method mix, are some of the challenges that ASHONPLAFA is facing and will continue to face in the near future. The *Strategic Plan* anticipates meeting these needs through expanding, diversifying and improving the quality of services. To do so will require new service delivery approaches, such as mobile clinics and the expansion of nurse staffed FP clinics beyond the regional level. New contraceptive methods such as NORPLANT® and the injectable progestogens, training in-country and abroad, improved project monitoring and implementation of quality of care in the regions and in the private clinics are planned and discussed in the strategic plan.

4.1.2 Quality of Care in the MCP

ASHONPLAFA has made a great effort to meet the proposed targets at a high level of quality; several obstacles have hindered success, however. Many service providers (e.g. the anesthetist technicians) resent changes in practices in which they are skilled. Some providers and staff are unaware of the HIV infection. In some cases there has been ineffective supervision. These obstacles have resulted in the lowering of the MCP quality of care in some of the private clinics.

The evaluation team's medical specialist observed faulty practices that should be promptly addressed. In one private clinic, poor compliance with infection control was observed during female VSC procedures. In a second clinic, the manipulation of contaminated surgical instruments, the routine use of excessive anesthetic doses, and unnecessary techniques to provide sedation for minilap -- possibly posing health risks to women who are sterilized, were noted. Two out of six ASHONPLAFA nurses in charge of the temporary methods omitted key steps when requested to demonstrate how they insert the IUD, (which may increase the risk of perforation). The one-year removal rates of the IUD in some of the regional clinics are between 15-40 percent which suggests that counseling was inadequate or that the IUDs may not be correctly inserted and thus result in bleeding and pain. The pregnancy rate in sterilized women in one of the regional clinics during the last two years was above the expected ratio (> 0.1 percent/year). This rate indicates careful review of each of the cases as well as the provider's training and skills is in order to promptly correct the existing situation.

Other factors (maintenance of equipment and repairs, sterilization techniques and basic supplies) were satisfactory; counseling and the use of the informed consent form were adequate. A report on complications is processed only when serious complications are presented; however, none have been reported since the mid-term evaluation. Occasionally CSP clients referred to the MCP for VSC developed minor infections (rather than serious complications) in connection with that surgery.

4.1.3 Interaction between the MCP and PVOs

How can the interaction between the MCP and PVOs and other referral mechanisms be improved?

MCP clients have diverse profiles: they are referred by satisfied clients, ASHONPLAFA's educators and community counselors; some visit the clinics as a result of promotional radio spots and messages about ASHONPLAFA's programs, and they are referred by field personnel from other NGOs. The exact numbers, by source, of those referred, however, is not available. ASHONPLAFA's educators and non-governmental organization (NGO) field workers give clients

coupons which they are supposed to produce when they request a service. Most of the times the coupons are lost or left behind by clients and the coupon system was dropped by admissions.

There is evidence that while there were very few contraceptive services provided by NGOs, NGO referrals to ASHONPLAFA's service outlets may have increased. Save the Children reported that in southern Honduras and in Pespire, when micro pharmacies were organized, community agents sold contraceptives and referred clients to ASHONPLAFA's clinics. CARE volunteers organized communities so ASHONPLAFA personnel could take PAP smears and distribute contraceptives.

4.1.4 Vasectomy Program

What can be done to improve and expand the vasectomy program ?

As Table 8 indicates, the project paper target of 500 vasectomies has been met. The required vasectomy clinic conditions were fully met in Tegucigalpa and San Pedro Sula in 1990. The most striking finding in the evaluation of the vasectomy program was the weakness in the promotional efforts carried out from 1992 to the present. This lack of interest in promoting male methods seems to have played a definitive role in the weakening of the program. The Catholic Church attacks have also affected the promotional efforts implemented during the first half of the project.

TABLE 8

MCP VASECTOMIES THROUGH JUNE 1994							
Year	1989	1990	1991	1992	1993	1994*	Total
Vasectomies	51	110	115	128	125	87	616

* January through June

The promotion of male contraception in the morning hours needs to be supplemented with aggressive promotion in male preferred radio and TV programs such as news, sports events, etc. Moreover, not every regional physician has been trained in the vasectomy technique and no prominent specialist in Urology has been attracted to support ASHONPLAFA's efforts to promote vasectomies as a safe, and cost effective contraceptive method. The use of creative advertising for service promotion using male educators to visit shops, male-only industries, taxi coöps, unions, etc. and vasectomized male field workers for service promotion, has paid off in El Salvador, Guatemala and Nicaragua and should also work in Honduras.

Conclusions

The MCP is the most successful ASHONPLAFA program in terms of CYP; although it has the highest immediate cost it is the most cost effective in the long run. MCP recovers on the average, one-third of its expenses (Central office expenses not included) but its growing expenditures, compared with income generated, makes sustainability distant. Clinics are underutilized; ample room exists for increased numbers of female VSC and vasectomies in the years ahead. While non-VSC MCP services increased significantly from 1989 to 1993, VSC services have not grown since 1992 due to a decrease in collaboration with IHSS and MOH hospitals.

Quality of care issues detected in this evaluation should be addressed.

ASHONPLAFA may play an important role in the promotion and introduction of new contraceptives in Honduras such as NORPLANT® and injectables and the provision of MCP services beyond the boundaries of the regions and the private clinics. Non-CYP producing MCP activities contribute to improvement of the ASHONPLAFA's image in the country and have a positive impact in cost recovery. Targets for these services should be included in the next project.

4.2 Community Services Program (CSP)

4.2.1 CSP Outputs

CSP activities, in operation since 1976, take place in 264 of the country's 294 municipalities. The CSP maintains 1,963 SDPs and provides contraceptives, information and referrals. The 27 municipalities with no CSP program are said to be located in areas too remote to monitor, and the costs involved in setting up posts and supervision would be very high. The distributors, now called community counselors, are supervised by 26 promoters. CSP distributes eight brands of pills and three of condoms which are sold at prices determined by ASHONPLAFA.. (See Annex 4 for further details.)

In this program CYP increased from 44,800 in 1989 to a projected 61,400 in 1994; however the average number of CYPs per distributor per year has remained unchanged during the period (30 CYPs/distributor/year). This trend will most likely continue in the future with the present program structure and operation. Tegucigalpa and San Pedro Sula Regions contain 50-60 percent of the SDPs and provide 55-60 percent of the program's CYPs.

CSP recovered 31 percent of its expenses in 1989, 67 percent in 1991 and 43 percent in 1992. This percentage will probably drop to about 34 percent in 1994 due to a substantial increase in direct costs between 1991 and 1993 and a relatively modest growth in fees collected from clients during the same period. (See Table 9).

TABLE 9

CSP TARGETS AND ACHIEVEMENTS

Indicators	Targets		Achieved		Percent Accomplished
Family planning service distributors	existing urban: 407 rural: 1,069 total: 1,539	additional 15 295 310	existing urban: 407 rural: 1,069 total: 1,539	additional 189 235 424	urban: 1200 percent rural: 80 percent
Active users	64-65,000 active users, modified to 256,230 CYP through 1994		projected 267,009 by the end of 1994		104 percent
PVOs in rural areas for referrals	eight		more than eight		100 percent

CSP provides good counseling and temporary methods in both rural and urban areas. IEC for the program has been affected by the reorganization; IEC was transferred to the Programa de Educacion Comunitaria (PEC) educators who report to a different office within ASHONPLAFA and may have shifted priorities to promote high yielding CYP services. Decreases in CSP IEC activities were observed between 1993 and 1994. ASHONPLAFA was addressing this concern during the evaluation and should continue to do so until resolved.

IEC materials were available in most of the sites visited. It was noted that leaflets and brochures contain printed text, i.e., are targeted at people who can read. Experience of other country FP programs is that IEC materials for the illiterate reinforce verbal messages that people otherwise quickly forget. The use of media to support CSP has room for improvement. Contracts for broadcasting radio messages and spots are handled in Tegucigalpa with marginal participation by the regions. The central office makes all decisions regarding message content, frequency and broadcast location.

4.2.2 Central Office Support

How has the central office improved its support to the program in the areas of transportation, IEC and expenses since the mid-term evaluation?

ASHONPLAFA has increased the level of transportation provided for clients from rural areas since the mid-term evaluation. Mini buses from Tegucigalpa, Juticalpa, and San Pedro Sula pick up prospective clients, deliver them to the clinics and take them back to their communities later in the day. Cooperation from NGOs such as PLAN in referrals and its willingness to pay for overnight stays of clients desiring VSC has somewhat increased the demand for VSC by poor couples. However, the lack of accessibility to services for clients who must travel long distances and remain away overnight is far from been solved.

Transportation of program personnel to and from areas with inadequate public transportation continues to affect performance. The poorest communities lack good roads and are distant from the regional clinics. ASHONPLAFA began to allow the CSP personnel to use vehicles to promote services, set up SDPs and to deliver contraceptives. The team, however, heard that the lack of vehicles and the use of the existing fleet for specific activities such as those of the unit promoters, excluded CSP personnel from benefiting from vehicles when visiting areas where transportation was difficult.

Conclusion

The CSP coverage has reached most parts of Honduras. The municipalities with no CSP are in remote areas which makes delivering contraceptives with the current model too costly. In spite of an increase in the total of SDPs since project start up, CYP per SDP has reached a plateau. This may be the result of the emphasis placed by CSP on expansion into rural areas where CYP per distributor yield is lower. The program sustainability has decreased since 1992 as the fees for services have grown more slowly than program expenses. This disparity in the growth of costs continues to be an unresolved issue; the grantee must decide between sustainability and increases in coverage.

ASHONPLAFA should reduce variety of brands in CSP because too many contraceptive brands in the hands of community counselors may create confusion.

IEC activities in CSP decreased between 1993 and 1994 after reorganization, when priority was apparently shifted to high yielding CYP activities; however, the CSP's activities may be receiving more attention now.

4.3 Social Marketing Program (SMP)

4.3.1 Background

ASHONPLAFA's social marketing began in 1981 with an USAID/W contract with Triton Corporation. In 1983, Triton obtained a direct agreement with ASHONPLAFA. In 1984 ASHONPLAFA introduced Perla, Norminest and Guardian into the market; low-dose Norminest was introduced in 1987. In August 1993, ASHONPLAFA introduced two contraceptives purchased with institutional funds: the low-dose oral, Lo-Rondal and the condom, Protektor. During the first years of the SMP, an ASHONPLAFA subsidiary, Drogueria Nobel, handled the distribution; Nobel, however, had managerial problems and the SMP was subsequently reorganized into ASHONPLAFA with the assistance of the Social Marketing for Change (SOMARC) project. Outputs of the project were to include: implementation of a contract with a commercial distributor, MANDOFER; expansion to cover 90 percent of the pharmacies in the country; the annual provision of 40,000 CYPs by 1994; and self-sufficiency (excluding costs of contraceptives) by the end of the project. (See Annex 5 for details on the SMP)

The contract with MANDOFER is being implemented and over 90 percent of pharmacies throughout the country are covered. Yearly CYP targets were met only in 1989. Total program CYP from 1989 through the first nine months of 1994 are 78 percent of the total planned for the period. SMP CYPs for the first nine months of 1994 are only 20,833**.**

ASHONPLAFA data on levels of self-sufficiency include the costs of contraceptives. Self-sufficiency first increased and then declined over the life of the project, from 56 percent in 1991, to 68 percent in 1992, to 58 percent in 1993 and 35 percent for the first nine months of 1994.

4.3.2 Results of the Marketing Strategy

The contract with MANDOFER, the largest distributor of pharmaceuticals in the country, has been the most successful component of the strategy. MANDOFER reports, and an ASHONPLAFA study and the team's data confirms, that MANDOFER is providing SMP products to over 90 percent of the pharmacies in the country. There is a large modern warehouse in Tegucigalpa; inventory control and management follow standard commercial practice. Orders are filled within the day and arrive within two to three days. Pharmacies as far away as La Ceiba are visited several times a week by MANDOFER.

Forty-five to 56 percent of the sales each month are in the zones of Tegucigalpa and San Pedro Sula. Sales have risen over the contract's life. Average sales, in lempiras, for the first six months for which data are available (February to July 1993) were L88,218. For the last six months, the average was L110,961. Table 5.1 in Annex 5 presents the volume of sales by MANDOFER by zone.

MANDOFER and ASHONPLAFA, however, have not worked closely enough together. ASHONPLAFA has not shared vital information with MANDOFER; for example ASHONPLAFA did not inform MANDOFER in advance of when or how the publicity launch of the two new 1993 contraceptives was to occur. MANDOFER's director of sales had not heard of the ASHONPLAFA marketing studies over the last 18 months on the relative availability, volume of sales and prices of SMP products, compared to commercial brands, nor had he seen or heard of the ASHONPLAFA study on SMP users completed in August. MANDOFER, however, is eager to work more closely with ASHONPLAFA and suggested in light of the data from the users studies on the quality of the SMP program (see Annex 5), that ASHONPLAFA develop literature for the pharmacies on advantages, disadvantages, contraindications and side effects of the oral contraceptives. They are very willing to help in the development of such literature, and in general, to work more strategically with ASHONPLAFA.

The development of a commercial product line has not been successful to date. As Table 10 indicates, of ASHONPLAFA's five products, only Norminest and Guardian are doing well. Sales of both products have steadily increased, except for a dip in 1991, over the life of the project. Sales in 1993 and projected sales for 1994 of Perla, the oral targeted to low income women, however, are only slightly higher than they were five years ago. Both new products of 1993, Lo-Rondal and Protektor, have been failures.

TABLE 10

SMP CYP ACHIEVED								
	1989-six months	1990	1991	1992	1993	CYPs for first 9 months of 1994	projected total 1994	projected total 89-94
Perla	5,367	11,804	10,129	11,972	11,528	8,335	11,114	61,913
Norminest	3,025	7,602	6,477	7,526	8,354	6,443	8,591	41,575
Lo-Rondal	-	-	-	-	972	30	39	1,012
oral total	8,392	19,406	16,606	19,498	20,854	14,808	19,744	104,500
Guardian	2,454	7,397	5,999	7,244	8,084	6,018	8,024	39,202
Protektor	-	-	-	-	1,177	7	10	1,187
condom total	2,454	7,397	5,999	7,244	9,261	6,025	8,033	40,389
total	10,846	26,803	22,605	26,742	30,115	20,833	27,777	144,889

ASHONPLAFA and MANDOFER attribute responsibility for the failure of Lo-Rondal and Protektor to the previous advertising firm. On February 25, 1993 ASHONPLAFA signed a one-year contract with Publicidad Comercial to develop a publicity plan for the social marketing program. Specifically, the publicity plan was to include: production of specific campaigns in the news, television and radio; modifications based upon lessons learned (through a preliminary testing); negotiations and contracts with intermediaries; development of publicity guides when necessary; revision of the plan, its strategy and messages depending upon the results of an initial evaluation; and the elaboration of other specific materials as requested by ASHONPLAFA.

ASHONPLAFA staff indicated that the work of Publicidad Comercial was poor in a number of ways. The firm didn't understand ASHONPLAFA and therefore was not able to effectively promote its social marketing products. It didn't use (stating it didn't have) the marketing plan developed by SOMARC. Billboards were the main vehicle of promotion, particularly for the condom, Guardian. The publicity for the two new products launched in August 1993 was totally off the mark. TV spots for Lo-Rondal spoke of how to take the pill rather than why to buy it. There was no publicity for the new condom, Protektor. MANDOFER commented there should have been meetings with "opinion leaders", group sales, medical visits and publicity for more than three months.

There is currently no contract with a publicity firm. The responsibility for new publicity contracts and campaigns, under the reorganized ASHONPLAFA, rests with the Division of Information and Marketing. The Division has met with publicity/advertising firms, provided them with information about the mission and values of ASHONPLAFA and is awaiting a decision by the Consejo Tecnico on how to proceed in light of the new USAID global contract, replacing the previous contract with Syntex Laboratories which provided Noriday, that is, Perla. ASHONPLAFA is also awaiting clarification on the future of Norminest.

ASHONPLAFA recently has conducted some excellent social marketing research. Two studies are discussed in Annex 5. There is little evidence that this research is being disseminated or used for program modification, however. MANDOFER, which should have been developing strategies with ASHONPLAFA over the issues identified in those studies, has seen neither of them.

4.3.3 Overlap between the CSP and SMP

The criteria used by a CSP promoter to open a new distribution post includes: community size of at least 50 households, willingness to cooperate with CSP, willingness to attend talks about the program, passable roads most of the year, and presence of one household willing to function as the SDP. Once a distributor is identified, she is trained on site and provided with pills, condoms and hand-out materials. The household is identified by posting the ASHONPLAFA logo outside. CSP stocks are Lo-Rondal, Norminest, Ovral, Microgynon, Nordette, Ovrette and Perla; Protektor, Guardian, and non-colored condoms. This variety may create confusion in some counselors' minds, although those visited during the evaluation were able to tell the differences among the pills.

The profile of an urban or peri-urban distribution post is quite different[14]: many are located close to pharmacies and MOH facilities. CSP distributors indicate that CSP outlets may supplement the SMP and may provide contraceptives to users during those hours that MOH facilities are closed. They may serve a different client than that of the SMP, and provide counseling and referrals that most pharmacies do not. However, the likelihood of inefficient duplication or competition with government facilities and SMP marketing channels is strong.

The SOW asked how innovative and successful the SMP has been in the development of marketing channels to cover geographic locations which MANDOFER does not cover. MANDOFER is doing a good job covering all towns large enough to have a pharmacy in the various geographic regions, except perhaps Gracias a Dios. It does not reach small rural villages. SMP has developed new marketing spots, but they are for the most part specific points in urban areas, and

[14] The criteria of a minimum of 50 households and passable roads were presumably developed with access to the post and ASHONPLAFA efficiency in mind; the urban and peri-urban posts are readily assessable, in terms of distance, to ASHONPLAFA and other service providers.

do not serve as marketing channels to rural areas. SMP lists 62 such points in Tegucigalpa, Comayagua, San Pedro Sula, Puerto Cortes, Olancho, Choluteca, Ocotepeque and El Progreso; the majority of these points are pharmacies. The SMP does not have volume of sales data for each point.

These sales points are similar to CSP sales to pharmacies and various non-traditional outlets. The CSP does not disaggregate sales to non-traditional sites so the team was not able to indicate either the number of such sales points or their total volume; however, they appear to be a small, but important minority of sales. For instance, in urban La Ceiba, the CSP promoter sells to two pharmacies, two supermarkets, two factories, three liquor stores, the Standard Fruit processing plant, the bus station, public open air market, and a fish packing plant. Volume is high in the supermarkets (see Table 5.1 in Annex 5). SMP and CSP advise that they sell to pharmacies which MANDOFER does not cover or to pharmacies which have run short that month. However, the team encountered three instances in which ASHONPLAFA CSP was directly competing with MANDOFER and suspect that such competition is quite common.

Conclusions

ASHONPLAFA and USAID need to devote serious attention to the SMP. The SMP has not done well. There are a number of possible reasons: poor and insufficient publicity, competition from the CSP, competition from other sources, lack of strategic direction and insufficient collaboration with MANDOFER. The program, led by a relatively new employee with no previous experience in family planning or social marketing[15], lacks strategic direction, coordination and sufficient operational control.[16] Additionally, as detailed in Annex 5, quality of care is a significant problem.

The team is aware that ASHONPLAFA's relationship with the provider of social marketing technical assistance in this project, SOMARC, was not good and ended in 1993. However, ASHONPLAFA needs intensive technical assistance over the long-term to: develop the current program director; revise and update the marketing plan; examine the overlap between CSP and SMP and develop clear strategic market niches for each; resolve the problems with moving from Perla and Norminest to other brands; re-launch Lo-Rondal and Protektor; and develop close productive relationships between the SMP, the Division of Information and Marketing, MANDOFER and to-be chosen publicity firms. In the new project, a new beginning must be made on a productive relationship.

To meet ASHONPLAFA targets, sales promoters have de-emphasized CSP promotion and education and have increasingly emphasized sales, creating competition for the SMP program.

Neither the CSP or SMP have been greatly successful in reaching new rural clients. Many of the new CSP "rural" SDPs are in peri-urban areas for cost reasons, creating overlap between the CSP and the SMP. The SMP has not been successful in developing marketing channels to rural areas. It is selling very low volume to specific points, largely pharmacies, largely in urban areas.

[15] The Director is not responsible for these problems: they existed before he arrived. He will need technical assistance, however, to resolve the problems.

[16] The MIS does not adequately supply the Division with data on key indicators; it is focused mainly on targets and volumes. While it is important to monitor against targets, it is also essential to monitor for growth over time; historical data on volume of sales by method, 1989-1994, had to be tallied by hand. Detail on the new "marketing channels" is very minimal; only a listing of pharmacies and posts which buy SMP contraceptives.

4.4 Information, Education and Communication

With its new organizational structure and its need to pursue a stronger IEC strategy, ASHONPLAFA has divided this task into two units. The first, the Department of Publicity and Public Relations, is under the Sales Information Division which has also absorbed the advertising function of the old Social Marketing Program. It is located in the central office, carries out or contracts, public relations, publicity, library, educational and promotional material production and audiovisual methods. The second, the Department Promotion, Education and External Training, is under the Division of Institutional Services.

What has been the impact of the IEC strategy?

A comprehensive list of activities is found in Annex 6, Table 6.1, along with estimates of impact which are more in the nature of outputs rather then impact. The Department of Publicity and Public Relations, however, attributes most ASHONPLAFA CYP to their work. The only surveys which really show impact are CPSs; these surveys, from 1981 to 1991, show a steady increase in knowledge of contraceptive methods over time (see Table 4.3, Annex 4). Since nearly all of the FP mass media and educational material until very recently came from the ASHONPLAFA IEC program, it is clear that the IEC program made an impact on the population. ASHONPLAFA has not done spot surveys to determine the affect of particular campaigns which would focus in on specific project activities.

Because of the continuous attacks on ASHONPLAFA and family planning, a major focus of this department has been in the area of public relations. The department has noted less frequent press attacks in over the project period, except for charges related to Ovrette in 1993, and a recent flare-up in relation to the World Population Conference in Cairo. There has been an increase in factual or even favorable articles about family planning; the number of visitors to library are increasing; and requests for pamphlets and manuals continue to increase. All these events create the impression that IEC has improved the climate for family planning.

As seen in Annex 6, the most important mass media tool continues to be the radio, whereas the newspapers and other printed materials reach much smaller and more specialized audiences. There were plenty of materials on hand at the regional centers and rural distribution posts to describe methods and to show where to go and seek service. The one exception was in the Santa Rosa Copan Region V office where they apparently did not order materials at the beginning of the year and have since run out. The radio campaign was evidently very effective in bringing in new clients to the two outside clinics of Puerto Cortes and El Progreso in Region II.

What has been the impact of the IEC program in targeting specific products, populations and/or regions in Honduras (emphasis on rural populations, adolescents and men)?

The ASHONPLAFA campaign on uterine and cervical cancer screening and detection, AIDS, and voluntary sterilization is paying off in an increase in the number of PAP smears taken, condoms being sold and voluntary sterilizations completed. There is spotty evidence of lower rates of teenage pregnancies, but this will need to be studied in the upcoming CPS.

However, as seen in the previous section**,** support provided to the SMP has not been used effectively. In the first place, it was used to hire at least two advertising firms during the life of project which, according to ASHONPLAFA, did not perform satisfactorily. Now the Division of Sales

Information is managing this task and does not yet have a contract for advertising. In both the SMP and CSP programs there is a pressing need for materials aimed at providing illiterates with more knowledge of the method they are using. These could include both product inserts as well as charts that the educators could use to inform potential clients. In the MCP program, flip charts being used by counselors were donated years ago and are both outdated and well worn.

How well is this Department providing PVO and MOH support through materials and technical assistance?

Both PLAN and Population Council indicated that their community groups were receiving materials from ASHONPLAF on family planning and on training for their organization staffs. The MOH Maternal Child Deputy Director indicated that they exchanged materials with ASHONPLAFA so both organizations would benefit. The team noted that ASHONPLAFA headquarters and the regional trainers were running many family planning classes for MOH doctors and nurses.

Are mass media sources being exploited to promote family planning as a concept as well as to promote ASHONPLAFA family planning services and programs? If not, what can ASHONPLAFA do to achieve this?

ASHONPLAFA is promoting family planning as a concept as well as promoting the Association. A good example was the recent participation of ASHONPLAFA in the "week of the family" in which ASHONPLAFA promoted family planning and responsible parenthood through 22 meetings with reporters, health personnel, community counselors and adolescent leaders and their parents—over 3,000 persons in all. In its public relations campaign, ASHONPLAFA has had to take a more general approach to correct misinformation that was being spread about methods and to identify the health benefits of improved planning of families.

ASHONPLAFA could do more, however. Billboards are old and washed out; these should provide product recognition for both old and new products. A user study contracted by ASHONPLAFA (described in Annex 5) indicated that SMP clients did not have good knowledge about the contraceptives that they were purchasing. A problem could be the lack of appropriate point of sale literature, appropriate mass communications to promote the product, and appropriate package inserts for barely literate persons (Guardian condoms do have such an insert).

Development of materials and mass communication by this department has somehow missed the mark. The omissions mentioned above occurred despite the thousands of radio spots, hundreds of pamphlets and posters and the promotion of information brigades listed in the above table. The responsibility for training the pharmacy employees lies with the Department of Promotion, Education and External Training. In the case of the CSP, training and materials were provided to most of the rural distributors. The problem may be in the number of contraceptives that they have to sell. These generally poorly educated rural women are selling eight different brands of pills and although many have similar advantages and secondary effects, some are quite distinct in their uses and effects. It seems much more responsible to reduce the variety of their stock and focus training and material on the ones that remain.

All radio spots and contracts are developed at ASHONPLAFA headquarters and as result did not take the special needs of the local Regional clinics and programs into consideration. Staff at the regional offices felt that they should be able to take a much more active role in preparing and contracting some of their own messages.

The Department of Promotion, Education and External Training, with locations principally in the regional offices, prepares educators, counselors and trainers to promote the programs to the public through interpersonal relations, education of community leaders, and training of staff from PVOs and Honduran government personnel. It includes 26 promoters and ten educators and counselors. It provides counseling at the clinics for sterilization acceptors. The Department's activities are shown in Table 11 below. The chief of the Department was unable to show the level of these activities for each year.

The activities for adolescents included life planning seminars, talks on adolescent pregnancy, AIDS, self esteem, values, decision making, contraceptives, sexual education and responsible parenthood. Seminars and training courses were held for community promoters, university students, officers and their wives in the armed forces, community leaders, teachers and nurses, professionals from the MOH and Ministry of Education (MOE) on reproductive health, sexual education, AIDS and sexually transmitted disease (STDs). A series of talks are given to private and public promoters, counselors and teachers in responsible parenthood, family planning, reproductive health, maternal risk factors, contraception, breast-feeding and AIDS.

TABLE 11

SUMMARY OF PROMOTION, EDUCATION AND TRAINING ACTIVITIES, 1989 - 1994

Activities	Number Activities	Number Participants
Adolescent Activities	405	5,478
Training Courses	703	N.A.
Seminars	390	N.A.
Series of Talks	11,996	N.A.
Talks	24,946	N.A.

Source: ASHONPLAFA Dept. of Pro., Ed., and Ext. Tng. The total number of participants for last four years was 84,123, many of the talks were one on one by educators.

The trainers, who usually work with professionals, look for a spin-off effect in their training. For example, armed forces officers are trained in contraception, AIDS, and STDs and given materials to train their troops; secondary school teachers receive different materials for their students. The educators work more closely with mothers, couples and lower level elementary teachers or community leaders to give the talks listed above and more directly to recruit new acceptors for family planning methods. The counselors and often auxiliary nurses assist in training other health personnel and provide counseling to new acceptors of voluntary sterilization and IUD insertion.

Some field staff commented that the educators spent too much time promoting clinical family planning methods and not enough time assisting the sales promoters in giving community talks at CSP rural distribution posts. There were also comments indicating that the educators and trainers felt stretched too thin too carry out all the tasks assigned, given the availability of transport and the difficult rural terrain. There was a real empathy between the educators and the rural poor: the educators described, with feeling, poor and uneducated women, many without husbands, trying to

find contraception that they could understand and afford. These people are the backbone of the ASHONPLAFA organization.

Conclusions

Because of the political climate in which it operates, ASHONPLAFA must continue to focus its IEC efforts on public relations. This effort, however, may be taking too much of the departments' time, because although certain broad national campaigns (on family planning to protect the health of the mother and child, to reduce adolescent pregnancies and on AIDS) have been successful, there are a number of weak points in the program. ASHONPLAFA has to continue to focus its advertising and mass media on brands in the case of SMP and on services in the case of the clinics. Campaigns similar to the Ofelia Mendoza journalists award, rewarding pharmacies for the best displays of MANDOFER and other contraceptive products, or presenting awards to high school students for the best essays on responsible parenthood, have not been carried out. Other innovative ideas in public relations could be considered for program support.

Other concerns:

- A portion of the mass communication budget should be managed partly by each region so that they can provide direct support to their programs.
- Materials need to be developed for illiterate consumers.
- Old materials and counseling tools need to be updated and replaced.
- Clinics need more direct program support.
- The IEC staff needs to focus its strategy on program promotion and support.

It may be that the FP educators and trainers are not conducting enough talks with target couples in the urban slums and rural villages. Perhaps the educators are spending too much energy in meeting their targets for VSC referrals or on other groups in society, such as MOH & PVO personnel, school students, military and other officials or selling PAP smears and IUD insertions. Perhaps ASHONPLAFA needs to increase the number of educators.

5 OTHER PVOs

5.1 Foster Parents Plan (PLAN)

How successfully has PLAN met its goals and objectives as set forth in the grant agreement with USAID (referrals, training etc.)?

The purpose of this grant was to "achieve a 20 percentage point increase (from 30 percent to 50 percent) in the use of family planning methods by women in union of fertile age in the rural Honduran communities where PLAN works." The 1987 CPS indicated the CPR for rural women was 30 percent (modern methods, 22.3 percent; and traditional methods, 7.6 percent.) The 1991 CPS showed a very slight increase in use of modern methods and a larger increase in use of traditional methods. The 1991 rates were 23.7 percent modern methods and 12.4 percent traditional methods. No specific objectives were identified in the program grant agreement. However, the grant agreement discussed the following activities and presented the outputs listed in Table 12.

- promotion of family planning
- training of community and institutional personnel in family planning and breast-feeding
- reinforcement of the contraceptive distribution system
- improvement of the PLAN-MOH-ASHONPLAFA referral system

TABLE 12

PLAN OUTPUTS: PLANNED, ACHIEVED AND CHANGE OF FOCUS			
Output	Number planned	Number achieved by 10/1/94	Any change in focus since Project start up
Plan promoters and regional coordinators trained in FP, breast-feeding and high reproductive risk	80 plan promoters 8 regional coordinators	95	PLAN changed program approach and cut staff; now no health specialists - instead 43 "generalists" promoters who empower the community
Health representatives, midwives and health guardians trained in FP, breast-feeding and high reproductive risk and will be provided contraceptives for distribution	100	2412	See above. 2412 persons trained including community volunteers. PLAN is not providing or distributing contraceptives.
School teachers trained in sexual education, family life and breast-feeding	350	392	none
WFA educated about family planning, breast-feeding and high reproductive risk	14,000	14,220 women plus 1230 men	Additionally, PLAN has developed IEC sessions for men
MOH physicians and professional nurses trained and given equipment for insertion of IUDs	40 physicians 120 nurses	49 physicians 117 nurses	PLAN has trained physicians and nurses; it is not, however, providing IUD equipment.
High reproductive risk women referred for voluntary surgical contraception	2,400	1780	This total includes 18 male VSC performed in the last six months.
Other methods of FP (not mentioned in grant but in PIO/T extension)	0	1063	These are principally IUDs.

What has been the impact of PLAN's training component?

PLAN completed or exceeded all of the process indicators for training listed in the preceding Table 12. Time did not permit, nor was there any baseline data, with which the team might have assessed training in terms of functional outputs, such as upgraded competence or percentage of trainees who are using their new skills. However, the real question is how PLAN's activities affected service outputs, defined in terms of access, quality and image?

PLAN's training did increase the accessibility of family planning for rural communities; the training of service providers near these communities expanded the number of possible service delivery points. Training probably improved provider competence. Most clearly, PLAN's family planning IEC activities improved the image of family planning, leading women and men to seek services.

What has been the impact of PLAN's referral component?

The team measured the results of PLAN's referral component and support for family planning in terms of three indicators of contraceptive practice specified in the evaluation handbook: number of users, CPR, and method mix.

PLAN works through a community health committee and community health volunteers (CHVs) in 348 rural communities. The CHVs refer women and men to five types of service delivery points, depending upon the client's method preference and location of that client: to ASHONPLAFA clinics for sterilization and IUDs; to ASHONPLAFA CSP distributors for pills and condoms; to three MOH CESARs where PLAN-paid doctors and nurses provide services; to MOH facilities without PLAN support; and to private ASHONPLAFA supported clinics. The community health committee often gives the client an advance and PLAN reimburses the expenses later, once receipts are produced.

PLAN support for family planning consists of education and promotion, referral to a specific SDP, money for transportation, food and lodging (if necessary) and, when absolutely necessary, payment of part or all surgery fees. Table 13 presents data on PLAN support for VSC of women (and 18 men) from PLAN communities in MOH, ASHONPLAFA and private clinics. The following data is on the number of women and men who presented PLAN with both receipts for travel and a written affirmation from the SDP that the person had received VSC.

TABLE 13:

NUMBER OF WOMEN AND MEN SUPPORTED BY PLAN IN VSC						
Goal	1989-8/92	9/92-3/93	4/93-9/93	10/93-3/94	4/94-9/94	total
VSC: 2400	635	237	204	392	312	1780

Additionally, over the project's life, PLAN has referred 1063 women for other family planning methods, principally for the IUD. In the last six months there have been 751 such referrals.

PLAN has also supported family planning service delivery in three underserved MOH CESAMOs (La Paz, Comayagua, and Juticalpa) through contracts with three physicians and three nurses to provide family planning services in those CESAMOs. The physicians provide services five hours a

day, three days a week and the nurses are full time. The number of family clients served is not included in the figures above, but would be reported in MOH statistics.

PLAN has assessed contraceptive use in the communities in which it works, and although these data are not of DHS caliber, the PLAN data are useful for assessing PLAN outcomes within PLAN communities. In September 1990, as part of its child survival baseline study, PLAN asked a sample of 500 women in 80 PLAN communities about contraceptive usage. In 1993, with the technical assistance of the Population Council, PLAN undertook a second survey, this time with a sample of 1500 women of fertile age. The following Table 14 presents PLAN data on CPR and method mix in 1990 and 1993.

TABLE 14

METHOD MIX IN PLAN COMMUNITIES		
	Baseline of 1990	1993 Survey
Percent using family planning (all methods)	25.7	29.9
	Baseline of 1990	1993 Survey
Method	percent of total users	percent of total users
oral contraceptives	40.2	28.8
condoms	3.4	3.6
IUD	8.5	11.2
other temporary	0.0	1.3
VSC (male and female)	38.5	45.2
traditional	9.4	9.8

The data show a slight increase in CPR (4.2 percentage points) and a clear switch from oral contraceptives to VSC and the IUD.

How have the frequent structural changes at the promoter levels affected program goals and performance?

As a result of policy changes at PLAN International Headquarters affecting PLAN programs throughout the world, in 1992 PLAN/Honduras began a process of changing its program approach from one of service delivery to one of community empowerment. The change led to a reduction in the number of promoters from 80 to 43 and from staffing with specialist promoters to staffing with generalist "facilitators". In the process, a number of health specialists left PLAN; time was required to train all generalists in reproductive health, IEC and referral. The result has been that although, understandably, 1990 and 1991 were years of building capacity, 1992 was also a year of few referrals for family planning services. However in 1993 PLAN appears to have consolidated the change. In 1993 PLAN supported 915 persons in VSC[17]; data for the first six months of 1994 indicates that 1994 will be even more successful.

[17] That same year, ASHONPLAFA reported 11,229 users of VSC. Although certainly some of the PLAN referred women used MOH facilities for VSC, the 913 people assisted by PLAN are 8% of the total number of VSC performed by ASHONPLAFA in 1993.

Conclusions

PLAN is unlikely to achieve the purpose of this grant, a 20 percentage point increase (from 30 percent to 50 percent) in CPR in the rural communities where it works. One reason is that a 20 percentage point increase was highly unrealistic. The second is that PLAN is not directly providing services as planned. However, there are some positive results of the grant: a slight increase in CPR and a significant switch from pills to IUDs and sterilization. It took several years for PLAN to yield any outputs, but within the last year, they are significant: 710 VSC procedures from these communities.

PLAN (and other PVOs) offer USAID/Honduras the opportunity to support work at the grassroots-level—and to promote participation and partnerships in family planning/population policy and programs with community-level groups, which are key strategic interests of the Office of Population.

5.2 The Population Council

The purpose of the buy-in with the Population Council was to develop six technical assistance and/or operations research projects, including at least three projects with private and voluntary organizations which currently do not provide family planning services. project implementation order/technician (PIO/T) 522-0369-3-00113 was approved by the Mission to buy-in to the centrally funded INOPAL II Project. The four year buy-in, estimated to cost $ 1,100,000, was updated in 1991; an additional $370,000 was obligated and the project was extended from June 30 through September 24, 1994. The Population Council was expected to conduct operations research and technical assistance activities in order to : a) increase the number of service delivery outlets, particularly in rural areas; b) improve the quality of family planning service delivery; and c) increase manager's capability to utilize data for decision making. Table 15 shows achievements made by of the Population Council toward the goals set:

TABLE 15

POPULATION COUNCIL ACHIEVEMENTS		
Goal	Prior to project	1989 - 1994
a)Increase in service delivery outlets by PVOs, particularly in rural areas	Minimal activity	• SDPs available in a few NGOs: Save the Children, Aldea Global, CARE (90 commun.) and AHLACMA • Referrals to ASHONPLAFA SDPs. • Ten PVOs assisted by AHLACMA to setup FP services
b) Improve quality of care of service delivery	N.A.	Provider-user communication and counseling skills improved in field workers and supervisors in NGOs
c) Increase manager's capability to utilize data for decision making	N.A.	• 250 managers from NGOs participated in six workshops. • Site visits organized to allow for managers to learn about FP delivery/program management

Rural obstacles still exist: there is insufficient knowledge of family planning methods and services; demand exceeds usage. PVOs, however, have helped increase access, knowledge, change in attitudes and practices and most importantly, many have decided to institutionalize activities.

How successful has the Population Council been in meeting its goals as set forth in the scope of work?

The Population Council successfully developed and implemented six technical assistance projects with Associacion Hondurena de Lactancia Materna (AHLACMA), Instituto Hondureno de Seguridad Social (IHSS), La Leche League, CARE and Save the Children (ASCH). In addition, it organized seven high-level workshops in reproductive health, quality of care, cost effectiveness analysis, the use of qualitative research methods and contraceptive technology. (Annex 7, Table 7.1). Moreover, The Population Council (PC) provided continuous technical assistance to the following non-grantee PVOs : PRODIM, AHLACMA, and Meals for Millions. AHLACMA produced a Reproductive Health Manual for field workers with assistance from the Population Council.

What has been the impact of integrating family planning into the ongoing activities of Save the Children and CARE?

ASCH and CARE promoters and middle management staff were trained by the Population Council. Both agencies have implemented IEC and made referrals to ASHONPLAFA's CSP and MCP SDPs. CARE trained its staff and established reproductive health counselors in at least 90 project communities. ASCH, after a one year trial period in 1992, agreed to have its micro-puestos (SDPs) stock and distribute contraceptives, and the volunteers became an important source for contraceptives. Counseling, referrals and prevalence increased in the project areas. ASCH has reported that the micro-pharmacies were self-financed through their sales, including a profit for the distributors. Both CARE and ASCH field workers and supervisors now believe that FP is an important component of MCH programs and are providing IEC and referrals to ASHONPLAFA. Doctors and nurses in 25 rural health clinics and centers in Region 5 of western Honduras, (where CARE was active) were trained in reproductive health and quality of care.

How effective has the Population Council been in providing TA to non-grantee PVOs in evaluation and program design of FP activities ?

The Population Council developed six technical assistance/operations research projects with limited FP activities with: the IHSS (reproductive health and prenatal care), AHLACMA (NFP and breast-feeding), SCHH (child survival and reproductive health), CARE (service delivery and quality of care), AHLACMA (breast-feeding and birth spacing in rural areas). The IHSS study was evaluated as a successful model to increase FP use. It has prompted the MOH to include postpartum and post-abortion contraception in the standards and procedures manual that was in draft form while the evaluation team carried out the final evaluation. Staff of two different Honduran NGOs traveled abroad with assistance from the Population Council to participate in FP-related events, training activities and in observation visits to other programs (Annex 7, Table 7.2).

Conclusions

The Population Council has created awareness, provided training and technical assistance to PVOs in family planning, operations research, quality of care, and research methodology. The road between training non FP organizations in service delivery and carrying out FP activities later, however, is a long and difficult one. This buy-in trained many people from different PVOs, but slow progress was observed in the provision of direct services. The resultant small numbers of CYP are not a good indicator of its accomplishments. The forthcoming prevalence survey will most likely confirm that rural residents in Honduras are better informed about contraceptive methods, have increased knowledge of where service delivery outlets are located and how modern contraceptives are used.

Continued assistance is needed to maintain trainees' and their supervisors' interest in FP, as most of the PVOs work in isolated areas and are currently engaged in activities that do not consider FP a priority. Having a resident advisor in the country has been the greatest asset of this buy-in as that person is seen as a trustworthy resource for technical assistance and networking.

6 RECOMMENDATIONS FOR THE NEW PROJECT

1. On Self-Financing:

USAID/Honduras and ASHONPLAFA together should negotiate self-financing targets for the next project, including targets for mid-point and end-point self-financing. The 1994 level of 27 percent, would be the beginning point; the target for the year 2000 might be 35 percent. Such targets would allow USAID to discuss self-financing issues during each planning cycle.

Essential to monitoring and evaluation of levels of self-financing is a good cost accounting system; ASHONPLAFA should make completion of such a system an absolute priority.

2. On Income Generation:

ASHONPLAFA should develop and test detailed strategies (operation research) for increasing revenues. One such strategy should include greater utilization of clinics: ASHONPLAFA could stagger clinic hours, provide more and better advertising locally and arrange for credit for middle class surgical procedures. The new project could also provide funds for the establishment of more mini-clinics, and expansion of reproductive health services laboratory facilities.

3. On CYP Growth:

In order to increase CPR and to maintain ASHONPLAFA market share, ASHONPLAFA should seek a yearly rate of CYP growth that significantly exceeds the rate of growth of the number of women in reproductive age.

4. On Regionalization:

ASHONPLAFA's Executive leadership should continue to provide support and direction to the regionalization process. Many activities should be undertaken to support that process:

- Strengthening of regional Boards of Directors
- Strengthening of the planning capacity of regional staff through training
- Provision of planning support from the central office to regional offices to enable them to develop regional plans in accordance with ASHONPLAFA goals, policies and strategies.
- Holding regular intra-regional meetings such as was done recently so that regional staff might analyze their performance, share ideas and develop greater competency.

5. On Personnel Management:

USAID should provide TA and local cost support to improve personnel management through development of a job classification scheme, a remuneration system, a training needs assessment and the development of a training program.

6. On the MIS:

ASHONPLAFA, IPPF and USAID/Honduras should ensure that the recommendations of the IPPF/MSH team are carried out promptly and as a high priority. Training staff to collect, analyze and

use data for decision making at all levels should be a priority. A follow-on project should include, as a precondition, that the needed systems have been developed, tested, and are reasonably well-working. Such an MIS would follow-up on the problems identified in the IPPF/MSH report, include cost accounting and would be measured by the following indicators:

- Adequacy of information support
- Use of information for management decisions
- Timeliness
- Quality of information

7. On Contraceptive Logistics:

Only one system, TecApro, should be used for logistics management, and it should be used to its full potential. ASHONPLAFA should set minimum and maximum stock levels for each SDP, train key personnel in logistics management and monitor and assure that all warehouses meet acceptable standards. Accurate contraceptive procurement tables (CPT) should be developed and TA provided.

8. On Medical/Clinical Services:

The program should seek to increase CYP outputs, productivity and utilization through: better promotion of the services, expansion of the morning shifts for VSC in those regions where demand for VSC is high, inclusion of new contraceptives not currently provided, such as NORPLANT® and the injectables (clinical trials in Tegucigalpa and San Pedro Sula), and improvement in cost recovery. New strategies for service delivery such as mobile clinics, nurse staffed mini-clinics and IUD insertion in rural areas should also be considered.

ASHONPLAFA should provide wider availability and promotion of vasectomy through use of male promoters who have had vasectomies.

ASHONPLAFA should address and remedy problems noted in quality of care (insufficient counseling, control of potential infection with HIV and training of providers in proper procedures).

ASHONPLAFA should develop a sliding fee scale; no client should be denied service because of his/her inability to pay.

9. On the CSP:

ASHONPLAFA and USAID should decide on the best balance between the number of urban versus rural SDPs. It should be understood that CSP going rural will make it less sustainable and less effective, in terms of CYP outputs. The issue of potential competition of CSP with SMP should also be addressed, and Operations Research has an important role to play here.

10. On the SMP:

USAID should provide several months of social marketing technical assistance (TA) a year to ASHONPLAFA to: train the current program director and selected personnel working in Marketing, Promotion, and Publicity; revise and update the marketing plan; examine the overlap between CSP and SMP and develop clear strategic market niches for each; resolve the problems with moving

from Perla and Norminest to other brands; re-launch Lo-Rondal and Protektor; and develop close, productive relationships between the SMP, the Division of Information and Marketing, MANDOFER and to-be chosen publicity firms. USAID should closely monitor the results of that TA and ensure that ASHONPLAFA receives and takes advantage of sufficient TA to remedy the major problems in this program.

11. On IEC:

USAID should provide technical assistance to the IEC program, in consultation with ASHONPLAFA, to develop materials for pre-literates and barely literates and to evaluate mass communications for different audiences (determine the percentage of the population in a target area who respond positively to IEC messages).

12. On PLAN:

USAID should continue to support PLAN's training and family planning referral activities. Additionally, taking advantage of PLAN's grassroots position, USAID should consider funding small, applied research projects to better understand rural demand for family planning; these might be joint PLAN/Population Council endeavors.

13. On Technical Assistance for ASHONPLAFA:

USAID should ensure that ASHONPLAFA receives high-quality sustained technical assistance over the next five years in: planning and administration, MIS, social marketing, quality of care, and IEC.

14. On Project Evaluation:

The indicators for this project have been principally process indicators. In the new project, ASHONPLAFA and USAID should monitor and evaluate project performance through functional, service and service utilization indicators. (The indicators are identified by program area in Annex 1.)

7 LESSONS LEARNED

As the team reviewed the list of lessons learned at the mid-term evaluation, it found that many are still appropriate to mention in this final evaluation.

Where there are conflicting objectives in the project, such as need to expand rural coverage to underserved rural regions and to achieve self-sufficiency, distinct agreements must be reached on where emphasis is to be placed and under what circumstances, so that the implementing institution has a clear target for its program.

Any organization which begins with considerable external support must develop a local constituency and a local support arrangement. ASHONPLAFA still depends mainly on two external donors and has been obliged to pursue self sufficiency primarily through client charges. The organization's dependence on external support has been justified in the short term by the serious problems of rapid population growth and the need to improve maternal child health but is not a sound situation for the long run. For long term stability ASHONPLAF needs to strengthen its community support beyond selling services.

Institutional change can be accomplished, but it is a slow process. The process must include technical assistance and training and a set of clear objectives to be accomplished within reasonable time frames.

Regular planning meetings should be held between major donors on one hand, and between donors and the grantee on the other, so that all are working toward common financial objectives. If all donors are trying to reduce support at the same time, then the grantee needs to work out a strategy to absorb those costs. The important point is to plan together with all strategies revealed.

If USAID wishes to assess the impact (changes in TFR and CPR) of a project, a population-based survey similar to the demographic and health surveys should be carried out and the data analyzed prior to the project evaluation.