Cruzada de la Esperanza (Crusade of Hope)
Women’s Health Promotion and the Prevention and Diagnosis of Breast Cancer, Cervical Cancer, Uterine Cancer, and Sexually Transmitted Diseases in Rural Honduras, 2008-2009

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Abstract
A pilot public health project in Honduras aimed at providing services for women’s health promotion and the prevention and diagnosis of breast, cervix and uterus cancers, sexually transmitted diseases and HIV/AIDS was implemented. “Cruzada de la Esperanza” targeted 789,415 women of fertile age older than 18 years in impoverished and hard to reach rural areas. The project was funded by The Democratic Republic of China-Taiwan and The Honduras Health Ministry. “COCSIDA” Centro de Orientaciòn y Capacitación en SIDA (Center for Counseling and Training on HIV/AIDS) was the institution administrating and implementing the project in 98 municipalities and 576 villages. The health threats in this population are due to the close relationship between women’s reproductive health issues and components of human sexuality, influenced by socio-cultural factors expressed through male “machismo”, female subordination and lack of empowerment and education. The project's demographic coverage was every person who directly or indirectly benefited from the services. The criteria for intervention were those for the targeted health threats and pregnant women. The Crusade's main goal was to decrease late detection for the stated cancers and other health problems. Another goal was the increase of access and services utilization including mammography, vaginal cytology, rapid HIV testing and counseling, diagnosis of sexually transmitted diseases and positive case referral to a higher quality health care center. By achieving the above goals the Honduras female population was educated to adopt better and safer health care practices and access to those services will increase. The main strategy of implementation was the use of 3 mobile mammograms, radiological and laboratory diagnostic equipped vehicles available in a community health fair atmosphere. The plan was to provide 10,800 mammograms, 25,920 ultrasounds, 25,920 vaginal cytologies, 12,920 rapid HIV tests and 20,000 sexually transmitted disease attentions. The Crusade began in May 2008 but ended in March 2009. A total of 98 municipalities in 13 departments and 263,242 people were serviced. A total of 330,154 attentions out of 312,736 planned (105.6%) were accomplished. Of these, 15,390 were mammograms, 9,187 were ultrasounds, 27,271 were cytologies, 13,681 were rapid HIV tests and 8,808 were STD attentions. 305 vaginal cytologies and 70 mammograms were suggestive of malignancy. 21 cases were HIV-positive. 100% of the suggestive malignancy and HIV cases were referred and inserted in a specialized institution for medical care. Due to the successful results, the funding donor entities granted one more year of activities, sadly canceled due to the Honduran political crisis.
Introduction
A pilot project in Honduras aimed at addressing a public health problem concerning women’s reproductive health issues was developed, implemented, and managed by the Centro de Orientación y Capacitación en SIDA - “COCSIDA” (Center for Counseling and Training on HIV/AIDS). The project was solicited by the Office of the Honduras First Lady, Señora Xiomara Castro de Zelaya, Honduras Presidential House, in 2007. The plan was born as a decentralized response to health problems and the lack of access to health services for the Honduran women living in impoverished rural areas. Application of the national Solidarity Network Strategy bridged the gaps in addressing socio-economic health issues in which the Honduras population was immersed. The concept was to provide services for women’s health promotion and the prevention and diagnosis of breast, cervix and uterus cancers, sexually transmitted diseases and HIV/AIDS. The project was designated as the Cruzada de la Esperanza (Crusade of Hope) because it was designed to bring hope to isolated communities using a mobile strategy.

Background
Regardless of where we find women geographically, their reproductive health is increasingly threatened as a result of detrimental conditions that make women easy victims. This is often expressed in the cases of breast, cervix and uterus cancers, sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS). Reproductive health is closely related to many components of human sexuality, which in turn are influenced by socio-cultural factors expressed through gender categories. The categories include roles and expressions, models, and image of masculinity. Negative effects of these factors result in situations such as abuse, violence, discrimination, subordination, atavistic rivalry and opposition that are compounded by lack of access to education (particularly sexuality) and health services [1].

These conditions can distort the perception that women have regarding risk factors affecting their health and lives, and also can disrupt their perception towards prevention. As a result, a relationship within a cultural framework in which there is a predominance of male power, can have negative impacts on female reproductive health.

In different geographical areas of the world, just being born female consigns differing predetermined social roles. The location of birth may place the woman in a relatively better or worse position, but everywhere there is some degree of open and ongoing violation of their fundamental human rights. It is noteworthy that by the very condition of being female, having a lack of equal rights with men, the woman is a social subject highly vulnerable to damage of her reproductive health as well as other components of health and life in general. The same biological condition of women, located in a "sexual status quo" that denies the power of decision over their own bodies and safeguarding of their health, assigns gender roles that compel this to be last on a scale of priorities meeting their needs, desires and aspirations.

Even within a country, region, department or local community, apart from individual differences that make us quite unique beings, it is true that there are many common elements that are thought to be particular categories such as gender and its ally, the particular culture of machismo so characteristic of Honduras. These categories also include occupation, residence, schooling, religion, marital status, social stratum, experience or lack thereof, etc. At times machismo
influences the members of each group in the way they think, express, act and feel in different situations of life, making them different and with their own characteristics.

Honduras is a Central American multicultural country (with several ethnic groups), historically influenced by European culture (Spanish colonization) in combination with the native culture (indigenous). It is also a changing country because of intra- and extra-territorial dissemination through modern migration and dissemination achieved through the means of mass media communication. Honduras’ particular features are mainly reflected in the roles and gender expressions that are imbued with beliefs, myths, taboos and practices that come to form their own values, but that according to their own idiosyncrasies have their individualities. These individualities influence all spheres of social reproduction. They are manifested in lifestyles that are expressed in particular behaviors related to the thinking, doing and feeling of men and women with regard to an important human element, which is sexuality. These behaviors primarily affect relationships that are important influences on the reproductive health of women.

The problems experienced by Honduran women in the field of reproductive health, especially those which deal with breast, cervix and uterus cancers, sexually transmitted diseases, and HIV/AIDS, are closely related to patterns of sexual behavior of people, their values, attitudes, beliefs, practices, and their culture. The prevalence of stereotyped patterns of masculinity centered on genitalia lead men to seek reaffirmation of their status as "macho" through sex with multiple partners. Seeking such reaffirmation has the subsequent development of risk practices with their permanent relationships and with the outside purchase of sexual services from women and/or other men [1].

In 1998 a qualitative study of contents - meanings of thinking, feeling and doing - of working women, men and the partners of those working women, regarding sexually transmitted diseases, HIV and uterus and cervical cancer was conducted. The study was located in the cities of La Ceiba and Tela in the department of Atlántida, Honduras. Examples of expressions gathered in the study showing feelings about conceptions of life, health, care and practices follow: - "the speech is fairly easy ... to care for life, but it is not so easy in practice because there is no time for oneself ... many responsibilities to fulfill, others are first and then we are ... ", "As women, we do not take care of our lives and our health ... if we would love ourselves a little bit like a human being... like women who are important in their homes ... just a little bit... we could change ...", "For us women it becomes more difficult because ... we keep an eye on the others, on the house, we do not take care of ourselves ...", "Sometimes we are not careful ... 3 to 4 years have elapsed before we have a medical checkup" and "Sometimes you want to get a medical checkup ... but one cannot because we have no money ... you have nothing so you are healthy my husband says and besides I have no money, you are lazy also ... Sometimes I feel sick and I have to be brave ... and lie down for a while ... work outside the home does not give us time to take care of ourselves ... and we could go to the health centers on the weekend but the health centers are closed ...", [2,3].

The backgrounds of the pathological conditions addressed in the Crusade of Hope project follow:
Breast Cancer
Breast cancer mortality increased in developing countries in the two decades from 1985-2005, amounting to 31% of the cases of breast cancer in the world. According to the Pan American Health Organization, in 2000 there were nearly 90,000 cases of breast cancer in Latin America. Compared to all other cancers, breast cancer incidence and mortality in women in Latin America ranked in either first or second place in each country. Breast cancer, along with uterine cancer was the leading cause of death in women between 35 and 64 years in Latin America. In fact, mortality from breast cancer was increasing in most countries of the Latin America region, surpassing the number of cases of cervical cancer. Uruguay has the highest mortality rate among Latin American countries, followed by Argentina. In the case of Uruguay, between 1996 and 1998 there was a mortality rate of 45 per 100,000 women between 25 and 75 years old. In Argentina there were around 34 to 37 deaths per 100,000 women between 25 and 75 years, between 1996 and 1998.

In Honduras, the prevalence of breast cancer between 1998 and 2000 was quite high, ranking second with 25% of the total prevalence related to other cancers. In 2002, there were reported 546 new cases of breast cancer in Honduran women. This incidence was second, only representing 17% of total new cases related to different types of cancer. Breast cancer is the second leading cause of cancer death among women in Honduras after cervical cancer [4].

Cervix and Uterus Cancer
In 2000, an estimated 470,606 new cases and 233,372 deaths from cervical carcinoma (cervical cancer) among women were reported worldwide. Furthermore, it was estimated that over 80 percent of this burden is present in less developed countries where this disease is the leading malignancy among women. In the region of the Americas, 92,136 cases and 37,640 predicted deaths were reported from cervical cancer, of which 83.9 and 81.2 percent correspond to Latin America and the Caribbean respectively. Latin America and the Caribbean have some of the highest incidence and mortality rates from cervical cancer in the world, only surpassed by East Africa and Melanesia.

In Mexico, where a cervix and uterus cancer screening program has been administered for over 20 years, less than 13% of potentially preventable cases have been avoided. In Costa Rica, none of the screening programs implemented since 1960 has had an impact on the incidence or mortality of cervico-uterine cancer. In Cuba, where a screening program has operated since 1968, there have been slight increases in the incidence and mortality, especially among young women.

In Latin America and the Caribbean, the survival rates of women with cervico-uterine cancer are smaller because they often seek care when the disease is advanced. The low survival is also related to inadequate palliative care and incomplete treatment. The incidence and mortality of cervico-uterine cancer is related to poverty, limited access to services, life in rural areas and low levels of education [5].

In Honduras, the statistical data for cervical cancer reports that for the year 2000, there were 833 new cases (incidence), a rate of 39.6%. The number of deaths was 329, a mortality rate of 16.8%.
For the year 2002, there were 664 new cases (incidence), a rate of 30.6%. The number of deaths was 361, a mortality rate of 17.2% [6].

**STDs and HIV/AIDS**

In 1997, Honduras reported 48% of all HIV/AIDS cases in the Central America region (6,057/12,529). Trying to explain why the number of reported cases and the pattern of the epidemic in Honduras have been different from the rest of Central America is not easy.

During the incubation period of the epidemic, the late 1970s and during the eighties, the social and political situation in Honduras was different from the rest of Central America. In the early 1980s Central America was characterized by strong social pressure to lead armed struggles in Guatemala, El Salvador and Nicaragua. With the victory of the Sandinistas in Nicaragua, the countries in Central America, especially Honduras, became the center of the Latin American continent's "Cold War". It is postulated that the heavy presence of foreign troops in Honduras was associated with an increase in prostitution and the incidence of STDs in cities where military bases were located and in places of entertainment frequented by this population [7].

In the official report for November 1997, the country reported a total of 10,537 people infected with HIV, 8,167 cases with AIDS and 2,370 asymptomatic carriers. Underreporting of cases was estimated to be 30% to 50%, which means that the number of cases of HIV/AIDS in Honduras oscillated between 10,617 and 12,250. The most affected group was the 20 to 39 years old, representing approximately 70% of all cases. Almost 20% of cases were between 15 and 24 years of age [7].

The pattern of transmission of HIV in Honduras has been different from the rest of Central America since the beginning of the epidemic, resembling more the predominant pattern in the Caribbean region. HIV is transmitted in Honduras primarily through sexual contact. Of a total of 8,167 cases of AIDS reported through November 1997, 7,525 (92.1%) corresponded to sexual transmission: 6,784 (83.0%) were heterosexual, 465 (6.1%) were bisexual and 276 (3.4%) were homosexual. HIV transmission in groups employing drug use or having blood transfusions was less than 1% of all cases reported. The male/female caseload until November 1997 was 1.8:1. Although this ratio was approximately 4:1 in the first two years of the epidemic, the value rapidly declined and has remained about 2:1 over the epidemic [7].

Although all departments and major cities reported cases, their geographical distribution was not uniform across the country. Almost 60% of cases were located in the main urban centers of the "Central Corridor Development", including Tegucigalpa, San Pedro Sula, La Ceiba, El Progreso, Comayagua, Puerto Cortés, Tela, La Lima and Choluteca [7, 8].

Generalized poverty, violence, lack of comprehensive public policy, and limited access to health services and education are some of the primary determinants of HIV infection [8]. Prevalence of HIV and AIDS is higher among certain ethnic groups such as the Garífuna, with a reported HIV prevalence of 8% [9].

In 1996, the World Health Organization (WHO) estimated that over 1 million people worldwide were infected with STDs daily. About 60% of these infections occurred among persons under 25
years, and of these, 30% were under 20 years. Between the ages of 14 and 19, STDs occurred more frequently in girls than in boys at almost a 2:1 ratio. An estimated 340 million new cases of syphilis, gonorrhea, chlamydia and trichomoniasis occurred worldwide in 1999. The incidence rates of STDs remain high in most of the world and in Honduras, despite advances in diagnosis and treatment that can quickly make many STD patients non-infectious and cure most [10].

The estimated global incidence of sexually transmitted diseases (STDs) was 333 million cases of curable syphilis, gonorrhea, chlamydia and trichomoniasis, which is of great concern because:

1) Untreated STDs facilitate HIV transmission.
2) Costs associated with undetected infections, untreated or poorly treated by self-medication, present a burden to people, communities and governments.
3) It may take several years of treatment with antibiotics and effective chemotherapeutic agents to treat these infections.

The consequences of infection vary among different populations due to the fact that biological, social, behavioral, economic and programmatic reactions influence the psychosocial and physiological outcomes in STDs. If not handled properly, STDs can lead to high costs, direct or indirect, and other implications for individuals and communities. These infections influence high morbidity and maternal and child mortality [11, 12].

**Limitations on Women**

In light of all the background information provided above, in Honduras, even if a woman gets a job which is considerably productive because it generates income to satisfy some personal or family survival needs, access to the power that knowledge and/or information provides is very limited. Because of this, most women workers are under-qualified for higher paying jobs and their educational level often does not exceed the six-primary/elementary grades. Knowledge about health issues is non-existent or limited, fragmented and of poor quality, making it difficult to safeguard health and life. Even though breast, cervix and uterus cancers, STDs, and HIV are among the leading causes of harm to the health of women, most women are totally unaware of the basic elements of these pathological conditions. They are also unaware of the close relationship between these conditions and with the serious risk to life and the social consequences of the individual case. At times, being unaware of the circumstances cited above is not so much the problem as is the women becoming an obstacle to her own health because of her socio-economic situation [1].

**Project Implementation**

The above stated background supported and justified the need to implement a project to increase access to health and service utilization for the diagnosis of breast, cervix and uterus cancers, STDs and HIV/AIDS. The following methods were utilized: mammography, cytology, rapid HIV testing with counseling, STDs screening, case referral to a higher health care level (hospital) and the adoption of special safe health practices in women of childbearing age in 13 departments, 98 municipalities and 576 villages in impoverished and hard to reach rural areas of Honduras.

Therefore, in 2007 COCSIDA was appointed and assigned by the Office of the Honduras First Lady Señora Xiomara Castro de Zelaya the challenge of developing a pilot for a decentralized project aimed to address a big public health problem in Honduras. The problem was and still is
Cruzada de La Esperanza (Crusade of Hope)

bringing health care services to communities in need in Honduras rural areas in order to prevent and diagnose breast, cervix and uterus cancers, STDs and HIV/AIDS.

COCSIDA, the Office of the Honduras First Lady and the Honduras Ministry of Health joined and integrated their institutional visions in implementing the project, Cruzada de la Esperanza. The government and the non-governmental institution's (COCSIDA) efforts were based on the knowledge and experiences gained to that date, work commitment and solidarity with the socially excluded populations. COCSIDA was a pioneer in developing and implementing this type of decentralized health care project of this magnitude in Latin America and Honduras.

The funding donors for this endeavor were The Democratic Republic of China-Taiwan, through its embassy in Honduras, and the Honduras Health Ministry, through an agreement to condone the debt between the government of the Republic of Honduras and the government of the Republic of Italy [13]. The Democratic Republic of China-Taiwan also donated the three mobile units for health services. These mobile units came outfitted with the necessary equipment to perform mammographies, ultrasounds, cytologies, rapid HIV testing, and gynecological evaluation kits (Images 1, 2).

Image 1. Mobile health service units

Above: Three mobile health service units were used for the Cruzada de la Esperanza.
Right: A mammography technician calibrates equipment in one of the mobile health service units.

Image 2. Equipment calibration

Methodology

The heart of this project was to contribute to the welfare and quality of life of rural Honduran women over age 18. The approach consisted of applying the inclusion criteria for each intervention, structured, contained and presented in a Basic Health Care Package of Attentions for education, information, access to diagnostic tools/methods, health services, and treatments which covered the learning needs and health care of women in rural areas in relation to the conditions mentioned. The Basic Health Care Package was developed through applications of educational information and training and diagnostic tools like: mammograms, breast ultrasounds
and gynecological/obstetric detection and syndrome management of STDs and rapid HIV testing with pre- and post-test counseling.

The project's overall objective was to contribute to early detection and reduce late detection of breast, cervix and uterus cancers and other problems related to sexual and reproductive health in women over 18 years old in 98 municipalities in 13 priority departments of Honduras during the period of April 2008 to March 2009. The project objective was reached through increasing access and utilization of services for diagnoses such as mammography, cytology, rapid HIV testing with counseling, STD screening and/or referral to a higher health care level (hospital) for special care as well as promoting the adoption of healthy practices. The components were: raising awareness in the adoption of healthy and safe practices (manual breast self-examination), increasing access to diagnostic services related to early detection and/or reducing late detection for breast, cervix and uterus cancers and other related issues such as STD/HIV (mobile diagnostic units), strengthening interagency and intersectoral coordination with all levels encouraging citizen participation from those who work within the theme of prevention of the targeted diseases, and strengthening national and local health policies and strategies in the field. Retrieving and applying successful experiences from national and international settings was the main strategy to impart a solid knowledge foundation at the community level for future processes that promote changes in risk behaviors related to sexuality and lives, based on reaching a systematic adoption of preventive and self-care actions [1,14,15].

Geographical Area of Interest
The Republic of Honduras is located in the heart of Central America and has a geographic area of 112,090 sq. km. (43,278 sq. mi.). Honduras is bordered on the northeast by the Republic of Guatemala and on the southwest and southeast by the Republics of El Salvador and Nicaragua respectively (Figure 1). The country's administrative divisions consist of 18 departments, further subdivided into 299 municipalities. A mountainous terrain with narrow coastal plains results in a climate that is tropical to subtropical, depending on elevation. Spanish is the official language but many Amerindian dialects are also spoken.

The government is a democratic constitutional republic consisting of three branches: executive, legislative and judicial. The President is elected every four years and is restricted to one term.
The gross domestic product (GDP) was $15.35 billion (2010 est., official exchange rate) with a per capita GDP (purchasing power parity) of $4,200. Honduras is one of the poorest countries in the western hemisphere, with about 65% of the population living in poverty. A core problem of the Honduran labor market is underemployment, meaning low-income low-productivity jobs. More than one-third of the Honduran workforce is considered either unemployed or underemployed. Historically dependent on exports of agricultural goods (coffee, bananas, shrimp, lobster, tilapia, corn, fruits, basic grains, African palm, and livestock), the Honduran economy has diversified in recent decades and now has a strong export-processing (maquila) industry, primarily focused on assembling textile and apparel goods for re-export to the United States, as well as automobile wiring harnesses and similar products. Remittance inflows from Hondurans living abroad, mostly in the United States, are the largest source of foreign income and a major contributor to domestic demand. Remittances totaled $2.8 billion in 2009, equivalent to about one-fifth of Honduras’ GDP. The country is showing progress in reducing poverty levels. Since 2000 Honduras has been implementing a Poverty Reduction Strategy in direct connection with the Millennium Development Goals with a central objective, investment in human capital in terms of poverty reduction and specific strategies in groups of extreme poverty.
The population in 2007 was 7,536,952 inhabitants (2011 est. = 8.14 million), with 52% living in cities. Ethnic groups include 90% mestizo (mixed Amerindian and European), 7% Amerindian, 2% black and 1% white. The population is predominantly young, with about 50% under 18 years old. Average life expectancy at birth is 73 years. The literacy rate for the entire population is about 80%.

The Honduras Health Care System is composed of both public and private sectors which are steered and regulated by the Honduras Ministry of Health. The public health sector is comprised of the Ministry of Health along with the Honduras Social Security Institute. Funding for the Ministry of Health is fully subsidized by the Honduras government. The Honduras Social Security Institute is responsible for collecting and managing fiscal resources and mandatory contributions from workers and employers in order to have access to Social Security and Social Security health care benefits. The private health sector is made up of private for-profit institutions and/or nonprofit organizations. The public sector has 30 hospitals nationwide, with 5,975 beds and the private sector operates 60 hospitals with 916 beds. Most of the physicians and nurses are employed by the Honduras Ministry of Health, followed by the Honduras Social Security Institute. Unfortunately medical resources are concentrated in the more developed cities of the country.

According to the National Demographic and Health Survey in 2005/2006, 88.3% of the population relied on the Ministry of Health, 9% was covered by the Honduras Social Security Institute and 2.7% opted for private health care. Public spending on health accounted, on average, for 6.7% of GDP. Health financing comes mainly from out-of-pocket spending (54%), national treasure, international cooperation and, to a lesser extent, from businesses.

Honduras presents an epidemiological profile in transition. Infectious diseases are mainly related to respiratory, digestive and chronic degenerative diseases. Cancer and cardiovascular disease have a greater presence in the adult population. Also, there are important diseases requiring scrutiny because of high transmission such as dengue, tuberculosis and HIV/AIDS. It is also worth mentioning the significance of external causes of injury as a result of violence (in its different types). Additionally, high numbers of mortality in women and infants occur during the perinatal period and result in deaths from preventable causes during childbirth and postpartum. The infant mortality rate in Honduras is around 25/1,000 and the maternal mortality rate is around 119/100,000.

Beginning in the early nineties and in the framework of Modernization and Reform of State, the country advanced a process of health sector reform. In this framework, the National Commission for the Modernization of Health worked on the definition of a proposed transformation of the system, based upon five components: Strengthening the steering role of the Ministry of Health; Progressive integration with the Honduras Social Security Institute; Comprehensiveness of the health services network; Decentralization and definition of equity, efficiency, and effectiveness; and Social participation as essential requirements of the health care model [16, 17].
Table 1. Honduras departments and named municipalities served

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>MUNICIPALITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlántida</td>
<td>La Ceiba, Corozal</td>
</tr>
<tr>
<td>Choluteca</td>
<td>Choluteca, Orocuina, Santa Ana de Yusguare, El Triunfo, Pespire, San Marcos de Colón, Namasigüe, Apacilagua, Marcovia, Monjarás</td>
</tr>
<tr>
<td>Copán</td>
<td>Florida, Copán Ruinas, Santa Rita, Cucuyagua, Veracruz, San Juan de Opoa, Dulce Nombre, San Jerónimo, Corquin, San Pedro de Copán, San José de Copán, San Agustín</td>
</tr>
<tr>
<td>Cortés</td>
<td>San Pedro Sula: Colonia Rivera Hernandez, El Cerrito, Armenta, Villanueva, San Francisco de Yojoa, Naco, Vida Nueva, San Antonio de Cortés</td>
</tr>
<tr>
<td>El Paraíso</td>
<td>Liure, San Lucas, Güinope, Teupasenti, Jacaleapa, El Paraíso, Danlí, Las Trojes, Yuscarán</td>
</tr>
<tr>
<td>Francisco Morazán</td>
<td>Tegucigalpa: Ciudad España, Colonia Nueva Capital - National Women’s Prison for Social Adaptation (PNFAS)</td>
</tr>
<tr>
<td>Intibucá</td>
<td>La Esperanza, Intibucá, Camasca, Colomoncagua, San Isidro, Jesús de Otoro, Magdalena, Santa Lucía, San Miguelito, Monte Verde, Yamaranguila, San Antonio, Concepción</td>
</tr>
<tr>
<td>La Paz</td>
<td>Marcala, Cabañas, Chinacla, San José, Santa Elena, Yarula, Opatoro</td>
</tr>
<tr>
<td>Lempira</td>
<td>Gracias, Belén, Las Flores, Lepaera, Cololaca, Guarita, Tambla, San Juan Guarita, Tomalá</td>
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<tr>
<td>Ocotepeque</td>
<td>Nueva Ocotepeque, San Marcos, Belén Gualcho, La Labor</td>
</tr>
<tr>
<td>Olancho</td>
<td>Juticalpa, Catacamas, Dulce Nombre de Culmi, El Rosario, Campamento, Manto, San Esteban, Salamá, Santa María del Real, La Unión, Yocón, San Francisco de La Paz, Esquipulas del Norte</td>
</tr>
<tr>
<td>Santa Bárbara</td>
<td>Quimistán, Pinalejo</td>
</tr>
<tr>
<td>Valle</td>
<td>Nacaome, Caridad, Aramecina, Langue, La Alianza, Goascorán</td>
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</table>

Applying these principles, the scope of work for the Crusade of Hope spanned the territory of the Republic of Honduras. The specific coverages were in 13 of the 18 Honduras departments. The project was initiated in areas that were most excluded from health services, suffering from poverty and high in neglected populations as defined in the Health Situation Analysis of Municipalities (ASIS - by Spanish abbreviation). The departments included: Atlántida, Choluteca, Copán, Cortés, El Paraíso, Francisco Morazán, Intibucá, La Paz, Lempira, Ocotepeque, Olancho, Santa Bárbara and Valle. In the targeted departments, 98 municipalities were visited and the surrounding populations of 576 villages had access to the mobile health care services, coordinated with the existing municipalities’ town hall committees in the areas. The Honduras National Women’s Prison for Social Adaptation (PNFAS - by Spanish abbreviation) was also included. See Figure 1 and Table 1 for a map and a listing of the locations serviced and see Image 3 for a picture taken at a typical town hall meeting.
Beneficiary Population Coverage

Beneficiaries were natural or legal residents who received direct or indirect benefits from the project. The targeted beneficiaries were especially women of childbearing age from 18 years and older and who were spontaneously requesting services related to breast cancer, uterine-cervical cancer, medical care to detect and treat sexually transmitted diseases and access to rapid HIV testing with counseling.

The direct beneficiaries were 789,415 women of childbearing potential, prioritized by age group according to inclusion criteria for this intervention (Table 2). This number corresponded to 26% of the general population of women in the country.

The indirect beneficiaries were all of those who did not directly receive services, but benefited from this program. These individuals participated in the educational and information process, the Crusade social mobilization and other related activities, but did not meet the inclusion criteria.
Table 2. Inclusion Criteria

<table>
<thead>
<tr>
<th>Mammography and breast ultrasound</th>
<th>Vaginal cytology</th>
<th>Rapid HIV testing with counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women of childbearing age with a history of breast cancer in their families</td>
<td>Women of childbearing age with uterine-cervical cancer in their family history</td>
<td>Women of childbearing age of 18 years and older who report having had sex or been exposed to some of the risks of HIV transmission</td>
</tr>
<tr>
<td>Women with breast tumors</td>
<td>Women of childbearing age who are sexually active</td>
<td>Women under 18 accompanied by a parent and/or family member and with parental written permission</td>
</tr>
<tr>
<td>Pre-menopausal women will receive a breast ultrasound</td>
<td></td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Menopausal women will receive a mammogram</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategies
To achieve the project objectives, it was necessary to clearly state the strategies to be implemented. Defining the strategies came by retrieving daily living experiences that foster an environment meeting the needs that sustain the achievement and capacity for solid and responsible health behaviors that were in harmony with cultural and personal values related to the life of the women. The defined strategies were:

1) Communicate rationales for the adoption of healthy behaviors
2) Promote and support health services, medical evaluations and diagnostic tests
3) Provide resources for prevention and control of conditions targeted
4) Refer patients to a higher health care level facility as warranted
5) Counsel before and after performing diagnostic tests such as mammograms, cytologies, ultrasounds, rapid HIV tests
6) Present social mobilization and political dialogue to keep issues on the public agenda
7) Encourage intersectoral coordination by fostering fraternal alliances within the community to support the improvement of the project
8) Advance institutional development to strengthen technical and financial capacity
9) Monitor, measure and evaluate implementation of activities and the extent of technical and financial assistance
10) Publicize the program to provide visibility to the participants, the private sector and the general population

Objectives
The project had a planned initial term of fifteen months, starting in January 2008 to March 2009. The presumed population that would benefit directly was estimated at 789,415 women of childbearing age and older. It was estimated that a population of 1,200,000 women of all ages would be indirectly involved (mass-communication media promotion). Other patient targets were: 25,920 receiving counseling before and after performing diagnostic tests, 10,800
mammograms, 25,920 ultrasounds, 25,920 cytologies, 12,920 rapid HIV tests, and 20,000 STD consultations.

**Objective No.1**
Sensitize the population to adopt healthy and safe practices. Develop a sensitization process by communicating information to the public through radio, TV and print media. Provide updated scientific information on the conditions targeted by this project. Offer the information clearly to diverse audiences. Inform the public about the timing of activities and interventions developed by the Crusade. Maintain a communication link between the project and the media outlets, since they are direct allies in the process to inform the community about the schedule/route of clinics, achievements and sharing scientific information. Conduct breakfast meetings to socialize with the different mass media venues to inform and obtain feedback.

**Objective No. 2**
Increase access to health services through a mobile crusade, operating mobile diagnostic care units (mobile mammography vehicles) outfitted with the necessary equipment for mammography, ultrasound, cytology, rapid HIV testing, and gynecological evaluation of STDs (Image 4). Provide health services utilizing a team of professionals and technicians in the field of medicine and public health.

**Image 4. Treacherous conditions**

**Image 5. Applicants in line**

Plan a critical route through each department, municipality and/or village, developed jointly with representatives of the Ministry of Health, local government, community-based organizations and civil society. Pre-position a project coordinator and a health educator a week in advance of arrival at each site for promotion, orientation, and registration of the population of women who request attention according to the criteria of inclusion. The advance team manages local coordination for the activities of the brigade and accommodation of the working team.
Receive women applicants for the service on a first come basis (except giving priority to the elderly, pregnant women and disabled) to be evaluated by the filtering unit team to define the behavior to follow according to each case (Image 5). Organize educational kiosks offering information (Image 6), providing complementary activities and guidance to waiting applicants. During the waiting time, prior to being examined, alternative means of health instruction are employed accompanied by educational games/entertainment activities recovering the traditions of the community (Bingo, Charades, Hispanic Lottery, mobile disco sound system with music appropriate for the event, etc.). Each woman receives a promotional bag containing educational materials and gifts. The festive atmosphere counteracts boredom and gains the attention of the participants (Image 7).

**Image 6. Educational kiosk**

A Peace Corp community volunteer presents an instruction session in an educational kiosk.

**Image 7. Festive atmosphere**

An educator and a nurse playing tic-tac-toe incorporating health education questions with waiting applicants to counteract boredom.

Twenty-five randomly selected participants are requested to complete “Initial” opinion surveys before entering the Educational Kiosk in order to assess knowledge levels about the topics of the conditions addressed by the Crusade. After completion of the health services a different set of twenty-five randomly selected participants are requested to complete “Exit” opinion surveys in order to assess the knowledge acquired. The brief surveys are composed of five questions. The surveys are the responsibility of a Local Community Committee volunteer in each locality. After the surveys are completed, they are handed over to the Crusade Educator for review and subsequently used to evaluate the clarity of information delivered to the diverse audience. This strategy is used to assist in monitoring, evaluating and correcting the impact of the on-the-spot educational interventions aimed to increase health services access. Establish a coordinated process with a health center with respect to the delivery of results for women whose case warrants a referral to a hospital level. The Crusade Social Worker makes the case insertion, referral and assigns a financial support payment of Lps. 600 (approximately US$ 30) to meet travel needs. The referred patient becomes fully responsible to continue with the second stage of the diagnoses and treatment (monitored by the community health center). HIV-positive cases that breastfeed are ensured to receive a month’s supply of “replacement milk”. The second objective and its strategies of a health fair environment, village approach, increase of service and
participation access, coverage, lower cost, intersectoral health activities and achievements is modeled after Indonesia’s Posyandus Approach [14,15].

**Objective No. 3**
Strengthen interagency and intersectoral coordination encouraging citizen participation. Interagency and intersectoral directing and implementing activities are inducted through a workshop addressing the themes of interest to the Crusade (Image 8).

**Image 8. Encouraging civil society participation in Corozal, Atlántida**

**Objective No. 4**
Endeavor to strengthen national policies and strategies to improve the health care opportunities for women at the local level in all areas of the country. This project is a unique venture in the history of public health services in Honduras.

The official launch day ceremony of the “Crusade of Hope” began in the city of La Ceiba and traveled to Corozal, department of Atlántida. Associated personalities and institutions were essential and permanent allies supporting the project. As their support was extremely important, the Honduras First Lady, ambassadors of the funding agencies, international and national organizations’ representatives, stakeholders and civil society attended the ceremony. On May 23, 2008 the Crusade’s three mobile health care brigades began their work serving the population of women in the community of Corozal and surrounding areas (Images 9, 10, 11).
Project Management

COCSIDA placed great trust in the human resources chosen for this project. Personnel were selected especially for their capabilities, potential and high degree of empathy with the socially excluded populations. The human resources team consisted of:

Medical, Professional and Technical Team

The team formed three brigades to serve 98 municipalities including 576 towns and/or villages. The medical, professional and technical team (Table 3) voluntarily managed a work schedule of up to twelve hours daily including weekends and holidays when working in the field. The brigade with performance efficiency greater than 85% was recognized and awarded some special treat (dinners, flowers, cakes). The brigades’ highly competitive spirits benefited women living in the neglected areas (Images 12, 13, 14).
Table 3. Medical, professional and technical team

<table>
<thead>
<tr>
<th>Number of Medical Doctors According to Area of Expertise:</th>
<th>Number of other Professional and Technical Members:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiologists</td>
<td>Registered Nurses</td>
</tr>
<tr>
<td>Gynecologist/Obstetricians</td>
<td>Psychologists</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Social Workers</td>
</tr>
<tr>
<td>Public Health</td>
<td>Lawyer</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1</td>
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<tr>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Management Team

The management team, beside its administrative duties, also accompanied the brigades in their respective tours around the country to monitor and evaluate the work process (Image 15, Table 4).
Volunteers

Community volunteers (municipal and community leaders, local health care center personnel, intersectoral, nursing school students, elementary school teachers, students, women associations, Honduras army personnel and community members in general)

Project implementation was supported by a team of local volunteers, whose roles and responsibilities were defined according to needs in the field. They were empowered by being recognized as part of the professional and technical team and with the delivery of a small monetary bonus for performance.

Equipment

The Democratic Republic of China-Taiwan donated the mobile mammogram units. The mobile units came outfitted with the necessary equipment to perform mammographies, ultrasounds, cytologies, rapid HIV testing, and gynecological evaluation kits. The Honduras Armed Forces loaned a truck to be used for logistics purposes. The remaining necessary equipment, materials and supplies for specialized and general medical, professional, technical and operative use were acquired following the funding agencies’ bidding guidelines on an as needed basis and stored in the project’s central warehouse (Table 5).

Operational Costs

The cost per treated person was approximately Lps. 104.95 (US$ 5.40) being within international indicators of efficiency.

Monitoring and Evaluation

The process of monitoring and evaluation was overseen by COCSIDA management and supported by the project's Monitoring and Evaluation Technical Assistant. Monthly executive
meetings were held to scrutinize the project's scope. COCSIDA’s proven experience with other projects guaranteed the success of the "Crusade of Hope".

Developing a computer-based tool for monitoring and evaluation facilitated the process for examining progress and learning from it. The database also included progress projections that facilitated comparisons between goals and achievements that allowed project managers to make timely decisions in support of the team. This information was useful for linking financial and technical aspects. The different data collection instruments (surveys, patient registration forms, etc.) were required to be clear and well defined for processing the indicators. The indicators were handled in the same spreadsheet. In the first five days of each month, the executive reports of the scope of the project, technical and financial, were delivered to the First Lady's Office and donor agencies.

Technical reports produced monthly, quarterly and annually were written to systematize support, improve and sustain the processes of promotion and prevention and as a basis for improving execution of the project as it continued and expanded in area and time. The reports were delivered to appropriate governing entities to enlighten the Honduran national and international partners.

**Budget**

Financial management was based on the accounting and administrative system proposed by the donor agencies and supplemented with COCSIDA’s administration procedures. Financial management as well as all activities of implementation, sustainability, monitoring, and evaluation of this project were critical to ensure success. The efficient financial management and optimization of financial resources, equipment and human resources allowed the cost per person intervened to be accomplished for approximately Lps. 104.95 (US$ 5.40), being within the International Indicators of efficiency. The project was fully subsidized by The Democratic Republic of China-Taiwan, through its embassy in Honduras, and the Honduras Health Ministry, through an agreement to condone the debt between the government of the Republic of Honduras and the government of the Republic of Italy [13]. All of the Crusade of Hope beneficiaries received health education, medical and therapeutic care free of charge.

**Sustainability**

Political and Social Acceptability (Non-Economic): Activities related to the processes of political dialogue, action mobilization and dissemination of interventions were developed and defined in advance and throughout the project. A project such as this that was implemented nationally had to clearly identify municipalities and/or villages to be served, requiring the development of cooperation among the Office of the First Lady, the funding donors and direct partners such as health and municipal authorities, media and volunteers. Last but not least and specifically, the female population of Honduras, who benefited from this project for the adoption of healthy behaviors, was the sustainability key to assure the worth of this process.

Strengthening of institutional and management capacity: The organizational experience of COCSIDA combined with its international donor support, including World Bank, Global Fund, PAHO/WHO, USAID-FHI, USAID-FFS, USAID-COMCAVI, and UNICEF, have allowed development of institutional expertise in proposal design, organization, monitoring and
Cruzada de La Esperanza (Crusade of Hope)

evaluation that are the bulwark of the institutional management capacity. The staff and volunteers in our institution have over ten years of experience in approaching and knowing the population targeted in the Crusade.

Links to previous and existing projects: Experience and connections to previous and existing projects managed by COCSIDA and coordinated with other institutions, such as the Ministry of Health and Education, Municipalities, Human Rights Commissioner, Media/Communication, Chambers of Commerce and other NGO’s is the foundation for the Crusade.

Results and Findings
The project plan was to provide 10,800 mammograms, 25,920 ultrasounds, 25,920 vaginal cytologies, 12,920 rapid HIV tests and 20,000 sexually transmitted disease attentions. The Crusade began in May 2008 and ended in March 2009. A total of 263,242 people from 98 municipalities in 13 departments were serviced. A total of 330,154 out of 312,736 planned attentions (105.57%) were accomplished. Of these, 15,390 were mammograms, 9,187 were ultrasounds, 27,271 were cytologies, 13,681 were rapid HIV tests and 8,808 were STD attentions. In total, 305 vaginal cytologies and 70 mammograms were suggestive of malignancy. Rapid HIV tests resulted in 21 cases that were positive. All of the suggestive malignancy and HIV-positive cases were referred and inserted into a specialized institution for medical care (Image 16).

Image 16. A breast tumor seen through the Crusade of Hope program

Another segment of the population that was partially reached included men, of which 589 were provided with direct care. Men joined the educational actions together with their partners at the household level. Approximately 50 men requested rapid HIV testing with counseling before and
after. Some 1,500 men received, based on their partner’s results, treatment for an STD. Also, 26 men reporting some indications of breast tumor had access to a diagnostic opportunity (Table 6).

Table 6. Crusade of Hope, consolidation of activity results and findings

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>PROGRAMMED</th>
<th>ACHIEVED</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total attentions</td>
<td>312,736</td>
<td>330,154</td>
<td>105.57</td>
</tr>
<tr>
<td>Contacted women in domiciliary visits and kiosks</td>
<td>93,000</td>
<td>93,038</td>
<td>100.04</td>
</tr>
<tr>
<td>Filter attentions</td>
<td>49,200</td>
<td>49,361</td>
<td>100.33</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td>25,920</td>
<td>9,187</td>
<td>35.44</td>
</tr>
<tr>
<td>Mammograms</td>
<td>10,800</td>
<td>15,390</td>
<td>142.50</td>
</tr>
<tr>
<td>Cervix-vaginal cytologies taken by medical doctor</td>
<td>25,920</td>
<td>27,271</td>
<td>105.21</td>
</tr>
<tr>
<td>Sexually transmitted diseases treated</td>
<td>20,000</td>
<td>8,808</td>
<td>44.04</td>
</tr>
<tr>
<td>Rapid HIV testing</td>
<td>12,920</td>
<td>13,681</td>
<td>105.89</td>
</tr>
<tr>
<td>Rapid HIV testing with pre- and post-counseling</td>
<td>27,200</td>
<td>27,362</td>
<td>100.60</td>
</tr>
<tr>
<td>Post-consultation orientation for cytology results</td>
<td>6,969</td>
<td>27,271</td>
<td>391.32</td>
</tr>
<tr>
<td>Cytologies analyzed by cytotechnologist</td>
<td>27,000</td>
<td>25,437</td>
<td>94.21</td>
</tr>
<tr>
<td>Prescriptions dispensed</td>
<td>21,866</td>
<td>21,866</td>
<td>100.00</td>
</tr>
<tr>
<td>Men receiving STD treatment thru partners</td>
<td>1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men receiving rapid HIV testing</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men with indications of breast tumor</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecological and obstetrical attentions (pregnancy control and more...)</td>
<td>10,414</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals to a superior level due to Gyn/Ob problems</td>
<td>1,140</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>REPORTED</th>
<th>REFERRED TO A CORRESPONDING LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix-vaginal cytology results suggestive of malignancy</td>
<td>305</td>
<td>305</td>
</tr>
<tr>
<td>Mammogram results suggestive of malignancy</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>HIV-positive cases</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

There were 41,612 mammographic films taken according to standards for the Breast Cancer Program. As a quality control measure, all positive films and 20% of the negatives were submitted to radio-pathology services. Aspects that contributed to these achievements were the human resources and the extended business hours. Up to twelve hours of daily direct care work was performed continuously, including weekends and holidays.

Given the impact of the “Crusade of Hope” activities, a reformulation of the initial Executive Brief document [1] was submitted to ensure project sustainability in 2009, at the request of the donor agencies. The following sources were referenced as a basis for reformulating the document: opinion polls, technical reports, monitoring practices, financial reports, and systematic reports of un-planned needs. The reformulation report achieved the desired results and the project was financed for another year in 2009-2010 by consent of the original funding.
agencies, the Democratic Republic of China-Taiwan and the Honduras Ministry of Health through the Office of the Honduras First Lady. Therefore, a second agreement was signed, thereby sealing the commitment to women in Honduras who live in areas of difficult access to health services.

Necessary information from this experience was compiled and delivered to the Honduras Ministry of Health. The information will be useful to redefine new strategies to address these problems in terms of health, taking into account that these conditions are closely related to poverty, limited access to health services, life in rural areas and low levels of education. This project helped to enlighten the situation of the targeted diseases in the poorest rural areas of the country. Another benefit will be to give continuity to the decentralization process, through the signing of agreements with civil society organizations.

The Cruzada de la Esperanza has been a unique project in the history of public health in Honduras, but sadly, it was canceled due to the Honduran political crisis in 2009.

Conclusions
The female population of Honduras, who benefited from this project for the adoption of healthy behaviors, was the sustainability key to assure the worth of this process. It became obvious while collecting background information for this project that there is much less statistical information about breast, cervix and uterus cancers compared to information about HIV/AIDS in Honduras. The need for more national research and information collection regarding these cancers is indicated.

Since the project ended abruptly due to the Honduras political crisis of 2009, the sustainability of international health care projects in general was a concern. International, national and local governments should support the sustainability of health projects and programs in order to address and arrest community health problems. Health care projects and programs should not suffer consequences due to international or national political crisis, since needy people are always at risk of health problems as a result. Projects, such as this one, should have and maintain sustainability in order to render services to those in need that live in isolated and rural areas.

We hope that through the success in developing and implementing this project, health and services coverage for other geographical areas in Honduras will be provided and extended. This is COCSIDA’s challenge, to improve or develop equal processes for serving those without access to health services and living in neglected areas, in the future.

Acknowledgements
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