AWARENESS Project
Honduras Country Report
2001–2007

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Georgetown University
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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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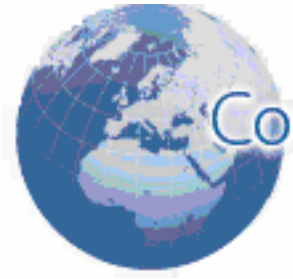
Acronyms

ASHONPLAFA	Asociación Hondureña de Planificación Familiar
CEVIFA	Centro de Vida y Educación Familiar
CRS	Catholic Relief Services
DHS	Demographic and Health Survey
FAB	Fertility Awareness-based Method
FBO	Faith-based Organization
IEC	information, education, and communication
IRH	Institute for Reproductive Health
MIS	management information system
MOH	Ministry of Health
NGO	Non-governmental Organization
SDM	Standard Days Method®
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development



Country Program Summary
Honduras

In 1999, IRH collaborated with ASHONPLAFA (Asociación Hondureña de Planificación Familiar) and the MOH on a diagnostic study to look at informed choice and natural methods. Results indicated a significant bias against natural methods by health programs and providers but an interest in natural methods by potential users. In 2001, IRH and ASHONPLAFA conducted an introduction study to test the feasibility of SDM integration into existing services. Positive results led to expanding access to the SDM within MOH and ASHONPLAFA services in six of 18 departments in Honduras.

To introduce the SDM into the MOH, IRH collaborated with Centro de Vida y Educación Familiar (CEVIFA), a Catholic organization already working with the MOH to provide the Billings method. This presented a unique opportunity to collaborate with a FBO that had a strong working relationship with public- and private-sector family planning programs. Program strategy focused on expanding SDM access to all 27 ASHONPLAFA and 150 MOH clinics in five key departments through research to establish best practices; partnership with CEVIFA; support for fertility awareness-based methods with UNFPA through CEVIFA; and demand creation for the SDM through awareness-raising activities. The introduction study showed that the SDM could be integrated into routine services; there was sufficient demand; and training providers and introducing SDM into clinic services improved client choice and quality of services. The primary reason for discontinuation after long-term use is desire for pregnancy.

Based on these results, ASHONPLAFA and the MOH expanded access to the SDM within their services. With UNFPA support, CEVIFA has integrated the SDM into MOH services and systems in five departments (in addition to the pilot study sites). At the national level, primarily as a result of CEVIFA's effective advocacy, the MOH included the SDM in its national norms, protocols, MIS, logistics systems, and IEC materials, as well as the curriculum of the national university nursing schools. CycleBeads are available through all ASHONPLAFA clinics and 30% of MOH clinics. UNFPA also integrated the SDM into their "reproductive health with gender focus" training manual for MOH nursing school facilitators. ASHONPLAFA and CEVIFA have integrated the SDM into their respective MIS, the MOH has begun the process of doing so. In 2003, the USAID/Honduras mission included the SDM in their strategic plan and requires that all collaborating agencies incorporate the SDM into their community-based programs. ASHONPLAFA, the MOH, and EngenderHealth include it in their annual work plans and budgets.

An assessment is planned for 2008 to assess the status of FAM in Honduras and identify potential needs for further assistance.

I. Introduction

Source: CIA World Factbook 2008

Honduras is one of the poorest countries in the Western Hemisphere. In 2005, with a population of 7.4 million, the annual growth rate was 2.6%, with 46% of the population living in urban areas. Some 40% of the population was under 15 years old, and 6% was 60 years and over. Indigenous groups represented 12% of the total population. Honduras has the second highest fertility rate (3.7) in Central America.[1]

Overall use of family planning has increased by 3% in Honduras since 2001. According to the 2005 Honduras Demographic and Health Survey (DHS), 65% of couples used family planning; 56% used modern methods and 9% used natural and traditional methods. Despite the decrease in natural method use from 2001 to 2005 (11% to 9%, respectively), the majority of natural and traditional method users continued to use ineffective methods such as withdrawal and periodic abstinence. Those who use these methods often do so without knowledge of more effective, easy-to-use natural methods. In fact, 20.2% of women who said they used periodic abstinence did not know their fertile period, and another 15.2% said that they were fertile at any time during their menstrual cycles. In addition, approximately 67% of married women who were not using family planning stated a desire to do so in the future, and 15.2% of non-users opposed contraceptives because of side effects, religion, lack of access, economic reasons, and husband's disapproval.[2] These women could benefit from information about the Standard Days Method® (SDM), a simple fertility awareness-based (FAB) method of family planning.

In 1999, the Georgetown University Institute for Reproductive Health (IRH), conducted a diagnostic study to look at informed choice and natural methods. IRH collaborated with the *Asociación Hondureña de Planificación Familiar* (ASHONPLAFA), an affiliate of the International Planned Parenthood Federation, and the Ministry of Health (MOH). ASHONPLAFA has worked for many years in family planning and reproductive health services. Since the 1980s, it has collaborated with USAID cooperating agencies, local nongovernmental organizations (NGOs), and the MOH to conduct family planning research, including coordination of the DHS data collection and reports. The diagnostic study results indicated that introducing the SDM in ASHONPLAFA and MOH services could improve quality of care and expand choice.

In 2001, as preliminary results from the SDM efficacy study became available, IRH collaborated once again with ASHONPLAFA to conduct a pilot study to test SDM integration into its clinical services and those of the MOH. To introduce the SDM into the MOH, IRH collaborated with *Centro de Vida y Educación Familiar* (CEVIFA), a Catholic organization that had already worked with the MOH for several years training public-sector providers in the Billings method. This presented a unique opportunity to collaborate with a faith-based organization (FBO) that was willing to work with multimethod family planning programs and the MOH. Furthermore,

[1] Secretaría de Salud (SS) [Honduras], Instituto Nacional de Estadística (INE) y Macro International. 2006. *Encuesta Nacional de Salud y Demografía 2005-2006*. Tegucigalpa, Honduras: SS, INE, y Macro International.

[2] *Encuesta Nacional de Salud y Demografía 2005-2006.*

CEVIFA's involvement with a Catholic Relief Services (CRS) child-survival project created another opportunity to test SDM introduction at the community level. The pilot study took place in eight ASHONPLAFA clinics, 16 MOH clinics in the capital region, and 16 rural communities (through CRS volunteers affiliated with MOH clinics) in the department of Choluteca. CEVIFA monitored the study and SDM implementation into services with the MOH and the 16 rural communities. Results from the pilot study indicated a strong potential for the SDM to address unmet need in Honduras.

This study set the stage for more recent accomplishments, which included expanding access to the SDM within MOH and ASHONPLAFA services in five of 18 departments in Honduras. Visibility and knowledge of the SDM increased through advocacy efforts such as presentations at national and international meetings and conferences. The SDM has been included in USAID's national strategy and the government's norms, and protocols, and the MOH considers it to have the potential to help reduce unmet need in hard-to-reach populations.

II. Objectives and Strategy

The goal of IRH's work in Honduras was to achieve sustainable SDM services within a comprehensive reproductive health program. Objectives were to create awareness of and capacity and support for the SDM and to ensure quality services.

In 2003, USAID and IRH's local partner organizations approved IRH's proposed strategy for achieving sustainable SDM services in Honduras. This strategy focused on expanding access to SDM services to all 27 ASHONPLAFA clinics and 150 MOH clinics in five key departments by conducting and disseminating research to establish best practices, partnering with CEVIFA to engage key MOH and church officials in policy discussions at the national level, continuing to foster support for FAB methods with the United Nations Population Fund (UNFPA) through CEVIFA, and creating demand for the SDM through awareness-raising activities.

III. Activities and Accomplishments

In 2000, ASHONPLAFA, in collaboration with IRH, carried out a diagnostic study (simulated client baseline study) to identify strategies to expand the availability of natural methods. Results showed a lack of informed choice and poor provider knowledge of FAB methods. In response, ASHONPLAFA, the MOH, and CEVIFA initiated a study in 2001 to test the introduction of the SDM into their programs. SDM users in this study were then followed for an additional two years. These studies showed that the SDM could be integrated into routine services, there was sufficient demand for the method, and that training providers and introducing SDM into clinic services improved client choice and quality of services. Based on these results, ASHONPLAFA and the MOH expanded access to the SDM within their services. Subsequently, the MOH included the SDM in its national norms, protocols, management information system (MIS), and information, education, and communication (IEC) materials.

Table 1: Partners, Roles, and Accomplishments

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Asociación Hondureña de Planificación Familiar (ASHONPLAFA)	• Pilot SDM study • Long-term follow-up SDM study • SDM scale-up • Training and integration of SDM into its services	• Research (data collection, entry, and analysis) • Technical assistance to interested local NGOs (including training) • Service Delivery	• Technical assistance (monitoring research, training, service delivery) • Funding • Dissemination of study results	• Studies completed and results disseminated • 100% of clinics offering SDM • 100% providers trained • SDM in norms, protocols, MIS, logistics/ commodities
Centro de Vida y Educación Familiar (CEVIFA)	• Training of MOH trainers/providers • Monitoring of SDM integration into MOH services • Guiding MOH in the integration of SDM into national norms and educational curricula	• Technical assistance to interested local NGOs (including training and supervision of MOH services)	• Technical assistance (training and monitoring CEVIFA'a assistance to MOH services)	• 30% of MOH providers trained • SDM integrated into organizational norms/protocols, MIS, IEC, and commodities and logistics
Ministry of Health (MOH)	• Advocacy for political support for SDM • Integration of SDM and scale up	• Service Delivery (SDM integration in family planning clinical services	• Dissemination of study results • Advocacy for political support	• SDM integrated in national norms/protocols, MIS, IEC, and progress towards including it in commodities and logistics system • SDM included in national nurse auxiliary/nurse training programs and training materials • SDM included in 2005 DHS

A. Research

i. Pilot Study

The pilot study that took place from 2001 to 2003 included quarterly interviews with 109 users, provider interviews, and simulated client visits. Results from the user interviews demonstrated that 33 percent of SDM acceptors had never used any method or used an ineffective method, that it was feasible to offer the SDM in both rural and urban settings, and that it could be offered by community promoters as well as clinically trained providers. The simulated client study showed that, after providers were trained in the SDM, 39 percent of clients felt free to choose their method as compared to 29 percent previously. In addition, 75 percent of clients felt they received sufficient information to select a natural method compared to 38 percent earlier. Following the introduction of the SDM, providers were also better able to address important couple issues like sexually transmitted infections and condom use. Overall, these results suggest that introducing the SDM into each program in Honduras contributed to improving informed choice and quality of services.

ii. Long-term follow-up study

Following the pilot study, ASHONPLAFA invited women who exited that study and were still using the SDM to participate in a follow-up study to learn more about long-term use and method continuation. Study participants who had completed 13 cycles of use, were using the method at the time the pilot study ended, and wanted to continue using the method were interviewed five times over a 24-month period following completion of the pilot study.

The study showed that discontinuation rates remained relatively low (<10%) during the first few months among those women who continued to use the SDM beyond the first year. After six months to a year of continued use, discontinuation increased again for reasons that included switching to another method, absence of partner, and wanting to have a baby. These observations indicated that reasons for discontinuation after long-term use have more to do with birth spacing and other life circumstances than with dissatisfaction with the method. Most women who discontinued because they got pregnant, had cycles out of range, or were dissatisfied with the method did so in the first months of use.

B. Building awareness of and support for SDM

i. Building awareness

Efforts to expand access to the SDM in Honduras included activities to develop demand for the method. IRH provided funding and technical assistance to partner organizations to develop and produce materials that complemented their existing family planning materials. ASHONPLAFA and the MOH included the SDM in method fliers and posters. CEVIFA worked with the MOH to raise awareness about the SDM during the first few months of services through temporary wall murals and banners, while MOH posters and fliers were being produced. CEVIFA also developed radio spots and spoke about the SDM on local radio stations in the two departments where the SDM was first introduced. Both ASHONPLAFA and the MOH included the SDM among other contraceptive options in their health fairs, loudspeaker announcements, community talks, and home visits. Local radio spots developed by the MOH also increased awareness of the SDM.

> *"I heard about the SDM from my work and so I…told [my wife], 'Let's use a method that is reliable and natural.'"*
> **-Husband of SDM user in his early 40s**

The following table shows awareness-raising activities by each partner organization during the project time period (2001 to 2005).

Table 2: Number of Awareness-Raising Activities (2001 to 2005)

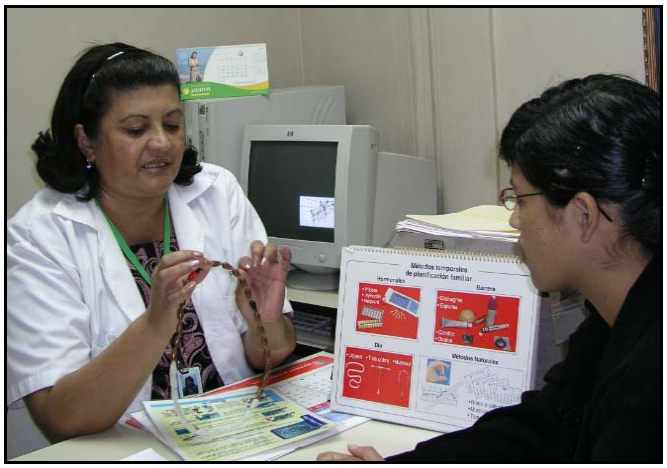
Activity	ASHONPLAFA	MOH	CEVIFA	TOTAL
Educational talks	3,259	2,661	579	6,499
Home visits	-	1,055	289	1,344
Loudspeaker vehicle trips	-	8	1	9
Radio spots	-	736	1,672	2,408
Health fairs	-	41	63	104
Murals	-	16	18	34
Number of people made aware of SDM	**16,259**	**35,440**	**8,992**	**60,691**

ii. Building support

Given the positive relationship that existed among the three local partners, (ASHONPLAFA, MOH, and CEVIFA), IRH could establish strong support and ensure sustainability of the SDM in Honduras. In 2005, CEVIFA used SDM research results to continue advocacy with the MOH and was instrumental in integrating the SDM into the MOH norms (included as an addendum in 2005) and the curricula of the national university nursing school (2005). At the same time, UNFPA integrated the SDM into its "reproductive health with gender focus" training manual for MOH nursing school facilitators (2005).

C. Developing the capacity of local organizations

During the pilot study period, IRH built the capacity of ASHONPLAFA and CEVIFA to provide training and technical assistance to a growing number of providers and NGOs interested in the SDM. As a result, both provided training and technical assistance to other NGOs such as Aldea Global, a small community-based organization, and several Catholic diocesan programs. Training workshops lasted two days and covered all the steps in a counseling session. Given the MOH's desire to expand access to the SDM to more clinics after the pilot study ended, IRH continued to support CEVIFA through a grant that complemented its natural family planning activities funded by UNFPA.



An ASHONPLAFA family planning provider explains the significance of the dark brown bead.

All three local partner organizations adapted SDM provider, client, and training materials to complement their existing family planning training and service delivery materials. From 2001 to 2007, the three organizations trained 918 providers (physicians, nurses, auxiliary nurses, and community health workers) in the SDM. Additionally, CEVIFA trained 32 official MOH trainers in the SDM. Since introducing the SDM in 2001, all three partner organizations reported approximately 2,211 new users.

Table 3: SDM Service Statistics by Partner Organization, 2001–2007

Name of Organization	Number of Providers Trained	Number of Sites with Trained Providers	Number of Trainers Trained	Cumulative Number of SDM Acceptors	Percentage of New Family Planning Users Accepting the SDM
ASHONPLAFA	54	27 clinics	3	447	0.5%
MOH	864	382 clinics in 5 departments	32	1,764*	Not known
Total	918	409	35	2,211	

Note: CEVIFA is not included in the table because it does not provide services.
***These data are considered very unreliable (see below).**

D. Incorporating SDM into reporting systems

The MIS capability within each of the three partner organizations differs greatly. ASHONPLAFA easily integrated the SDM into its well-organized and computerized MIS during the 2001pilot study. However, the MOH's MIS is dependent on overworked and untrained providers who do not enter any method adopted by family planning users into their register on a regular basis. CEVIFA worked with public-sector providers and administrators to ensure the inclusion of the SDM in their MIS. Although the MOH added the SDM to its MIS in 2001, data have not been entered consistently and are unreliable. The program uses proxies such as CycleBeads sent to the MOH and reports from CEVIFA to estimate number of SDM users and CycleBeads re-supply. Approximately, 7,000 CycleBeads have been sent to Honduras since 2001, and sources report that a very small number remain in stock for MOH use. Thus, the figures in Table 3 very likely represent an undercount of SDM users.

E. Generating commitment of resources to SDM by governments, NGOs, or donor agencies

CEVIFA expanded the SDM to five additional departments (in addition to the two pilot study departments) with a grant from UNFPA. The funds leveraged from UNFPA during the first two years (2003–2005) covered the costs of SDM IEC materials, CycleBeads, training, monitoring, and supervision of MOH providers. With the experience of the first expansion, CEVIFA obtained additional support from UNFPA, but this has been limited to monitoring and supervising the five departments. CEVIFA has leveraged the UNFPA funding to ensure full sustainability of the SDM in these departments. CEVIFA will continue to look for financial support from different donor agencies for further expansion efforts. In 2003, the USAID/Honduras mission included the SDM in its strategic plan, and since then it has required that all relevant USAID programs incorporate the SDM into their community-based programs. To date, ASHONPLAFA, the MOH, and EngenderHealth have included the SDM in their annual workplans and budgets.

F. Incorporating SDM into the logistics system

CycleBeads are available through all ASHONPLAFA clinics and in 30 percent of MOH clinics. Integration of the SDM into ASHONPLAFA and MOH contraceptive logistics systems began with a temporary code for CycleBeads until the contraceptive inventory forms were reprinted during the pilot study. After the study ended in 2003, CEVIFA continued to meet regularly with the MOH to guide the full integration of the SDM into the logistics system; ASHONPLAFA completed integration into its logistics system by the end of the study.

G. Summary of experience of SDM introduction and expansion

With a long-term objective of including the SDM as a sustainable part of the method mix in Honduras, IRH addressed policy, training, IEC, and commodities. IRH developed the capacity of a well-established family planning agency and a highly respected FBO to provide technical assistance to the MOH and other organizations and professionals interested in providing the

SDM throughout the country. IRH also tested the introduction of the SDM in different types of service delivery organizations, which resulted in a strategy for scaling up the SDM in Honduras.

Since the completion of pilot studies with the three local partners, IRH expanded SDM services to its current availability in five departments, with 918 providers in 409 clinics trained to offer the SDM. As of March 2007, there were more than 2,200 recorded SDM users. Data from 2006–2007 alone indicate that demand for the SDM has continued steadily since the end of USAID/IRH and UNFPA funding.

As described above, the SDM has been included in national norms and protocols, the USAID/Honduras strategic plan and mission-funded family planning program requirements, and the MOH/UNFPA pre-service curricula for auxiliary nurses.

Dissemination of research results and advocacy efforts such as CEVIFA presentations at national meetings and conferences increased awareness, interest, and demand for the SDM. As a result of the project, CEVIFA's enhanced capacity, research findings, the integration of the SDM into norms and protocols, and lessons learned have all provided a strong basis for achieving good-quality, sustainable SDM services in Honduras.

IV. Challenges

Integrating the SDM into three types of service delivery systems (ASHONPLAFA, MOH, and through CRS rural health volunteers affiliated with MOH clinics) was challenging. Working with a private family planning agency allowed IRH to introduce the SDM into a well-established organization with a history of high-quality services. On the other hand, these family planning providers were skeptical of the feasibility and acceptability of the SDM. In fact, these providers had forgotten most of what they had previously learned of any FAB method. Introducing the SDM into the public sector brought another set of challenges, such as constant staff turnover at all levels and scarce resources. This resulted in delayed integration of the SDM into the national norms/protocols, MIS, commodities and distribution system, as well as slow expansion of provider training and supervision during the first three project years.

V. Lessons Learned

Research conducted in Honduras provided valuable lessons for other countries seeking to introduce the SDM into different types of service delivery systems (public, private, and community-based FBO). Honduras found the SDM feasible to offer through different settings and provider types, in that community providers (health promoters) were able to provide the SDM as well as or better than clinic-based providers. Health promoters were motivated from the start and reported a close relationship with the community, allowing them to easily broach the subject of couple communication. However, clinic-based providers needed support from their supervisors to keep them motivated and to improve skills to handle couple issues during counseling. Finally, making certain that a committed and responsible partner like CEVIFA continues to train, monitor, and foster backing for SDM integration ensures long-term support for the SDM.

VI. Future Plans

The focus of IRH's work in Honduras was to build local capacity and achieve SDM sustainability. CEVIFA needs continued assistance to leverage funds from donors and build political support for continued SDM services. Since the end of the pilot studies, small NGOs have continued to show interest in integrating the SDM into their programs. Expansion of the SDM to all ASHONPLAFA clinics and 382 public-sector clinics in five departments has generated demand, making it necessary for both ASHONPLAFA and CEVIFA to ensure CycleBeads supply for the next years. Additionally, USAID and EngenderHealth have awarded grants to CEVIFA to provide SDM training and technical assistance to the MOH and private-sector ob/gyns.

Based on results of the expansion of the SDM into five departments with UNFPA funding, CEVIFA may obtain support to continue expansion to another five departments, bringing the total departments offering the SDM to ten of 18 in the country. As interest and funding from donors and USAID cooperating agencies grows, CEVIFA will continue to offer SDM training and technical assistance for SDM integration into services, and to find new venues to provide the SDM such as the private sector (i.e., private physicians and other natural family planning organizations). ASHONPLAFA will continue to partner with Christian Aid, an organization funded by USAID to expand family planning services in rural communities. As ASHONPLAFA expands its work at the community level, it will look for opportunities to collaborate with NGOs working in rural areas and ensure that the SDM is included in their workplans. In 2008, CEVIFA plans to convene a regional meeting to share experiences and lessons learned among all organizations in Honduras that have worked with the SDM and natural family planning organizations from other Central and South American countries.