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STATE OF THE PRACTICE BRIEF

Moving Contraceptive Security Forward with Political Commitment and Financial Capital

Policy environment and resource mobilization facilitate access to family planning; next steps should focus on effectively reaching the poor.

DELIVER, 2005

Field visit to a rural Ministry of Health clinic in the community of Buena Vista de Olancho

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Contraceptive security has been achieved when individuals have the ability to choose, obtain, and use quality contraceptives whenever they need them.

The second-largest country in Central America, Honduras is mountainous in most areas and is marked by fertile plateaus, river valleys, and coastal plains. In 2004, the population reached about 7 million, growing at an annual rate of 2.2 percent.[1] In 2004, its gross national income per capita was estimated at U.S.$2,760. Forty-four percent of the population is living below the international poverty line of U.S.$2 a day.[2]

Like other Latin American countries, Honduras has steadily and significantly decreased its total fertility rate (TFR) in recent years, from an average of 5.6 children per woman in 1987 to 3.3 in 2005.[3] See figure 1. Honduras has also made impressive gains in its contraceptive prevalence rate (CPR), with an increase in use of all methods from 41 percent in 1987 to 65 percent in 2005. More recently, overall CPR rose slightly from 62 percent in 2001 to 65 percent in 2005.[4] In 2005, the use of modern methods increased from 51 percent to 56 percent, while use of traditional methods fell from 11 percent in 2001 to 9 percent in 2005. See figure 2. Method mix indicates the use of a variety of contraceptive methods in 2005, including 33 percent voluntary sterilization, 21 percent injectables, 17 percent oral contraceptives, 10 percent intrauterine devices (IUDs), 4 percent condoms, and 14 percent traditional methods.[5]

Although these figures provide evidence of the increasing importance women and men in Honduras attribute to planning their families, there is still much work to be done before contraceptive security is achieved and all Hondurans are able to choose, obtain, and use their preferred contraceptive method. For example, in 2001, although the country's overall unmet need was 11 percent, unmet need for the poorest women was more than twice as high at 23 percent,[6] indicating huge inequities in access to family planning (FP) services across socioeconomic segments of the Honduran population.[7]

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Figure 1. Total Fertility Rate (children per woman) Women of Reproductive Age (in union)

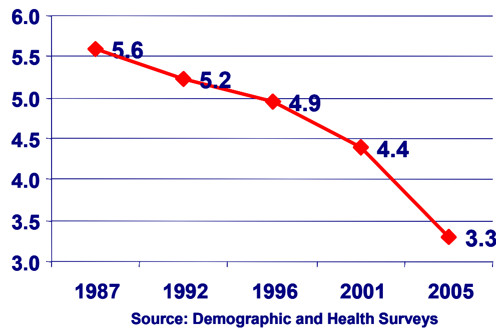
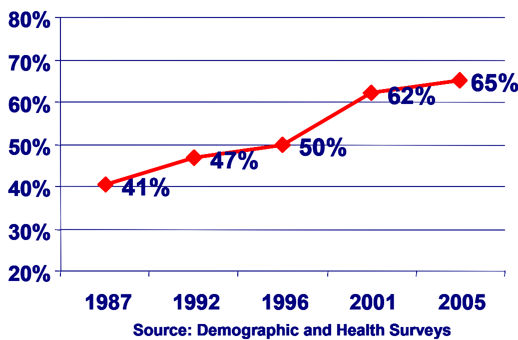


Figure 2. Contraceptive Prevalence Rate (all methods)



These inequalities are also shown when comparing TFR and CPR by departments in the recent 2005/2006 National and Demographic Health Survey. The Lempira Department showed the highest TFR of 5.5 children per woman and the lowest CPR (44.5 percent all methods), while Comayagua shows 3.8 TFR and the highest CPR (64 percent all methods).[8]

Nonetheless, in recent years the largest reduction in TFR took place in rural areas, where the average number of children per woman decreased dramatically from 5.6 in 2001 to 4.1 in 2005,[9] suggesting that some vulnerable groups may have experienced improvements in access to FP services since 2001.

This decrease in TFR can in part be attributed to a six-point increase in the overall contraceptive prevalence rate (from 55 percent in 2001 to 61 percent in 2005) among women in rural areas. With women in urban areas maintaining a relatively stable CPR (70.4 percent in 2001 to 70 percent in 2005), the increase in use among women in rural areas may be the biggest reason for an overall rise in CPR during the last several years.[10]

Another possible factor in the reduction of the TFR, however, may be the increase in the use of modern contraceptive methods, which have greater effectiveness. Trends in modern method mix illustrate that the rise in contraceptive use has primarily been concentrated in increased use of injectables (10 percent to 14 percent) and voluntary sterilization (18 percent to 21 percent) between 2001 and 2005.[11] In addition, there was an increase in use of IUDs from 5 percent in 1991 to 10 percent in 2001,[12] although some of this gain has slipped in recent years—IUD use dropped to 7 percent in 2005.[13]

These historic gains may have resulted from successful interventions taking place throughout the late 1990s that aimed at increasing access to IUDs by enhancing the capacity of Secretariat of Health (SOH) auxiliary nurses to provide this service and improving the quality of medical equipment in health facilities. In addition, as a result of these capacity improvements, in 1999 the SOH changed the National Women's Health Service Delivery Guidelines to explicitly authorize auxiliary nurses to insert IUDs, deliver Depo-Provera, and take Pap smears.[14] These strategies appear to have expanded access to IUD insertion services in the past. Perhaps innovative information, education, and communication (IEC) strategies, training in contraception eligibility criteria, and appropriate counseling can help preserve some of the capacity developed in the 1990s. Such interventions can assist in improving quality of FP services, reducing medical barriers to service provision, addressing traditional myths and misperceptions about IUDs, and improving knowledge and understanding so that women can have access to their contraceptive method of choice.

As of 2001, the main public sector providers of family planning information and services in Honduras were the SOH—covering 41 percent of FP users—and the Honduran Social Security Institute (SSI)—covering 5 percent.[15] The HSSI functions as

the health service provider for formal sector[16] employees, providing a basic insurance package to employees and their families; however, HSSI FP coverage has historically been minimal. On the other hand, the private sector, which includes nongovernmental organizations (NGOs), private hospitals, clinics, and pharmacies, covered 54 percent of all family planning users in 2001.[17]

Within the NGO sector, the Honduran Family Planning Association (ASHONPLAFA) is the main provider of FP services—covering a substantial 29 percent of all FP users. This NGO operates 24 clinics and has a well-developed, successful community outreach program with 1,631 community service distribution points. ASHONPLAFA also provides social marketing services and distributes contraceptives to hundreds of traditional commercial outlets. Through well-established social marketing programs, ASHONPLAFA and another major NGO player, the Pan American Social Marketing Organization (PASMO), have been vital in allowing access to affordable contraceptives in pharmacies and other traditional outlets.

In sum, in 2001, the public sector (SOH and SSI) served 41 percent of FP users while ASHONPLAFA served 29 percent of users across all socioeconomic quintiles.[18] Voluntary sterilization was the most commonly used modern method, followed by orals, injectables, IUDs, and condoms. The demand for injectables will probably continue to increase given the current level of unmet need. Condoms are distributed mainly by private pharmacies. Finally, the SOH has increased public sector coverage in recent years, from 35 percent in 1996 to 41 percent in 2001. This increase in coverage has mostly served women in the lowest socioeconomic segments of the population.[19]

PUBLIC SECTOR AND NGOs SET ASIDE FUNDING FOR FUTURE PROCUREMENT OF CONTRACEPTIVES

During the 1990s, USAID was the only donor providing contraceptives to the SOH, averaging approximately U.S.$350,000 worth of donated contraceptives per year; USAID donations ended in 2005. In 2002, in spite of the lack of a formal phaseout plan, the SOH began to purchase contraceptives with its own funds, using the United Nations Development Programme (UNDP) as a funding and procurement vehicle. The Government of Honduras decided to use UNDP as a funding and procurement channel to guarantee an efficient and transparent mechanism for obtaining contraceptives. In Honduras, under the UNDP project, all ministries (Health, Education, Agriculture, and Finance) procured their goods through UNDP by way of national and international bidding processes.

By 2002, both the SOH and ASHONPLAFA had covered 38 percent of their contraceptive needs.[20] In 2004, the SOH procured approximately U.S.$300,000 worth of injectables, and financed and procured more contraceptives in 2005. In 2006, the SOH budgeted U.S.$1 million, which covers nearly 100 percent of its estimated contraceptive needs, and are planning to procure 100 percent of all needs in 2007.[21] As a result, today all SOH regions include contraceptives in their annual operational budgets, which represents a way to institutionalize future funding allocations for contraceptive procurement. These types of financial commitments will help smooth the transition process and ensure services are not interrupted once donations cease.

HSSI, on the other hand, has also received donations from USAID and the United Nations Population Fund—mainly condoms, oral contraceptives, IUDs, and injectables, except from 1998 to 2002. Unlike other FP providers in Honduras, HSSI does not yet purchase contraceptives and has not developed procurement plans for the near future.

POLITICAL WILL TRANSFORMS THE FUTURE OF CONTRACEPTIVE SECURITY IN HONDURAS

In addition to increased service provision and resource mobilization, the Government of Honduras has shown an outstanding commitment to comply with a series of international conventions and treaties—in particular, the Convention to Eradicate all Discrimination against Women (CEDAW). In 2000, the Honduran Congress passed Legislative Decree 34-2000, the Equal Opportunities for Women

Law. This law requires the government to guarantee every woman the right to exercise her reproductive rights and freely decide the number and birth spacing of her children. The law also focuses on preventing adolescent pregnancies through enhanced sexual and reproductive health IEC programs and provision of FP counseling services. Such political will to help protect the rights of Honduran citizens to plan their families will go a long way toward securing the health of its women and children into the future.

In 2002, the National Institute of Women (INAM), a governmental institution, developed an unprecedented policy titled The National Policy for Women, which includes the First National Plan for Equal Opportunities, 2002−2007. This is the first public policy ever approved that requires the government to expand and strengthen FP services and counseling in order to guarantee that men and women can fully exercise their reproductive rights. This policy and plan, made official by the president through Executive Decree 15-2002, requires the government to reduce maternal and child mortality rates as well as transmission of HIV. Moreover, in June 2006, INAM signed a cooperative agreement with the SOH to implement health actions described in the National Policy for Women.

WOMEN'S GROUPS JOIN FORCES TO ADVOCATE FOR EQUAL OPPORTUNITY AND ACCESS TO REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES FOR ALL HONDURAN FAMILIES

In every country, civil society groups play a pivotal role in promoting democracy and community participation in health care issues. Civil society participation, including women's movements, is an essential component of ensuring improvement in health and population indicators over time. In Honduras, women's movements that have actively advocated for reproductive rights and have sought policy dialogue with governmental leaders have been fundamental in improving access to family planning services and ensuring improvements in maternal and child health.

Today, Honduras hosts numerous women's groups and associations advocating for women's rights (including sexual and reproductive rights), and promoting knowledge about and access to FP services in order to guarantee that men and women are afforded the services Honduran law assures them. Moreover, some of these women's organizations played an important role in the development of the National Policy for Women, with the involvement of more than 62 organizations and numerous women representatives from regional organizations.[22]

CHALLENGES AND NEXT STEPS

Honduras faces several challenges over the next few years in maintaining the gains it has made in contraceptive prevalence and simultaneously reducing unmet need, especially among poor and hard-to-reach populations. To efficiently coordinate the use of scarce resources for family planning, stakeholders will need to adopt a total market approach.[23] Such an approach can help various providers analyze the market and the comparative advantages of both public and private service providers, including social marketing organizations, toward maintaining CPR and serving the most difficult to reach populations.

Some of the challenges ahead include dramatically improving and institutionalizing the SOH contraceptive supply chain in order to reduce stockouts; maintaining the private sector market share by securing availability of socially marketed products; reducing unmet need among the poorest populations served by the SOH; increasing FP services provided by SSI and including family planning in the SSI benefit package; and developing a phaseout plan for contraceptive donations through a collaborative process with international donors as well as key family planning providers in Honduras. Certainly, when the 2005−2006 Demographic and Health Survey is released, joint in-depth analysis of FP indicators and trends will be extremely useful to further examine the FP program and identify achievements as well as challenges for the future.

Although the recent increase in proportion of FP users served by the SOH is a positive trend, it also represents a challenge to the SOH to secure enough public funds to meet this increasing demand while serving the hardest-to-reach segments of the population. Simultaneously, there are opportunities to continue improving quality of care through innovative strategies that offer comprehensive FP services; for example, continuing to enhance auxiliary nurses' capacity to provide IUD insertion services. Last, the contraceptive security (CS) Committee may want to consider involving others from government, civil society, and the commercial sector as well as seeking partnerships with the private sector as a way to promote health sector-wide support for achieving CS in Honduras in coming years.

ENDNOTES

1. USAID. June 2006. *Country Health Statistical Report: Honduras.* http://dolphn.aimglobalhealth.org.
2. World Bank. 2006. *World Development Indicators.* http://devdata.worldbank.org/wdi2006/contents/index2.htm.
3. Comparison of data between Reproductive Health Surveys and Demographic Health Surveys (2001 vs. 2006) has limitations due to differences in sample size, different women's age groups, questionnaire design, different stratification (regions vs. departments), and other methodological differences.
4. Health Secretariat of Honduras, et al. 1988 and 2002. *Honduras: National Survey of Epidemiology and Family Health (ENESF)–1987 and 2001.* Atlanta: Centers for Disease Control and Prevention.
5. Honduras National Institute of Statistics and ORC Macro. 2006. *Honduras: National and Demographic Health Survey 2005–2006: Preliminary Report.* Tegucigalpa: National Institute of Statistics.
6. Taylor, P. et al. 2004. *Regional Contraceptive Security Report: Latin America and the Caribbean: Findings and Recommendations.* Arlington, Va: John Snow, Inc./DELIVER, and Washington, DC: The Futures Group/POLICY II Project, for the U.S. Agency for International Development.
7. An estimate of unmet need is currently not available for 2005 as only preliminary results have been published from the most recent Demographic and Health Survey (DHS) report.
8. 2006 Annual Report Measure Evaluation Honduras. PowerPoint Presentation dated August 2006.
9. See note 5.
10. See note 5.
11. See note 5.
12. Health Secretariat of Honduras, et al. 1992 and 2002. *Honduras: National Survey of Epidemiology and Family Health (ENESF)–1991 and 2001.* Atlanta: Centers for Disease Control and Prevention.
13. See note 5.
14. Irma Mendoza and Ricardo Vernon. 2001. *Promoting Reproductive Health Services in Rural Communities in Honduras.* New York: Population Council.
15. An estimate of source of supply is currently not available for 2005 as only preliminary results have been published from the most recent DHS report.
16. The formal sector is that area of economic activities that is formally recorded by the state; in other words, the area in which it can intervene either directly or indirectly.
17. Health Secretariat of Honduras, et al. 2002. *Honduras: National Survey of Epidemiology and Family Health (ENESF)–2001.* Atlanta: Centers for Disease Control and Prevention.
18. See note 17.
19. See note 6.
20. See note 17.
21. USAID/Honduras Performance Monitoring Plan "Strategic Objective 3: Healthier and Better Educated People," table of Secretariat of Health contraceptive procurement 2004–2005.
22. The National Policy for Women, *First National Plan for Equal Opportunities 2002–2007.* Tegucigalpa.
23. A total market approach requires recognition of the contribution different public, NGO, and private suppliers can make in meeting client needs, and that populations may have a different willingness and ability to pay for FP methods. It involves an analysis of the contraceptive market by different segments defined by the different socioeconomic and geographic characteristics of FP users to better serve the entire population.

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