

**MATCHING GRANT**

**Cooperative Agreement**

**between**

**The Agency for International Development**

**and**

**The People-to-People Health Foundation, Inc.  
(Project HOPE)**

**Annual Report**

**October 1, 1993 - August 31, 1994**

**Ecuador, Guatemala, Honduras, Swaziland**

**August 1994**

# PROJECT HOPE

Founded in 1958

THE PROJECT HOPE HEALTH SCIENCES EDUCATION CENTER, MILLWOC, VIRGINIA 22646

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August 31, 1994

Ms. Devorah Miller  
Project Officer  
BHR/PVC, SA-8  
Matching Grant Program  
U.S.A.I.D.  
Washington, DC 20523

Subject: Cooperative Agreement No. FAO-0158-A-002071-00

Dear Ms. Miller:

In accordance with Section 1E.2.(a)1 of the above-referenced Cooperative Agreement, please find enclosed nine (9) copies of the Annual Report that includes:

- Guatemala MCH Progress Report
- Honduras MCH Progress Report
- Honduras Village Health Banks
- Ecuador Village Health Banks
- Swaziland MCH/AIDS
- Financial Report

Each progress report is followed by the individual program financial report and appendices where appropriate.

Five copies are for BHR/PVC and you offered to send the required copies directly to the four Missions.

We hope you had a fruitful trip to our projects and look forward to the opportunity to hear your comments and suggestions on this report and the site visits.

Sincerely,



W. Jeff Waller  
Regional Director  
for The Americas

WJW/jr

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## I. EXECUTIVE SUMMARY

The second year of the above referenced Cooperative Agreement has been one characterized by the evolution of a better focus on the various project objectives and solid progress being realized toward them.

### Guatemala Maternal Child Health

In Guatemala notable success has been realized with the integration of all public and private regional resources to address the MCH objectives set out for the very poor indigenous women and children of the Central Highlands. The demonstration health unit has been selected and education curricula development is well under way.

The second year objective of developing an Income Generation strategy has been slow, but as of this report date three cost recovery strategies are being actively pursued. A significant issue remains in terms of finding the appropriate technical assistance to help us further our progress in this area.

### Honduras Maternal Child Health

After a slow start considerable progress has been achieved in this report year. The organizational objectives of the program have been achieved, the data collection is near completion, and the continuing model is now being formulated.

Unfortunately, the Income Generation component of this project has been abandoned for lack of funding to make a realistic attempt at the design and implementation of such a strategy.

### Honduras Village Health Banks

Under the dedicated efforts of field and HOPE Center Income Generation staff, twenty six examples of this unique Village Health Bank Model are operating with good results. The necessary education to allow the project to grow prudently will be offered to both Village Health Bank projects in the Fall of 1994.

The health education components that have been initiated and the implementation of the financial management information system were important landmarks of success in this last year. Portfolio management and sustainability objectives are being met.

### Ecuador Village Health Banks

While the Ecuador Village Health Bank project has presented a more difficult environment for progress than has Honduras, the efforts of a dedicated staff have shown good results during this report year.

Inflation, a logistically more dispersed network of target populations, and a minimal national experience base of poverty lending programming has resulted in slower progress than has been realized in Honduras. Despite these challenges, good progress has been made in that 13 Banks have been inaugurated and are operational.

In general the Banks have functioned well. During the last six months various problems have evolved relative to the operation of individual Banks, but these concerns have been addressed directly and prudent action has been taken to redress them. It is worth noting that the actions taken in Ecuador have been adopted to the benefit of the management of the Village Health Banks in Honduras.

We believe the next grant year will be one of measured growth and the refinement of the Village Health Bank model in Ecuador. We anticipate continued evolution of operating strategies to meet the distinctive needs of the rural environment in Ecuador that will result in the substantial long-term success of this very unique project.

#### Village Health Bank Monitoring and Evaluation

During the reporting year a formidable team of professionals from George Washington University Center for International Health and Project HOPE have designed and implemented the first phases of a monitoring and evaluation tool. It is expected that the outcome of this evaluation will produce for Project HOPE and the poverty lending community a report on how well this unique blending of Village Bank and Maternal Child Health technologies will positively enhance the well being of the target populations of poor women and children in Central and South America.

#### Swaziland Maternal Child Health AIDS

The notable progress in this project has been in the development of a professional, modern organizational model for the AIDS education for TASC, the AIDS education NGO that was created by Project HOPE under previous grants. TASC has taken steps that bode well for its ultimate ability to become financially self sustaining.

While the more specific objectives of AIDS education for Maternal Child Health target populations is progressing, it is the creation of a Board of Directors and the hiring of professional management capability that can lead to long term self sufficiency that is of most interest to Project HOPE. We believe the attainment of high quality technical assistance in the coming year will be the key to continuing progress towards this objective.

#### Conclusion

Overall, the Matching Grant is meeting the objectives of BHR/PVC and Project HOPE.

The understanding, interest, and skills in managing financial sustainability strategies is growing throughout the Foundation; from the health promoters in the field to the executive management team at HOPE Center. The integration of the new "balance sheet" oriented financial systems with Project HOPE's traditional grant accounting systems and the blending of health education with Village Bank technologies are providing constant challenges to the Foundation. However, progress is being made and expectations remain high that a new and effective way for Project HOPE to carry out its mission is being forged within this Matching Grant.

## II. 1993-1994 ANNUAL REPORTS

### A. GUATEMALA Matching Grant Annual Report

#### EXECUTIVE SUMMARY

This report is based on the DIP objectives and covers the 12 month period of 9/1/93 to 8/31/94.

1. *DEVELOPMENT OF A MATERNAL-CHILD HEALTH PLAN.* The Health Area, covering the Department of Totonicapán has developed two annual plans (calendar year 1993 and 1994) for the department as a whole and for each of the nine districts. The plans (POAs) involve the Ministry of Health (MOH), major PVOs/NGOs, international donor agencies (e.g., UNICEF and PAHO), and the Catholic Church in the programming, implementation, and evaluation of maternal and child health (MCH) activities. In two districts, 100% of programmed activities were executed; in the other seven districts, 65% of programmed activities were accomplished. In addition, the Health Area Council was developed and is now functional to conduct this planning process on an annual basis.
2. *COORDINATION WITH THE CHILD SURVIVAL PROJECT.* Training methodologies, management of cases of acute respiratory infections and diarrheal disease episodes, and educational materials were standardized.
3. *SELECTION AND APPOINTMENT OF PROJECT STAFF.* The project has an almost full component of employed staff.
4. *SELECTION AND DEVELOPMENT OF A DEMONSTRATION HEALTH CENTER AND HEALTH POST.* A Permanent Commission of Continuing Education was developed with representation of the Health Area (MOH), major PVOs/NGOs, and international donor agencies to guide the health education needs for the Department of Totonicapán on a continuous basis. This Commission has finally approved the use of the Health Center of San Cristóbal, Totonicapán as the demonstration health center. In addition, a study on the effectiveness of all health centers and health post (infrastructure, human and material resources, availability of norms, programmed activities, supervision, and logistical support) was completed in June 1994, using a methodology proposed by PAHO and modified for local use. Two health centers were classified as good, the remainder as adequate. Of the health posts, one was rated as good, nine as adequate, and seven in critical condition. The study results assisted in the selection of the demonstration health center.

5. *ASSESSMENT OF TRAINING REQUIREMENTS OF HEALTH CARE PROVIDERS, PHARMACISTS, AUXILIARY MAYORS, AND CIVIL REGISTRARS, AND DEVELOPMENT OF CURRICULA AND TRAINING COURSES.* Curricula were developed and 37 auxiliary mayors and 5 civil registrars trained in epidemiological surveillance and collection of accurate vital statistics. This information is used by the MOH and its district offices to plan activities based on the Department's and districts' disease profiles.
6. *TRAINING COURSE DEVELOPMENT.* The following training courses were implemented:
  - o Use of timers to diagnose pneumonia in children under five: MOH staff of two districts;
  - o Management of the cold-chain: MOH staff of all nine districts;
  - o Course for auxiliary mayors and civil registrars (see above);
  - o One course for pharmacists.
7. *MONITORING AND EVALUATION.* Project HOPE collaborated with USAID's Quality Assurance Project in the assessment of cost-effectiveness of various supervisory strategies (preliminary draft available).
8. *LESSONS-LEARNED EXCHANGE.* Planned for 1995.
9. *COST-RECOVERY/FEE-FOR-SERVICE.* Three cost recovery strategies will be actively pursued during the remainder of the project.
10. *MAJOR ADDITIONAL ACTIVITIES.* The project's Detailed Implementation Plan was revised to improve its use for the management and monitoring of the project's activities. The revised DIP will be submitted shortly to the USAID Project Officer for approval.

## DIP OBJECTIVES AND PROGRESS

### Objective 1.

#### *DEVELOPMENT OF A MATERNAL-CHILD HEALTH PLAN*

Annual operational plans (POAs) were developed and were/are being implemented by the Health Area and its nine districts for the first time with the active participation of representatives and human and material resources from PVOs/NGOs, international donor agencies, the Catholic Church. The majority of planned

activities were implemented jointly. Activities that were not executed in 1993 were rescheduled for 1994, in addition to new activities. These POAs specify financial and human resource commitments to priority activities in each district and the Health Area as a whole and maximize the use of scarce local resources. This joint planning and implementation process for MCH activities serves to strengthen the relationship between the MOH and other MCH providers and reduces duplication of efforts and wasting of resources.

#### Achievements.

The Health Area Council, with representation from the MOH, PVOs/NGOs, international donor agencies, and the Catholic Church is now fully functional. Rules and regulations have been developed and accepted. The Council is the entity which will set standards for MCH activities and be responsible for the yearly development of the POAs at the Health Area and district level.

#### Limitations.

- o The Health Area Chief has not yet designated an individual to act as the permanent representative on the Health Area Council and to assist in monitoring the progress made in implementing the POAs. Because of the multiple responsibilities of the Health Area Chief, this has resulted in a bottleneck for decision-making.
- o A greater emphasis is needed on follow-up and monitoring of the Health Area and district POAs.
- o The technical teams from the districts also lack knowledge and management capabilities to appropriately channel technical and financial requests for the development of scheduled activities to appropriate decision-makers.
- o Lack of involvement in the planning process by the appropriate representatives of the central MOH (Department of Planning and Department of Maternal-Child Health).

#### Objective 2.

##### *COORDINATION WITH THE CHILD SURVIVAL PROJECT*

MCH staff have assisted the CS staff in the review of various norms and training curricula for child survival interventions.

#### Achievements.

- o Training methodologies for promoters and traditional birth attendants (TBAs), using a methodology called CAP ("cycle of participatory learning") and an adult education approach,

have been standardized.

- o Twenty-six staff of the MOH were trained in standard case management of acute respiratory infections, using the CAP approach.
- o Audiovisual materials for health education and promotion (videos, cassettes, etc.) were translated into K'iche.

#### Limitations.

The CS project has ended on 8/31/94. However, Project HOPE is still conducting an integrated nutrition project in Totonicapán that will coordinate activities with the MCH project.

#### Objective 3.

##### *SELECTION AND APPOINTMENT OF PROJECT STAFF*

Instead of the sanitary inspector, an adult educator will be hired, given extensive training requirements at all technical levels of the MOH.

#### Achievements.

The MCH project has a cohesive work team with extensive experience, both technically and administratively.

#### Limitations.

The project is considering contracting a specialist in adult education to serve as a short-term consultant. An appropriate individual has been identified, but not yet contracted.

#### Objective 4.

##### *SELECTION AND DEVELOPMENT OF A DEMONSTRATION HEALTH CENTER AND HEALTH POST.*

A Permanent Commission on Continuing Education with rules and bylaws was established. This entity will be responsible for the continuing education process. With the support from this Commission, a conceptual framework with criteria and guidelines for the selection and operations of the demonstration health units was developed with input from the Division of Human Resources of the central MOH.

A study of the effectiveness of all MOH health services (excluding the departmental hospital) was conducted. Results were presented to the Health Area team and the Permanent Commission on Continuing Education. The study provided criteria for the selection of the demonstration health center.

A human resource data bank, SIGLO, which tracks human resources and training for the whole department was developed with the Pan American Health Organization (PAHO). Pertinent staff information is in process of being entered. A training module is part of SIGLO and has already been developed, but not yet installed in the computers of the Health Area, nor have staff been trained in its use. This module will be used to evaluate the training activities.

The Health Center of San Cristóbal, Totonicapán was selected as the demonstration unit by the Permanent Commission on Continuing Education and is being modified for its education role. A bibliography and educational materials have been selected and compiled for the information center at the demonstration health center.

#### Achievements.

- o Because of the results of the study on the effectiveness of health services, the Health Area has distributed surgical and office equipment to the health districts based on established needs.
- o The Permanent Commission on Continuing Education is meeting regularly and is adjusting to its role to guide the continuing education needs of MCH staff.
- o The computerized system for tracking human resources will facilitate the monitoring of staffing needs and training..

#### Limitations.

- o The health center of San Cristóbal, Totonicapán, will require some remodeling to accommodate clinics and class rooms.

#### Objective 5.

##### *ASSESSMENT OF TRAINING REQUIREMENTS OF HEALTH CARE PROVIDERS, PHARMACISTS, AUXILIARY MAYORS, AND CIVIL REGISTRARS, AND DEVELOPMENT OF CURRICULA AND TRAINING COURSES*

Thirty-seven assistant mayors and five civil registrars have been trained, using adult education methodologies, in disease surveillance (monitoring for measles, polio, diarrhea and cholera outbreaks) and in improving their classification of causes of death for neonatal tetanus, pneumonia, diarrhea and cholera in children under five. These activities were conducted in two out of the nine districts (San Vicente Buenabaj, Momostenango).

Twenty pharmacy managers were trained in the health district of

San Vicente Buenabaj in the treatment of pneumonia and diarrhea, using adult education methodologies.

#### Achievements.

- o This training opportunity has motivated auxiliary mayors and civil registrars to improve the information they provide to the MOH which is critical to responding with appropriate activities to disease outbreaks and changes in the cause of child deaths.

#### Limitations.

- o District personnel have to become more involved in the training of these human resources and in using their information for programming and decision-making.
- o Auxiliary mayors change from year to year. A proposed alternative is to train a member of the community (ex-mayor) who in turn would train new mayors locally. This alternative will be explored with the Permanent Commission on Continuing Education.
- o With respect to the verbal autopsies, auxiliary mayors have stated that it is difficult to capture maternal deaths during the first two trimesters. The questionnaires developed so far are still undergoing testing, to determine how well they are understood and being used by the auxiliary mayors.

#### Objective 6.

##### *TRAINING COURSE DEVELOPMENT.*

MOH staff in two districts, Santa Lucia La Reforma and San Cristóbal, Totonicapán (27 persons in total) were trained in the clinical management of pneumonia using timers to count respiratory rates after a member of the Project HOPE MCH team had attended a Latin American workshop on Clinical Management of Patients with acute respiratory patients.

#### Achievements.

- o Knowledge of a practical, low cost, and effective method to diagnose pneumonia in children under five by MOH staff and community volunteers.
- o Better knowledge and practices of MOH staff in managing the cold-chain.

Objective 7.

*MONITORING AND EVALUATION*

A cost-benefit study was conducted in collaboration with USAID's Quality Assurance Project managed by University Research Corporation. This study compared different supervisory methods, taking into account both costs and effectiveness of each method. A preliminary result determined that the review of clinical histories has the lowest overall cost.

Objective 8.

*LESSONS-LEARNED EXCHANGE.*

A workshop with the Honduras MCH project is planned for 1995.

Objective 9.

*COST-RECOVERY/FEE-FOR-SERVICE.*

Three cost recovery strategies will be actively pursued during the remainder of the project. Project HOPE has met with two local organizations, Kunajel Junam and Jal Achi. The common interest is to develop a small private clinic that would provide services for a fee or using an insurance scheme for the members of these two organizations. Project HOPE is in contact with two organizations that have developed such models in Bolivia to provide technical assistance.

Under the CS project, Project HOPE established Oral Rehydration Units that provide treatment to children with diarrhea and pneumonia, and support the nutritional rehabilitation of at risk young children. The MCH project will assist these successful community based units in providing these services for small fees to generate income for the promoter and train them in basic accounting and reporting skills.

Project staff will work with the local TBAs in developing cooperatives at the district levels to improve their capability of purchasing essential supplies and develop standards of care. Priority will be given to develop a first cooperative in the district of San Cristóbal, Totonicapán, a district that was not covered by CS.

Objective 10.

*MAJOR ADDITIONAL ACTIVITIES.*

DIP objectives and activities are not clearly measurable which makes it difficult to use as a management and monitoring tool. A revised DIP will be submitted to the USAID Project Officer for

approval.

### MAJOR ACHIEVEMENTS

1. Integration of NGOs, international donor agencies, and MOH personnel to improve the efficiency and effectiveness of Health Area services in Totonicapán. Development of the Health Area Council and the Permanent Commission on Continuing Education.
2. Results of the study of efficiency of health services, now used by the Health Area in allocating resources. This study has also pointed out the need for more supervision and resulted in appropriate remedial actions .
3. Establishment of the Permanent commission on Continuing Education responsible for all continuing education needs and the demonstrative unit. The formation of this Commission has facilitated the organization and scheduling of training activities, with a focus on the need for a permanent multi-agency effort to support these needs. It has also allowed a greater integration and support from all levels of the MOH (central to local).

### SIGNIFICANT BARRIERS TO SUCCESS

The MOH, as all public institutions was on strike for more than three months, starting in January 1994. Even though MCH activities under this project continued, MOH staff were not involved. This substantially affected progress, delayed programming and implementation of area and district level POAs, and delayed the selection of the demonstration health center. Extra efforts had to be made to re-integrate the appropriate MOH staff into the planning and implementation process.

The process of planning and implementing of activities jointly with other PVOs/NGOs, international donor agencies, and the MOH requires many additional steps to achieve an objective. In some cases this requires more time than if only one institution were involved. However, in the long term, results are more sustainable and costs of activities are reduced.

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**GUATEMALA-MATERNAL CHILD HEALTH (MCH)**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	222,059	59,320	162,739
Travel	62,529	6,887	55,642
Income Generation	30,000	0	30,000
Other Direct Costs	114,088	14,441	99,647
Procurement Costs:			
Supplies/Equipment	45,358	35,965	9,393
Services	25,524	1,414	24,110
Evaluation	26,527	0	26,527
Indirect Costs	122,133	32,626	89,507
<b>GRAND TOTAL</b>	<b>648,218</b>	<b>150,653</b>	<b>497,565</b>

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MATCHING GRANT ANNUAL REPORT

SEPTEMBER 1, 1993 - AUGUST 31, 1994

BUDGET NOTES

COOPERATIVE AGREEMENT NO: FAO-0158-A-002071-00

This note is to formally document the budget reallocation that was made from the Swaziland MCH/AIDS program to the Guatemala MCH project and to the Village Health banks in Honduras and Ecuador. These changes were made at the time of the first annual report of the above referenced cooperative agreement.

The net effect of the change was to transfer \$70,000 dollars from the Swaziland MCH/AIDS project to the following projects:

Guatemala MCH for the purpose of developing an income generation strategy	\$30,000.
Honduras/Ecuador Village Health Bank project for a monitoring and evaluation strategy	<u>\$40,000</u>
Total transferred	\$70,000

These changes are reflected in the budget reports included in this annual report.

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Project HOPE/MCH Guatemala  
 Matching Grant Workplan  
 September 1, 1994 - August 31, 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
Improve maternal and child health	<b>1. Improve Quality of Care at Health Services</b>			
	Development of a demonstration health center in Totonicapán that will train 100% of all new health center and post staff and 15% of NGO staff, based on assessed training needs	<ul style="list-style-type: none"> <li>- Remodeling of demonstration units to meet training needs;</li> <li>- Identification of NGO staff working in MCH;</li> <li>- Development of a revolving pharmacy at the demonstration unit;</li> <li>- Development of curricula;</li> <li>- Development of a resource center/library;</li> <li>- Development of a trainer/facilitator team;</li> <li>- Development of a MCH survey;</li> </ul>	<ul style="list-style-type: none"> <li>- Trained staff in all districts and with NGOs working in MCH;</li> <li>- Administrative activities completed in 90%; technical activities in 25%;</li> </ul>	Ongoing, throughout duration of project
	Training of 150 individuals in charge of first, second, and third level pharmacies in the districts of San Vicente Buenabaj, San Andrés Xecul, and San Cristóbal, Totonicapán	<ul style="list-style-type: none"> <li>- Selection and training of individuals managing pharmacies;</li> <li>- Training follow-up through ongoing supervision;</li> <li>- Development of an information system to capture referrals made to health facilities by individuals managing pharmacies;</li> </ul>	<ul style="list-style-type: none"> <li>- 54 managers of pharmacies trained in standardized case management of children with pneumonia and diarrhea;</li> <li>- Verbal autopsy methodology implemented;</li> </ul>	September 1994 - April 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
	<p>Development of a epidemiological surveillance system in the district of the demonstration unit by training auxiliary mayors in the reporting of target diseases (measles, polio, and cholera) and training of civil registrars in improved classification of causes of death (neonatal tetanus, diarrhea, pneumonia, and maternal deaths).</p>	<ul style="list-style-type: none"> <li>- Selection and training of auxiliary mayors and civil registrars in the district of the demonstration health center;</li> <li>- Identification and training of district health staff;</li> <li>- Follow-up to training through regular supervisory visits;</li> <li>- Development of a reporting system and follow-up of trained auxiliary mayors and civil registrars;</li> <li>- Implementation of a functional system of district morbidity and mortality for programming of resources and planning of activities;</li> </ul>	<ul style="list-style-type: none"> <li>- High risk communities in the district of the demonstration unit identified;</li> <li>-- 80% of auxiliary mayors and 100% of civil registrars trained;</li> <li>- Functional epidemiological surveillance system in place, providing timely information to the district for planning and implementation of activities;</li> </ul>	<p>February 1995</p> <p>March 1995</p> <p>April 1995</p>
<p><b>2. Second Component: Inter-institutional Coordination and Local Programming</b></p>				

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
	<p>Development and implementation of a system of local programming by the MOH with participation from PVOs/NGOs, international donor agencies, and the churches, including an ongoing monitoring and evaluation component.</p>	<ul style="list-style-type: none"> <li>- Implementation of regular annual POA programming meetings at the Health Area and district level, involving PVOs/NGOs, international donor agencies, and the churches providing MCH activities;</li> <li>- Implementation of regular annual POA evaluation meetings at the Health Area and district level to assess quality of activities implemented, programming process, and barriers and limitations;</li> <li>- Assistance to districts in developing district epidemiological profiles through household surveys, epidemiological surveillance, and reporting of vital statistics;</li> <li>- Quarterly meetings assessing progress made in the implementation of the Health area and district POAs;</li> <li>- Assistance to the health Area and district of the demonstration unit in the implementation of select activities;</li> </ul>	<ul style="list-style-type: none"> <li>-- Completion of annual workshop to evaluate the POA of the Health Area and districts;</li> <li>- Quarterly meetings with staff of the districts to follow-up activities planned in the POAs;</li> <li>- Monthly meetings of Health Area Council;</li> <li>- Health Area and districts implement at least 60% of programmed activities;</li> <li>- Submission of results on the cost-benefit study with the Quality Assurance Project</li> <li>- Monthly programming meetings involving PVOs/NGOs and the MOH to implement activities planned in the POAs;</li> </ul>	<p>November 1994</p> <p>September 1994 - August 1995</p> <p>January 1995</p>
<b>3. Third Component: Development of Cost-Recovery and Fee-for-Service Models</b>				
	<p>Develop a private clinic with a local NGO and develop a fee-for-service or private insurance scheme.</p>	<ul style="list-style-type: none"> <li>- Meetings with identified local NGOs;</li> <li>- Feasibility study, using focus groups, to establish fee levels and needs;</li> <li>- Provision of basic supplies;</li> <li>- Selection and training of staff;</li> <li>- Development of administrative procedures and accountability systems;</li> <li>- Ongoing administrative and technical supervision;</li> <li>- Promotion of clinic services;</li> </ul>	<ul style="list-style-type: none"> <li>- Development of a privatization of health care model with local NGOs;</li> </ul>	<p>September 1994 - August 1995</p>

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
	Assist Traditional Birth Attendants (TBAs) to organize themselves into district level cooperatives to improve quality of prenatal and peri-natal care and provide basic supplies in a sustainable manner.	<ul style="list-style-type: none"> <li>- Organize district level meetings with TBAs;</li> <li>- Assist them in developing standards and norms for quality maternal care;</li> <li>- Develop rotating basic supply system to be managed by TBAs;</li> </ul>	<ul style="list-style-type: none"> <li>- TBA cooperative in district of demonstration health center or other priority district;</li> <li>-TBAs begin purchasing own supplies without Project HOPE or MOH subsidies;</li> </ul>	August 1995
	Assist local oral rehydration units to generate reasonable incomes for individuals in charges of them.	<ul style="list-style-type: none"> <li>- Development of regulations of services provided and fees to be charged by oral rehydration units;</li> <li>- Individuals managing oral rehydration units trained in management of basic diseases and accounting;</li> <li>- Functional information and supervision system developed;</li> <li>- MOH and NGO/PVO staff trained in providing supervision;</li> </ul>	<ul style="list-style-type: none"> <li>- 25 oral rehydration units providing at least Q200 per months to individual managing it;</li> <li>- Less than 20% loss of established oral rehydration units per year;</li> </ul>	September 1994 - August 1995
<b>4. Fourth Components: Exchange of Lessons-Learned</b>				
	Implementation of a Lessons-Learned Workshop with the Honduras MCH project	<ul style="list-style-type: none"> <li>- Prepare workshop agenda with Honduras MCH;</li> <li>- Implement workshop;</li> </ul>	- Workshop implemented;	August 1995

**B. HONDURAS**  
**MCH Progress Report**

The Continuing Education Program for Nursing of the Metropolitan region (Tegucigalpa, Honduras) has in its strategic plan, a goal to develop new models of maternal child care to guarantee the sustainability of MCH activities in Region target areas and thereby contribute to improving the health status of the population, especially children and mothers.

Following an analysis of the implementation plan developed by the first Program Coordinator (who left the position in October 1993) and counterpart staff of the Metropolitan Region, a new strategic planning document was developed. This plan addresses the learning needs and deficits identified during the needs assessment conducted in the initial stage of the program. Continuing Education was viewed in the new plan as a process and not sporadic events.

A rapid evaluation of the Metropolitan Region nurses who participated in the workshops on epidemiologic bases, self esteem and educational methodologies in 1993 was conducted. This evaluation indicated that most of the participants have not practiced the knowledge, nor developed a training plan for their staff, reflecting the need to rethink the training strategy. training methodologies were included which incorporate both intense service training and application time, supported by supervisory process as basic strategies in the development of continuing education.

The new plan contains the following strategies:

1. To focus the responsibility of conducting the Program in the Regional Headquarters.
2. To get participation/expertise of local nurses in conducting the educational program.
3. To initiate the new Educational Programs with the auxiliary nursing staff of the Regional Nursing Department.
4. To strengthen the nurses' and auxiliary nurses' knowledge of Epidemiology.
5. To strengthen the Nursing staff's knowledge and skills in maternal-child health, integrating Epidemiology, Management and Social Participation.
6. To develop a model of Nursing Practice in maternal-child health.
7. To monitor the quality of nursing practice in Metropolitan

Region services.

8. To develop educational materials to support the educational process.

#### OUTPUTS DURING PERIOD

Development of workshops on Educational Methodologies that trained 42 Professional Nurses, in September - October 1993.

In 1994:

1. Established the method to develop Program counterparts to participate in the further development of program activities:
  - At the Central level of MOH - Collaborated with Division of Human Resources, Maternal Child, Epidemiology and Woman Health and Development.
  - At the regional level with regional medical and nursing leadership.
  - At target area level with practicing nurses currently working in the area.
2. Conducted an information sharing session with nurses to present the proposed program activities and coordinate the activities with other programs. In this meeting 22 persons participated including representatives from other programs:
  - Nutrition and Health - World Bank/MOH
  - Strengthening of Nursing JICA/MOH
3. A rapid survey was conducted with Metropolitan Region Nurses. The objective of this survey was to identify needs regarding MCH Program development. The survey study was carried out with 26 Professional Nurses. From the results of the survey it was found that: 90% of Nurses had not initiated the educational activities with the auxiliary nurses of their (Health Centers) indicating that they:
  - do not have the space, time, or financing, that they were delayed while waiting for Regional directions, or delayed until they received the Self Esteem Workshop
4. An examination of the current status of Nursing performance was done and a profile of hoped-for performance following the continuing education activities was developed.
5. On March 18, 19 and 20 a Workshop on " Epidemiological Thinking Applied to Work with Population" was carried out

with the participation of 36 Nurses of the Metropolitan Region. The sessions were conducted by 2 local nursing experts in Epidemiology.

6. The Didactic Plan was outlined for workshops with auxiliary nurses, in coordination with staff working on Development of Women in the MOH.
7. From June 27 to July 1, 1994 the first workshop "Valorización de la Auxiliar de Enfermería como Mujer y Trabajadora de la Salud y Nuevos Enfoques en la Prestación de Servicios" was carried out for 20 auxiliary nurses and the training process of facilitator/trainers for the next workshops was initiated.

This first workshop was evaluated very positively, increasing the expectations among the auxiliary nurses group.

8. Two information modules were developed to support the auxiliary nurses' and professional nurses' understanding of epidemiological thought and the practice of Social Epidemiology. The didactic unit for auxiliary nurses is titled "La Auxiliar de Enfermería en la Práctica de la Epidemiología Social ("The Auxiliary Nurse in the Practice of Social Epidemiology") and the information module for Professional Nurses is titled "La Enfermera en la Enseñanza y Práctica de la Epidemiología" ("The Nurse in the Teaching and Practice of Epidemiology").
9. Currently at 90% of the Health Centers in the Metropolitan Region educational activities have been initiated so that a rapid survey can be carried out, specifically assessing the main health problems addressed at the Health Centers. Currently 12 of the 16 Health Centers are developing at least 12 assessments on ARI, CDD, EPI, Family Planning, Cervical Cancer, Uterine Cancer, Reproductive risk and others. These assessments will generate activities with the population to address problems from prevention to treatment.
10. To support the development of this process, project staff have initiated a supervisory structure, checked assessment protocols and assisted with any identified weaknesses in the Nurses' plans. This support includes a bibliography to assist staff in understanding the problem as well as the information modules to refer to.
11. The Teaching Plan is also outlined as a product for an "Exchange of Experiences" Workshop on:
  - Tuberculosis and Sexually Transmitted Diseases
  - Maternal Child
  - Pediatric Health Care

This activity will be developed once the rapid survey ends. It will be carried out at the local level, which will enrich the staff by their own learning about different experiences.

12. Technical Assistance has been provided to the Metropolitan Regional Nursing staff, through established coordination with the MOH staff.
13. Assisted with 2 Workshops on "Autoestima para Enfermeras" (Self esteem for Nurses) in the School of Nursing at the National University.

#### **PROCESS AND ADVANCES OF PROJECT**

When the Project was examined it was found that there was a delay in activities; and for that reason a strategic plan was developed. The outputs mentioned in the previous section indicate significant advances by the program in the last few months.

The assistance of a local nursing consultant has helped at the local level where the greatest impact will be realized.

The development of the various assessments being implemented, and the methodology of rapid surveys demonstrate the effectiveness of the teaching. The support given by providing guidance and supervision promotes more dynamism in the work. The methodology of work combining concentration (workshops, sessions, interchange) and dispersion (activities at local level) has provided beneficial results. Also, the design and development of information teaching modules on social epidemiology have provided the best support to the task of conducting assessments at the local level. At the health center level, the delivery of educational bibliographic materials was initiated to support the identification of problems. A key reason for the recent advances in the project is the Project HOPE Coordinator's availability to develop the different activities of the program.

#### **PLANNED ACTIVITIES FOR PERIOD SEPTEMBER 1994 TO AUGUST 1995**

1. By December 31, 1994, 213 auxiliary nurses will be trained on "Valorización de la Auxiliar de Enfermería como Mujer y Trabajadora de la Salud y Nuevos Enfoques en la Prestación de Servicios" Workshop, (Assessment of the Auxiliary Nurse as a Woman and a Social Worker with Additional Focus on Service Provision.)
2. By December 31, 1994, 14 rapid surveys will have been conducted by nurses identifying different health issues in each center. (ARI, EPI, DDC, Family Planning and Reproductive Risk, Cervical Cancer, Tuberculosis, Sexually Transmitted Diseases).

3. By December 31, 1994, 8 of 16 health centers will be working with their communities developing plans to address the findings of the surveys.
4. A "lessons learned" workshop on applying social epidemiology will be conducted in September 1994.
5. A Workshop on "Vigilancia Epidemiologica" will be developed/implemented in October 1994.
6. By December 31, 1994 the implementation of a model for "Nursing Standards of Care for a Maternal Child" practice will be designed and initiated.
7. An information training module on Maternal Child Attention will be designed and developed by December 31, 1994.
8. By December 31, 1994 a proposal for the organization and operation of two Maternal Child Demonstration Units will be developed, utilizing the new MCH model of health care.

#### **FOR 1ST SEMESTER OF 1995**

9. The development of educational programs focusing on Maternal Child Health care will be continued.
10. A workshop on "Intercambio de Experiencias" (Exchange of Experiences) will be developed between the Guatemala and Honduras MCH Matching Grant programs.
11. An Information/Teaching Unit will be developed on social participation and managing Maternal Child Health Care will be developed.
12. Maternal Child Nursing at the regional level will be monitored based on this designed model.
13. The production, results of organization and resources available for Maternal Child attention will be monitored.
14. A survey with nurses', users, community, and other health team members' opinions about Maternal Child care will be designed, applied and analyzed.
15. It is expected that by the first semester of 1995 the 16 health centers (CESAMOS) of the Metropolitan Region will be developing activities based on population needs as a result of the rapid surveys.

#### **LIMITATIONS IN PROGRAM DEVELOPMENT**

1. It is difficult to coordinate the current process because

this is the first such experience for nurses in the Metropolitan Region.

2. The change of authority at Headquarters level impedes the development of the program's activities.
3. The Nursing staff's lack of stability in their jobs limits the program's progress.
4. The non-experience of Nursing staff in the educational process retards the program's advances.
5. The educational process has long term outputs.

#### **CONCLUSIONS**

1. Despite constraints in 1993 the Program continues through the first semester of 1994.
2. There is interest, particularly in Nursing at the local, in the results of the Rapid Surveys.
3. The best outputs of the Continuing Education process will be at midterm and long term time periods.

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**HONDURAS-MATERNAL CHILD HEALTH (MCH)**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	104,812	40,653	64,159
Travel	111,931	13,725	98,206
Other Direct Costs	98,096	13,857	84,239
Procurement Costs:			
Supplies/Equipment	72,791	20,079	52,712
Services	50,581	10,847	39,734
Evaluation	33,546	0	33,546
Indirect Costs	57,646	22,360	35,286
<b>GRAND TOTAL</b>	<b>529,403</b>	<b>121,521</b>	<b>407,882</b>

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## **C. VILLAGE HEALTH BANKS**

### **I. Introduction**

At the beginning of Year 2 of the activity (September 1993), the two Health Village Bank (VHB) programs had been active in their credit operations for only 3 months. This second year of activity was the first active year of a health/credit education program. By September 1993, the two countries staffs had received their initial training, the credit policies were in place, and the first round of cycle 1 loans were in process.

Both countries' VHB's programs aimed toward the same goals related to creating a program model that provides health education and credit benefits to poor women. To that end, they set goals to achieve:

- A. Health education with credit provision.
- B. Credit provision (VHB Implementation), Portfolio and Sustainability Systems Development
- C. Training on all levels to achieve the above.

The country specific reports for the Ecuador and Honduras Village Health Bank Programs will follow the above mentioned order, with pertinent subdivisions related to each heading; plus program changes, challenges; and plans for Year 3.

## **Honduras VHB Annual Report**

The Village Health Bank model was born in Honduras when Project HOPE Child Survival (CS) staff began to wonder if credit supported micro-enterprise activities might provide their poor clients the means for health, or the means to implement the life-saving CS strategies they had been taught. Originating in a country rich in village banking experiences, the Honduras program has had obvious advantages in learning and implementing the methodology. However, it faces the same challenges in reinforcing village bank organizational discipline, reinforcing its staffers knowledge, and growing at an intelligent rate where sustainability is sought, but quality is not compromised.

### **A. Health Education**

#### **Achievements**

The health curriculum was designed in Honduras by experienced Project HOPE CS staff who teamed up to create innovative skills, games, and design events that mix education with relationship building between VHB's and growth in self-esteem and personal power for individual VHB members. The curriculum, which uses all the CS messages, but teaches them one per cycle as of the second cycle, was designed and implemented. To date the messages for the second, third, and fourth cycles: Maternal Health, IRA and Diarrhea, have been designed in Honduras and used in both countries.

The education prepared for the VHB health officers encompasses one theme at a time. In May the CS and Income Generation (IG)\* staff united to train 17 Health officers from 12 banks on the first module dealing with women's health. This 2 day, 8 hour training is a prerequisite for health officers to initiate providing Health Messages to VHB members.

Health education was interrupted while the baseline of the impact evaluation was executed and retraining was provided when activity resumed in July 1994. Retraining was offered to fourth cycle health officers on Maternal Health. Despite the delay in health education offerings caused by the baseline collection, women did read their passbook health education messages and two women were able to detect breast cancer as a result.

In the case of Honduras both IG and CS teams are housed in the same office and continually coordinate activities together. For the baseline survey CS staff supported the IG staff in order to finish in two months. This allowed for savings, since in the case of Ecuador additional staff had to be hired.

\*IG staff refers to Project HOPE Field Staff as distinct from VHB Staff who are the volunteers that run the individual VHBs.

## **B. Credit Provision**

- 1. VHB Implementation**
- 2. Portfolio Management Systems**
- 3. Sustainability Tracking Systems Design and Management**

### **Achievements**

1. **VHB Implementation** The Honduras Program has developed various methods of promoting VHB's and monitoring their growth. Promotion and organization of VHB groups is sought through the following methods used by IG and CS staff together:

In Honduras promotion and organization of VHB's has come naturally since most groups have approached the program. Also the IG and CS staff stay in close contact and keep track of natural community sources of village bank formation such as community leaders, women who are natural organizers, health volunteers, and others who might direct them to a group.

Once a group is organized into a VHB, they are invited to motivational meetings that include training on Project HOPE, IG, prerequisites, policies and objectives. This allows selection of women to be VHB members.

In this reporting period Honduras promoted, organized and implemented 26 VHBs with a total of 655 members, an average of 25 members per group. The current loan portfolio shows the total level of member savings of US \$103,484.40, the level of total loan portfolio out \$366,200 = Total of loans disbursed \$817,150.00 minus total repayments to date \$450,950.00. Six banks have 0 savings because they are new banks and do not have an initial balance sheet at the beginning of their first meeting.

**Monitoring** VHB monitoring is provided by the promoters who detect problems and seek solutions. Monitoring includes both financial and organizational development oversight. **Financial duties** include: supervision and reinforcement of bookkeeping practices, internal policies definition for Internal Account (IA) loans, control and supervision of documents pertaining to IA credit, supervision of IA credit, External Account (EA) and IA arrears control and coordination of action to take for debt repayment; filling out of loan applications; closing cycles; financial statements per meeting. **Organizational development duties** include the supervision of health officers planning of income generating activities such as food sales or raffles, monitoring the selection of new members so that rules are being followed, Popular Economic Education (PEE); and gathering baseline information for impact evaluation.

**Internal Account and Capitalization of VHB's**, All VHB's in cycles 2, 3 and 4 have

implemented Internal Account Credit. Each VHB decides the interest rate (currently 5%/month for members and 10%/month for non-members) and the selection of members and non-members eligible for a loan. In the case of Honduras some VHB's had IA arrears take place within the cycle although payment is made at the seventh and final meeting. And to date no IA arrears have caused delays in recapitalization. Since it is a persistent problem, however, the IA policies must be revised at the second year training, and staff will be trained on feasibility assessment of small businesses in order to better guide the VHB's when making decisions about IA loans. The IA has the peculiar trait of being the most valuable tool for the village banks to grow and become independent, but it is lethal if not adequately managed. For this reason the program has established controls within the VHB's such as tracking the IA books. At the Program level, Honduras has just created a proposal for tracking EA and IA individual/VHB arrears in the Financial Management Information System (FMIS).

The Average rates of capitalization for the 26 current banks are as follows: 300 Lempira (Lps) for banks in the first cycle (after paying their initial administrative costs ); Lps 750 for banks in the 2nd cycle; Lps 1100 for banks in the 3rd cycle. This means that by the fourth cycle an average bank could have capitalized to about Lps 7,000. Average rate of savings for the current VHB is Lps 3000 for banks in 1st cycle, Lps 4000 for banks in 2nd cycle and Lps 5,000 for banks in 3rd cycle. This means that by the beginning of a fourth cycle a VHB can have a level of its **own capital and members savings** of as much as Lps 10,000 after paying the administrative costs of each cycle.

**2. Portfolio Management Systems** In February the two countries' programs agreed on the three types of reports to be reduced by the FMIS using the three sources of data: VHB applications, individual applications, and VHB income statements. The three types would be **portfolio measurement reports, impact, and sustainability tracking reports**. The formats and the root sources of information were agreed upon, but each country decided to use their own programmer in order to ease the troubleshooting stages.

To date the reports coming out of the Honduras system include the following:

**Portfolio measurement reports:**

Historical data of External Account and Internal Account This report shows each VHB's membership, credit disbursement, and payments in capital, interest and commission.

Summary of Inflows to the External Account and Internal Account

Tracks the inflows part of each VHB's income statement which includes level of EA capital, interest, and commission payments, as well as all inflows for the IA, capital, interest, late fines, income from activities, and sale of inventory.

### Summary of Outflows of the VHB's

Tracks the outflows part of each VHB's income statement which includes, savings withdrawals, payments to HOPE program, administrative costs, promoter payments, buying of inventories and others.

### External Account Arrears reports

Tracks delay in paying the program. By policy, Honduras has the VHB's pay the program interest and commission at each meeting. This, however, does not track an individual's delay in paying EA capital. To date this information is not being gathered at the Program level, but does exist at the VHB level.

By hand: the Monthly Portfolio Report is being kept by hand until the programmer finishes inserting it into the system. This performs a more complete tracking of VHB growth in the number of banks and members, the credit portfolio, (by tracking the three bank accounts where credit capital is kept), external account and internal account portfolio and arrears, cost per dollar spent, and level of sustainability. The section of this form that cannot be reliably filled out is the internal account arrears.

Pending: Internal Account arrears reports will not be available until the team starts gathering reliable arrears information from each meeting. The format has been designed by the team and the programmer will incorporate it into the system.

### **Impact measurement reports**

Individual financial statements information for each meeting is inserted into the system and it emits the balance sheet for that particular VHB meeting.

### Microenterprise Management System (MEMS) (Appendix B)

Pending: the design of the Socio-Economic report which will result from socio economic data related to food intake and health expenditures which is gathered in each External Account application.

### **Sustainability measurement reports**

Program Income Statements and Balance Sheets are slated to be reduced by January 1995, because the Program's entire history of expenses has to be inserted into the double entry accounting system. For now, the Program Accountant has designed the Program Income Statement and Balance sheet which takes into account the institutional development costs and operational costs. This allows the operation to derive a level of profit or loss; and a balance that includes the downsizing of the grant as the program revenues rise.

### **3. Sustainability Tracking Systems**

Given that this is a new program in an organization that has not worked with income generating programs before, the HOPE VHB Program is slated to grow to cover only

its operational expenses. To track the arrival to that point, a "sustainability model" based on certain growth assumptions, was constructed for the DIP. Using this "model", as a basis for comparison, both countries have started tracking their sustainability. Honduras' tracking to August 20, 1994 showed it at 28%. To get that number, the accountant and staff learned to do the following exercise.

The Sustainability Report (**Appendix C**) is simply the sustainability model filled in with real

data for each period. The MEMS and Monthly Portfolio Report provide the number of banks, members, and revenues coming into the program, which are inserted into the revenue part of the model.

Then the Operational Expenses (OE) have to be separated from the Institutional Development (ID) expenses. This is done by analyzing each cost and deciding which are OE and which are ID. ID costs are those that jump start or initiate the program; OE are those costs that keep the activity running, and will be incurred well past the end of the grant. With this in mind in the monthly expense report costs are coded for Operational Expenses or for Institutional Development.

### **Concerns**

Tracking arrears at each VHB meeting is a major concern. Since each VHB pays interest and commission to the program on a bi-weekly basis, tracking of the receipts into the system is easy to do. The Program FMIS tracks by-weekly payments to the Program, but late payments inside cycles by members to the external and internal account are only tracked at the VHB level.

Given that the production of reports is fairly new, the team still has to learn to analyze and troubleshoot using these reports. Further reports need to be designed to move from the financial to the programmatic, such as promoter productivity tracking, training tracking, and Program Progress tracking.

### **C. Training**

The crucial component to the entire operationalization of this activity has been the training for the staff, the management committees and the VHB members.

#### **Achievements**

**IG personnel** received the following training this year:

- Financial Management workshop directed by Dr. Cheryl Lassen.
- Strategies to improve micro enterprise management sponsored by Save the Children/FOPRIDEH.

Training improvement skills, directed by Jean McGregor/HOPE  
Financial information systems, directed by Dr. Cheryl Lassen and Ing. Jesus Torres.

**VHB Members Training** Curriculum modules have been perfected for the following courses: Pre-credit training, Management Committee Training for the EA and IA, Financial Management training to perform cash book and Financial Statement.

To date the Honduras team has performed 26 pre-credit training sessions, lasting 9 hours each with 655 women participating. The themes included organization and formation of a VHB, duties and rights and prohibitions of the members, EA policies, VHB financial management, arrears, misuse, and internal rules.

**Management Committees (MC)** must undergo training sessions which include: general management of the MC; debt recuperation methods; arrears and misuse control; money management rules; practice of the use of external account books.

Upon finishing the first cycle, all MC's have received IA training including: IA management; IA loan conditions; IA bookkeeping practices; and feasibility analysis for IA loans.

**Cash Book and Financial Statement** training was provided to all Management Committees in Second and Third Cycles in May 1994 to lead them towards independence in perfecting their cash book management and doing their own financial statement and balance sheet at each meeting.

In Honduras, every VHB meeting is closed by the MC members checking the cash in hand against the Summary Book, against the individual EA and IA account books, and then filling out the cash book.

### **Member Training**

**Workshops** have been provided to members to help them improve their business techniques and increase their markets including 1) Food Packaging -attended by 33 members; 2) Pastry-making - attended by 8 members; and 3) Food Preparation - training on nutrition values of commercial foods, emphasizing hygiene and nutritional content. Soy based and traditional foods were promoted.

**Recreational Educational Gatherings** The Honduras IG and CS teams unite to organize recreational educational gatherings of 3 or 4 VHB's to celebrate a national or female related feast, such as the Day of the Woman or Mother's Day. At these gatherings they have activities that stimulate participation, improve interpersonal relationships, exchange experiences on how to improve VHB management, and brainstorm on ideas for small businesses. Five recreational educational gatherings were held using themes

such as: participation of women in a family's economic life, health and credit integration, and popular economic education.

**Training Curriculums** In this period the following training curriculum were designed, proven, and revised: motivational training; pre-credit training; MC training; Health Officials training; and workshops for food packaging and recreational educational workshops.

### **Baseline for Impact Evaluation**

One priority focus for Project HOPE is the assessment of the health impact of its "village health banks" on the health status of mothers and their young children. Because of Project HOPE's mission of "helping people to help themselves" in the area of health, pure poverty lending programs, as implemented by the Grameen Bank and FINCA, do not fall under this mission statement. It is, however, expected that the hybrid model of village banking combined with education in maternal and child health will afford long-term health benefits to the bank members and their young children. To assess this hypothesis, a work group of Project HOPE headquarters staff and faculty of the George Washington University developed an impact assessment model that will compare health knowledge, practices, and coverage levels of Project HOPE's village health bank members (experimental group) to those of two control groups: women and their children participating in village banks without health and women and their children living in the same geographical areas that are exposed to maternal and child health education (see **Appendix D** for the design of this component). Positive results of the "village health banks" on health status is crucial for the continual and expansion of such activities under Project HOPE's mission.

Ecuador initiated the baseline data collection for the impact assessment component on July 14, 1994 and has completed the necessary number of surveys for the experimental group, 96 bank members with children under two and 96 bank members who are women of fertile age.

### **Concerns**

Because of delays in the development of the impact assessment strategy, some of the baseline data may be positively affected by women's exposure to health information in their passbooks and health education talks given by the health officers.

\$20,000 each has been allocated to the impact assessment component of the Honduras and Ecuador IG projects. Because additional staff were hired to conduct the KPC surveys, this amount may not cover the cost of this component for the duration of the project. Project HOPE and the participating faculty from the George Washington University are committed to identify other sources of funding to successfully complete this activity.

## **Specific Achievements**

- Putting credit policies to work is one of the biggest achievements of the program thus far. Wide acceptance by participants and communities that have spontaneously come to us requesting the opening of a VHB has shown the target populations belief in the success of the VHB model.
- Recuperation of 100% of credit dispersed on time.
- FMIS at 90% functioning
- Manual control of administrative and financial systems at VHBs which allows for transparency of operations.
- Perfect monitoring of VHB finances through the financial statement which detects fund management problems in a timely fashion.
- Recapitalization of VHBs for second, third and fourth cycles as programmed.
- Organization and operation of 26 VHBs reaching 655 women in 21 communities.
- Incorporation of productive community activities by VHB members in specific health related areas such as community clean-ups.
- Obvious improvement in individual VHB members businesses,
- Independence of members from "loan sharks".
- Coordination of activities between CS and IG.

## **Honduras Annual Plan September/94 through August/95**

The following objectives have been established for the period September 1994-August 1995.

1. Promote and Organize 15 new VHB's within the target area. Provide credit, health and popular economic education to new and on-going VHB's.
2. Supervision and monitoring of all VHB's for timely detection of problems, troubleshooting, and resolution.
3. Promote capitalization of VHB's through motivation for savings, improved management of IA, development of group Income Generating activities.

4. Promote and conduct training sessions of VHB members, management committees, and health officials.
5. Plan and conduct training for Income Generation staff. (Second Year training slated for November 1994).
6. Plan and conduct training activities to support inter-personal, and inter-VHB relationships, health education, recreational activities, and popular education economic and health education.
7. Plan and conduct training sessions specifically directed to members of VHB's, for business management.

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**HONDURAS-INCOME GENERATION (IG)**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	368,127	105,639	262,488
Travel	92,166	20,555	71,611
Credit Funds	392,687	0	392,687
Other Direct Costs	104,986	34,434	70,552
Procurement Costs:			
Supplies/Equipment	52,449	42,621	9,828
Services	31,167	24,538	6,629
Evaluation	76,157	0	76,157
Indirect Costs	203,845	58,754	145,091
<b>GRAND TOTAL</b>	<b>1,321,584</b>	<b>286,541</b>	<b>1,035,043</b>

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MATCHING GRANT ANNUAL REPORT

SEPTEMBER 1, 1993 - AUGUST 31, 1994

BUDGET NOTES

COOPERATIVE AGREEMENT NO: FAO-0158-A-002071-00

This note is to formally document the budget reallocation that was made from the Swaziland MCH/AIDS program to the Guatemala MCH project and to the Village Health banks in Honduras and Ecuador. These changes were made at the time of the first annual report of the above referenced cooperative agreement.

The net effect of the change was to transfer \$70,000 dollars from the Swaziland MCH/AIDS project to the following projects:

Guatemala MCH for the purpose of developing an income generation strategy	\$30,000.
Honduras/Ecuador Village Health Bank project for a monitoring and evaluation strategy	<u>\$40,000</u>
Total transferred	\$70,000

These changes are reflected in the budget reports included in this annual report.

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BEST AVAILABLE COPY

Instructivo MEMS						
Fecha de: <u>Julio 1993 a Marzo 25 1994</u>						
					Lempiras	Dollares
1	Nombre del Pais	HONDURAS				
2	Tasa cambio este mes	7.09				
3	No. bancos acumulados (hasta esta fecha)	17				
4	No. miembros acumulados	431				
5	No. prestatarios acumulados	441				
6	Porcentage de miembros que son mujeres	100%				
7	No. prestamos a empresas comunitarias	-				
8	Valor de Prestamos a empresas comunitarias	-				
9	No. prestamos individua'es este mes	CE	783	3		
10	No. prestamos individuales este mes	CI	104			
11	Valor de la cartera prestada a individuos este mes	CE	417150		58836.64	
12	Valor de la cartera prestada a individuos este mes	CI	42630		6012.70	
13	No. acumulado de prestamos individuales	CE	783.00			
14	No. acumulado de prestamos individuales	CI	104.00			
15	Valor acumulado de prestamos individuales	CE	417150		58836.64	
16	Valor acumulado de prestamos individuales	CI	42630		6012.70	
17	Tamano promedio de prestamos individuales acumulados	CE	532.76		75.14	
	Valor prestamos individuales acumulados					
	No. Prestamos individuales acumulados					
"	"	"	"			
		CI	409.90		57.81	
18	Tamano promedio de prestamo por individuo este mes	CE	532.76		75.14	
	Valor de prestamos individuales este mes					
	No. prestatarios individuales este mes					
"	"	"	"			
		CI	409.90		57.81	
19	Porcentage de autosostentabilidad acumulada a la fecha				0.17	
	Ingresos acumulados		37662.28			
	Relacion a gastos operacionales acumulados		222163.9			
20	Cantidad de ahorros a la fecha					
	Ahorros acumulados - Retiros Acumulados = Ahorros a la fecha				59609.10	8407.49
21	Promedio de ahorros por socia				138.30	19.51
	Ahorros a la fecha (No.20) acumulados a la fecha					
	Relacion a No. socias a la fecha acumuladas a la fecha					
22	Valor de capital propio de BC's (acumulado)				7301.14	1024.78
23	Tasa de Interes por ciclo	26% + 2%	Interes/mes	5%		
24	Tasa de Commission por ciclo	1.2%	Comm/mes	.15	50,055.00	7060.37
25	Cantidad (porcentaje) de Prestamos en:					
	Comercio General			61.46		
	Comercio Agricola					
	Animales					
	Artesanias					
	Alimentos			36.90		
	Fabricacion/Produccion			1.42		
	Servicios			0.22		

100%



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Instructivo MEMS							
Fecha de: 20 de mayo al 17 Junio 1998						Lempiras	Dollares
1	Nombre del Pais	HONDURAS					
2	Tasa cambio este mes	8.35					
3	No. bancos acumulados (hasta esta fecha)				18		
4	No. miembros acumulados				462		
5	No. prestatarios acumulados				463		
6	Porcentaje de miembros que son mujeres				100%		
7	No. prestamos a empresas comunitarias				-	-	-
8	Valor de Prestamos a empresas comunitarias				-	-	-
9	No. prestamos individuales este mes		CE		130		
10	No. prestamos individuales este mes		CI		14		
11	Valor de la cartera prestada a individuos este mes		CE		69750	8353.29	
12	Valor de la cartera prestada a individuos este mes		CI		6850	820.36	
13	No. acumulado de prestamos individuales		CE		484		
14	No. acumulado de prestamos individuales		CI		203		
15	Valor acumulado de prestamos individuales		CE		534200	63476.05	
16	Valor acumulado de prestamos individuales		CI		102550	12255.03	
17	Tamano promedio de prestamos individuales acumulados		CE				
	Valor prestamos individuales acumulados				540.14	64.69	
	No. Prestamos individuales acumulados						
**	**	**	**				
			CI				
					505.32	60.52	
18	Tamano promedio de prestamo por individuo este mes		CE				
	Valor de prestamos individuales este mes				53654	64.26	
	No. prestatarios individuales este mes						
**	**	**	**				
			CI				
					459.29	55.60	
19	Porcentaje de autosostentabilidad acumulada a la fecha					21.64%	
	Ingresos acumulados				63166.80		
	Relacion a gastos operacionales acumulados				296867.96		
20	Cantidad de ahorros a la fecha						
	Ahorros acumulados - Retiros Acumulados = Ahorros a la fecha				81547.66	9802.11	
21	Promedio de ahorros por socia						
	Ahorros a la fecha (No.20)				177.16	21.22	
	Relacion a No. socias a la fecha						
22	Valor de capital propio de BC's (acumulado)				19235.54	2303.65	
23	Tasa de Interes por ciclo	12%	Interes/mes				
24	Tasa de Comission por ciclo	2%	Comm/mes				
25	Cantidad (porcentaje) de Prestamos en:						
	Comercio General				53.85		
	Comercio Agricola						
	Animales						
	Artesanias						
	Alimentos				40.77		
	Fabricacion/Produccion				5.35		
	Servicios						

Instructivo MEMS							
Fecha de: .. 18 Julio a 13 Julio 1944						Lempiras	Dollares
1	Nombre del Pais	HONDURAS					
2	Tasa cambio este mes	8.60					
3	No. bancos acumulados (hasta esta fecha)	18					
4	No. miembros acumulados	462					
5	No. prestatarios acumulados (socios + no socios)	264					
6	Porcentaje de miembros que son mujeres						
7	No. prestamos a empresas comunitarias						
8	Valor de Prestamos a empresas comunitarias						
9	No. prestamos individuales este mes		CE	26			
10	No. prestamos individuales este mes		CI	10			
11	Valor de la cartera prestada a individuos este mes		CE	14150	1045.55		
12	Valor de la cartera prestada a individuos este mes		CI	4360	506.43		
13	No. acumulado de prestamos individuales		CE	1035			
14	No. acumulado de prestamos individuales		CI	213			
15	Valor acumulado de prestamos individuales		CE	545350	63161.63		
16	Valor acumulado de prestamos individuales		CI	106020	12434.58		
17	Tamano promedio de prestamos individuales acumulados		CE				
	Valor prestamos individuales acumulados			52481	6161		
	No. Prestamos individuales acumulados						
	" " " "		CI	502.06	58.38		
18	Tamano promedio de prestamo por individuo este mes		CE	544.23	63.25		
	Valor de prestamos individuales este mes						
	No. prestatarios individuales este mes						
	" " " "		CI	436.00	50.70		
19	Porcentaje de autosostentabilidad acumulada a la fecha			25.15%			
	Ingresos acumulados			76202.04			
	Relacion a gastos operacionales acumulados			302.56959			
20	Cantidad de ahorros a la fecha						
	Ahorros acumulados - Retiros Acumulados = Ahorros a la fecha			81437.64	10161.4		
21	Promedio de ahorros por socia			189.26	22.01		
	Ahorros a la fecha (No.20)						
	Relacion a No. socias a la fecha						
22	Valor de capital propio de BC's (acumulado)			23005.43	2675.05		
23	Tasa de Interes por ciclo	12%	Interes/mes	1648.00	197.44		
24	Tasa de Commission por ciclo	2%	Comm/mes	283.00	32.91		
25	Cantidad (porcentaje) de Prestamos en:						
	Comercio General	14	53.85				
	Comercio Agricola						
	Animales						
	Artesanias						
	Alimentos	10	38.46				
	Fabricacion/Produccion	2	7.69				
	Servicios						

	NIVEL DE SOSTENIBILIDAD														TOTALES	
	PERIODO 1		PERIODO 2		PERIODO 3		PERIODO 4		PERIODO 5		PERIODO 6		PERIODO 7			
	Jul 21 - Oct 2	Tasa 6.8	Oct 21 - Jan : Tasa 7.15	Jan 21 - Mar 21 : Tasa 7.33	Mar 21 - Abril 20	Abri 21 - Mayo 20	Mayo 21 - Jun 20	Jun 20 - Jun 30	Lempiras	Dollars	Lempiras	Dollars	Lempiras	Dollars	Lempiras	Dollars
UNKS	8		12		16		17			17		18		18		
DESEMBOLSADOS	8		4		4		1									
TOTAL PRESTATARIAS (SOCIAS)	173		10		10		6			4		5		3		
LUMEN	85,300.00	12,544.12	231		230		162			462		462		462		
EVA CAPITAL			133,200.00	18,629.37	131,350.00	17919.509	100,600.00			67,300.00	8,444.17	69,750.00	8,353.29	45,050.00	5,238.37	
RESOS DE INTERESES	3,810.00	560.29	12,788.98	1,788.67	11,066.97	1509.8126	5,871.00	764.45	7,142.25	901.80	7,881.00	943.83	4,294.50	499.36		
RESOS COMISION	545.73	80.26	2,127.75	297.59	1,844.83	251.68213	969.49	126.24	1,190.45	150.31	1,313.54	157.31	715.76	83.23		
RESOS DE PRES.GRPS	24.89	3.66	417.28	58.36	2,247.00	306.54843	404.98	52.73								
INGRESOS	5,024.85	649.81	17,478.63	2,144.11	15,158.80	1,208.0491	7,245.47	943.42	8,440.84	1,065.76	9,194.54	1,191.14	13,035.28	1,515.73		
INGRESOS DEL AÑO						4,756.86										
OPERATIVOS															75,578.41	69,877.62
70 - 73 Salarios																
76 Bienes					276.77		11279.19	1,468.64	12,718.79	1,605.91	16,906.23	2,024.70	8,629.62	1,003.44		
78 Arriendos seguros y servicios					1,856.45		1523.67	198.39	3,398.96	429.16	5,866.57	702.58	1,687.93	196.27		
80 Honorarios, consultores					1,386.94						2,801.84	335.55				
82 Correos y embarques					60.71											
86 Libros y publicaciones							299.44	38.99								
87 Impresiones					0.58						18.00	2.16				
88 Viajes locales, servicios vehiculos					136.42				24.50	3.09	253.20	30.32				
88 (Vialicos Local)					1026.32		563.5	73.37	4,734.50	597.79	917.50	109.88	244.00	28.37		
90 (Tel. local)					807.83		829	107.94	24.80	3.13	547.60	65.58	77.50	9.01		
96 (Cargos de Banco)					665.11				23.83	3.01			62.56	7.27		
Gastos Operacionales					290.90											
93-30 de junio 1994					3,387.14		14494.8	1887.3438	20925.38	2642.0934	27310.94	3270.7713	10701.61	1244.3733		
Utilidad/Ganancia																40,379.41
de Sostenibilidad																30,501.79

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Honduras  
Appendix C  
"Sustainability Report"

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ITEM	CODE al cual se suma	COSTS DISPONIBLE											
		A Hope Cen Del pres. original	B Honduras Del DIP	C Hope Cen Gastos de Reportes Hope Cen	Honduras	E Hope Cen Sol/Deb A-C	F Honduras Sub/Deb B-D	G Hope Cen Prom/mes C/17	H Honduras Prom/mes D/17	I Hope Cen Presupuesto Original	J Honduras Pres. del DIP	K Hope Cen Propuesto Prom/mes I/12	L Honduras Propuesto Prom/mes J/12
Salarios	70	40716	34368	34,636.78	49,479.31	6079	-15111	2037	2911	42751	41841	3563	3487
Overtime						0	0	0	0	0	0	0	0
Benefits	71			0.00		0	0	0	0	0	0	0	0
Taxes	73			0.00	0.00	0	0	0	0	0	0	0	0
Adquisicion de bienes	76		35278	7,229.62	32,710.34	-7230	2568	425	1924		4200	0	350
Ariendo, Seguros, Servicios	78		9936	44.71	9,179.57	45	756	3	540		3780	0	315
Utilizacion de Computadoras	79			0.00		0	0	0	0			0	0
Honorarios Consultores	80	20000	20000	18,720.00	3,751.71	1219	16248	1105	221	16000	2500	1333	208
Construccion de Hospitales	81					0	0	0	0			0	0
Correos y Embarques	82	3600	2370	2,086.99	680.29	1513	1690	123	40	3780	1260	315	105
Fondos de Credito	84		25596	0.00	0.00	0	25596	0	0		48566	0	4017
Libros y Publicaciones	86			139.05	0.58	-139	-1	8	0			0	0
Impresion Arte	87			155.18	-295.03	-155	295	9	-17			0	0
Viajes HQ	8801	3749	2440	2,927.99	0.00	821	2440	172	0	2296		191	0
Perdiem HQ	8803			2,017.19	427.67	-2017	-428	119	25			0	0
Conferencias HQ	8805			100.00		-100	0	6	0			0	0
Viajes Consultores	8831	3749	2440	1,932.12		1817	2440	114	0		5360	0	447
Perdiem Consultores	8833			3,171.21		-3171	0	187	0			0	0
Otros Viajes	8821											0	0
0101 Vehiculo			5250	0.00	2,410.42	0	2840	#VALUE!	#VALUE!			0	0
0501 Transp. Int'l											5513	0	459
0103 Perdiem local	8823		15966		4,107.68	0	11858	0	242		20624	0	1719
0503 Perdiem Int'l												0	0
Telefono y fax	90	3600	3000	1,249.15	2,086.22	2351	914	73	123	3780		315	0
Miscelaneo	96			2,102.50	2,840.00	-2103	-2840	124	167			0	0
Depreciacione	98					0	0	0	0			0	0
TOTAL DIRECT COSTS		75414	156644	76,512.49	107,378.76	0	0	0	0			0	0
Multiplier @.55		22394	18902	19,050.23	27,213.62			0	#VALUE!			0	0
TOTAL COSTS		97808	175546	95,562.72	134,592.38			1121	1601	23513	23013	1959	1918
Credit Funds								5001	7917	92120	156657	7677	13055
TOTAL AVAILABLE PROGRAM SITE COSTS (12mths)				160,244.00									
TOTAL SPENT SITE PROGRAM COSTS (17mths)				87,740.00									
Underexpenditure/Over Expenditure				72,504.00									

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17 Meses (10/92-3/94)  
GASTOS

CODE	ITEM	DISPONIBLE		C HC Expenditurea from HC Reports	Site	HIOPE CENTER Instit Dev	DesInstit HONDURAS Instit.Dev	Operacionl Operacionl	Total Honduras
		A HC From MGProp	B Site From DIP						
70	Salarios								
76	Adquisicion de Bienes	\$40,716	\$34,368	\$34,368.72	49,479.31	\$31,502	21,831.83	27,647.48	49,479.31
78	Arriendo, Seguros,		35,278	7,238.62	32,710.34	6,907	30,853.69	1,856.65	32,710.34
79	Utilizacion de bienes		13,536	45	9,179.57	45	7,792.63	1,386.94	9,179.57
80	Honorarios Consultores	20,000	20,000	18,720	0.00				0.00
81	Construccion de Hospitales				3,751.71	18,720	3,691.00	60.71	3,751.71
82	Correos y Embarques	3,600	2,370	2,088	0.00				0.00
84	Fondos de Credito		25,596		680.29	2,088	680.29	0.00	680.29
86	Libros y publicaciones			139	0.58	139	0.00	0.58	0.58
87	Impresion y Arte			155	-295.03	155	-431.45	136.42	-295.03
8,801	Viajes HQ	3,749	2,440	2,927.99	0.00	5,011			0.00
8,803	Perdiem HQ			207.19	427.67				427.67
8,805	Conferencias HQ			100.00	0.00		311.70	115.97	427.67
8,831	Viajes Consultores	3,749	2,440	1932.12	0.00	5,103			0.00
8,833	Perdiem Consultores			3171.21	0.00				0.00
8,821	Otros viajes				0.00				0.00
	0101 Vehiculo		5,250		2,410.42				0.00
	0501 Viajes Intlstaff				0.00		1,384.10	1,026.32	2,410.42
8,823	0101 Perdiem local		15,966		4,107.68		3,415.82	691.86	4,107.68
	0501 Perdiem Int'l				0.00				0.00
90	Telephon. Teleg	3,600	3,000	1249.15	2,086.22	1,241	1,421.11	665.11	2,086.22
96	Miscelaneo			2102.50	2,840.00	2,073	2,549.10	290.90	2,840.00
	Depreciacion				0.00				0.00
	<b>TOTAL COSTOS DIRECTOS</b>	<b>\$75,414</b>	<b>\$160,244</b>	<b>\$76,582.72</b>	<b>107,378.76</b>	<b>\$72,984</b>	<b>73,499.83</b>	<b>33,878.94</b>	<b>107,378.76</b>
	<b>CAPITAL DE CREDITO</b>			<b>81,035.00</b>	<b>0.00</b>	<b>81,035</b>			<b>0.00</b>
	<b>MULPLICADOR</b>	<b>2,239,380</b>	<b>1,890,240</b>	<b>19,080.23</b>	<b>2,721,362.05</b>	<b>1,732,610</b>	<b>1,200,750</b>	<b>1,520,611</b>	<b>2,721,362</b>
	<b>TOTAL</b>			<b>176,667.43</b>	<b>134,592.38</b>	<b>171,345.10</b>	<b>85,507.32</b>	<b>49,085.05</b>	<b>135,592.38</b>
	<b>GASTOS TOTALES PARA HC, HONDURAS (DES. INSTIT. + OPERACIONES)</b>								<b>311,259.81</b>

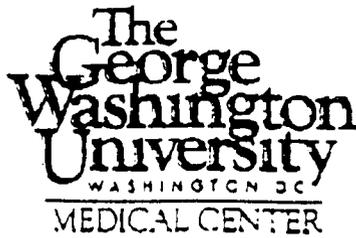
Nota: Dentro del rubro miscelaneo para Honduras operacional esta Garantia en cambio de dolares a Lempira de \$ . . . Esto se debe contabilizar como credito en cambio de gast il programa.

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Matching Grant  
October 1992 to March 1994 Expenses

ITEM	CODE	080-431-0999 ECUADOR IG		080-251-0999 HONDURAS R		080-251-0999 HONDURAS MCI		080-241-0999 GUATEMALA MCI		080-571-0999 SWAZILAND MCI		080 571-0999 SWAZILAND AIDS	
		HC3471	Site 3472	IIC 3471	Site 3472	IIC 4011	Site 4012	IIC 4011	Site 4012	IIC 4011	Site 4012	IIC 1011	Site 1012
Salaries	70	32,803.32	50,878.48	34,638.78	49,478.31	11,361.75	18,378.95	11,780.24	22,721.08				
Benefits	71												
Taxes	73												
Supplies	78	6495.14	65,034.43	7,238.62	32710.34	4,808.25	13,623.38	4,208.53	29,814.80				
Occupancy	78	1476.67	4,341.57	44.71	8,178.57	8.85	2,805.88	8.97	208.28				
Computer Util.	79												
Prof Fees/Contr SVSC	80	18,808.00	208.74	18,780.71	3751.71	6,725.85	38.34	690.45	107.88				
Hospital Construction	81												
Postage & Shipping	82	1,189.31	825.52	2,086.88	680.29	874.43	403.22	398.19	364.62				
Awards and Grants	84		8,574.16										
Books and Pubs	86	182.28	178.10	139.05	0.58								
Printing/Artwork	87	175.44	527.40	155.18	(285.03)	1,264.58	49.84		18.18				
HQ staff Travel	8801	2318.85		2,827.89		171.15		3.00	(148.51)				
	8803	842.34		2,017.19	427.87			627.24	62.43				
	8805	150.00		100.00				1,053.51					
Consultant Travel	8831	3,447.78	0.00	1,932.12		1,663.81							
Consultant Perdiem	8833	3,171.21	0.00	3,171.21		1,174.00							
Other Travel	8821	188.10	14,704.19		2,410.42			254.00					
	8823	234.00	14,473.83		4,107.88			19,228.14	125.00	2,035.36			
Impact Evaluation		1314.82						6,380.75	688.00	1,817.28			
Telephone/Teleg	90	1,406.55	3,371.64	1,249.15	2,088.20	585.28	2,720.88	699.52	1,378.62				
Miscellaneous	98	1,873.50	(1,684.81)	2,102.50	2,840.00		695.08	240.00	1,032.47				
Depreciation	98												
<b>TOTAL DIRECT COSTS</b>		<b>76,095.32</b>	<b>181,031.83</b>	<b>78,582.20</b>	<b>107,378.76</b>	<b>28,645.85</b>	<b>65,643.83</b>	<b>21,153.65</b>	<b>58,490.31</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Average exp / month		4,476.19	8,472.47	4,504.84	6,316.39	1,685.05	3,861.40	1,244.33	3,489.43				
Multiplier @ .55		18,041.83	27,873.70	19,050.23	27,213.62	8,248.98	10,108.42	6,478.13	12,486.59				
<b>TOTAL COSTS</b>		<b>94,137.15</b>	<b>188,905.83</b>	<b>95,632.43</b>	<b>134,592.38</b>	<b>34,894.81</b>	<b>75,752.25</b>	<b>27,632.78</b>	<b>71,986.90</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Capital Credit		283042.78		230224.81									
Total Direct Costs	HC	281,152.51			81,836.89								
Total Indirect Costs	HC	49,820.15			311,759.81								
<b>TOTAL COSTS</b>		<b>310,972.66</b>			<b>378,524.10</b>								
<b>TOTAL COSTS HOPE CENTER AND SITE</b>					<b>77,692.34</b>								
					<b>454,216.44</b>								
					<b>765,189.10</b>								

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THE GWU CENTER FOR INTERNATIONAL HEALTH

**Project HOPE / GW Center for International Health  
Village Health Banking and Income Generation Project  
IMPACT EVALUATION PROTOCOL**

by

Rosalia Rodriguez-Garcia<sup>1</sup>, MSc, PhD  
Stephen Smith<sup>2</sup>, PhD, James Macinko<sup>1</sup>, MA  
with Bettina Schwerthelm<sup>3</sup>, MD, and W. Jeff Waller<sup>3</sup>

## **I. PROJECT BACKGROUND**

### *A. Goal and Rationale*

Project HOPE's village banking and income generation project began in Ecuador and Honduras in August of 1993. The project was developed on the premise that maternal and child health programs have often been limited in providing sustained improvements in health and nutrition because of constraints due to poverty. Simply put, poor families many times cannot afford the nutritious foods, medicines, health services, or environmental conditions they need for protecting their health and participating fully in their development status. Consequently, the goal selected for this project was: *to improve the health status of low-income women, mothers, and their infants and young children in Ecuador and Honduras, by creating "village health banks" that combine loans and popular economic education with maternal and child health promotion activities.*

The approach used by Project HOPE consists of integrating maternal and child health with village banking, and is based upon lessons learned in previous child survival and village banking experiences. The strengths of the health-bank approach over the traditional child survival approach include: 1) Village health banks seek to supply the *means* as well as the knowledge necessary to improve nutrition and health service utilization, and to promote health seeking behaviors; 2) Peer pressure and group solidarity are used as a means to encourage the practice of health seeking behaviors; and 3) Village health banks contain an element of financial sustainability.

### *B. Interventions*

1. Provision of credit and basic business skills to low-income women for use in productive activities. Banks are divided into loan cycles each of which lasts for 16 weeks.

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<sup>1</sup> George Washington University Center for International Health

<sup>2</sup> George Washington University Department of Economics

<sup>3</sup> Project HOPE

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2. Provision of health promotion activities focusing on maternal and child health (MCH). Village health banks, designed under the Project HOPE model, incorporate health promotion efforts with credit in order to improve the health of women participating in the project and their children. These health interventions take place in the form of 15 minute health talks and other activities at each biweekly meeting of the bank lead by the health officer of each bank. All bank members are required to attend. Health messages for each cycle are printed on the reverse of each borrower's account booklet. The health promotion component begins with the second cycle of each bank. Topics change each bank cycle.

- Cycle 1: No health-related activities
- Cycle 2: Maternal and women's health
- Cycle 3: Management of Acute Respiratory Infections (ARI)
- Cycle 4: Control of Diarrheal Diseases (CDD) and basic hygiene
- Cycle 5: Nutrition and management of child illnesses
- Cycle 6: Expanded Programme on Immunization (EPI)
- Cycle 7: Determined by the health needs/priorities of each bank.

In addition, the health officer of each bank monitors immunizations of children and women, records births/deaths, weighs children under two on a quarterly basis, and refers members to local health services for care.

## II. CONCEPTUAL FRAMEWORK FOR THE IMPACT EVALUATION

### A. Background

The theoretical basis of this project stems from the recent series of Human Development Reports, by the United Nations Development Program, especially the 1993 report on broadening participation in development; and the 1990 and 1993 World Bank World Development Reports on poverty and health, respectively. These reports in turn have synthesized some of the most important theoretical and empirical contributions from the fields of development economics and international health during the past 15 years.

The Human Development Reports and the 1993 World Development Report: Investing in Health have cited convincing evidence on the interrelationships between health and income. Taken together this evidence shows that we cannot automatically expect income to rise among the absolutely poor without improvements in their health status; and on the other hand, increases in income do not automatically result in improved health status.

The Human Development Reports have proposed a framework in which the level of a country's development is dependent not just on per capita income but equally on benefits from health (H), education (E) and (weighted) per capita income (Y). Thus, the human development index, HDI, is a function of all three elements,  $HDI = f(H, E, Y)$ . Increases in income are always assumed to positively affect welfare, though at a steeply declining rate after a given point. Health is measured by life expectancy. Education is measured by a combination of the level of literacy and years of schooling according to world norms. The Human Development Index and the

theory behind it provides the rationale and framework for the evaluation of the village bank projects.

One weakness of the HDI is that it focuses on averages across countries and fails to acknowledge the impact of the distribution of income and welfare within a country.<sup>4</sup> Here we may supplement the HDI with ideas found in the 1990 World Development Report by stipulating that income benefits in turn depend on the average level of income (Y), the level of absolute poverty (P) and inequality (I). For the purposes of this framework we may define *absolute poverty* as "the resources needed to keep one's level of health and the health of one's family from falling, given one's age and using standard inexpensive technology." Of course, this level does not stand still as knowledge improves, but for the period of this evaluation, the absolute poverty line may be taken as fixed. In practice, we may define the absolute poverty line at a given level of real income. *Inequality* can be defined as the share of national income held by the top 20%, or by other measures such as the Gini coefficient, which summarizes income-share measures.<sup>5</sup>

In Ecuador, the UNDP estimates that 56% of the population lives in absolute poverty. In Honduras, 46% of the population is estimated to be absolutely poor. Inequality is also high in both countries. In Honduras the highest 20% of the population possess 63.5% of all income. Official figures are not available for Ecuador, but given the level of absolute poverty and a GNP per capita of US \$1,000 (nearly twice that of Honduras) inequality is also expected to be quite high.<sup>6</sup>

To develop a more complete framework for the village health banking and income generation project and its evaluation, we may expand the ideas in the previous paragraphs as follows: Welfare from health is defined broadly as life expectancy, but for our purposes it is perhaps more relevant and useful to be defined in terms of improvements in MCH, and consequently, in measures such as the nutritional status of infants and small children. With a further analogy, we may seek a measure of "absolute health deprivation," such as the number of people with no access to preventive MCH care. For consistency with the other HDI components and to incorporate the health and education aspects of the project, we may expand this idea further by supposing that welfare from education will depend not just on its average level, but on how equally distributed are years of schooling, and how many people fall below a threshold level of education, which in most cases can be taken as functional literacy and numeracy.

Within this context, three broad strategies for socio-economic development may be identified:  
1. *Modern sector enrichment*, in which the incomes of those who already have modern jobs

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<sup>4</sup> Rodriguez-Garcia, R. and Goldman, A. (eds.) *The health-development link*. Pan-American Health Organization, 1994.

<sup>5</sup> For a full development of the ideas in this paragraph, see Gary Fields. *Poverty, inequality and development*, Cambridge University Press, 1980.

<sup>6</sup> Data from the *Human Development Report 1993*, UNDP, Oxford University Press.

increases; this will not directly benefit the target population and evidence for trickle-down effects is very sparse.

2. *Modern sector enlargement*, in which more of those from the traditional sector are absorbed into modern jobs; this process has many advantages, including a reduction of poverty and eventual reduction of inequality, but it tends to be very slow, and hence will not affect the majority of the target population for possibly many decades.

3. *Traditional sector enrichment*, in which incomes of those without modern jobs increases. This includes the relatively new strategy of development represented by village banking and microenterprise development. While it may not quickly lift the level of incomes of participants over the threshold target, it has the advantage of increasing incomes of many, in principle, a large majority, toward the threshold target.

Implicitly, this project has accepted the traditional sector enrichment framework as a feasible way to proceed within the health and development framework. Thus, the next step is to examine microenterprise development strategies, the way in which village banking works, and their relation to health.

#### *B. Microenterprise Development Strategies*

Throughout the world, the tendency for the average size of enterprises to increase, measured by the number of employees, has reversed in the last decade. In the US, where half of all employees work in firms with less than 100 employees, and self-employment is growing rapidly, a growing percentage of small businesses are owned by women. In fact, women own over one-third of small businesses in the US, compared to less than one-quarter a decade ago. These trends are mirrored in Latin America and elsewhere in the industrialized and developing world. In Ecuador, more than half the working population is self-employed. A majority of entrepreneurs in Honduras are women, as are about one-third in Latin America as a whole.

The potential role of women is extremely important from the point of view of our development framework. First, women tend to have much lower incomes and wealth than men, thus attention to their development potential is weighted more heavily. So-called "trickle-across" of income and education from husbands to wives has proven surprisingly small in practice. Second, women have the primary role in caring for children. Mothers are more likely to spend extra resources on children than fathers. The poor tend to have higher birth rates, and poor nutrition and other factors tends to cause poverty to be transmitted across generations. The health and economic productivity of children, both now and after they become adults, will be dependent on the mother's health and development status and their own nutritional status, more than on most other factors.

The gap between very small and larger enterprise productivity is vastly greater in developing countries than in developed countries. This provides significant opportunities for raising

productivity and hence incomes. For example, given two people of equal native ability, it is easier to raise the productivity of a low-productivity person than to raise the productivity of a high-productivity person. This may be understood as an effect of the law of diminishing returns. Providing more capital, education and other resources to those working with fewer of those factors can be expected to produce larger productivity gains than when provided to those already working with more of such resources, other things held constant. In developing countries, microenterprises, especially those run by women have, in fact, tended to exhibit extremely low productivity. Empirical studies have shown that microenterprise development strategies have been able to raise productivity of microentrepreneurs when implemented effectively.

The question, then, is what factors have been most important in preventing microenterprises from raising their levels of productivity. A large and growing body of evidence from around the world suggests that *the most important factor is lack of access to credit*, this lack of credit particularly, though certainly not exclusively, affects women borrowers, for reasons ranging from lack of property rights to local cultural prejudice, but of which lack of collateral is arguably the most important. Village banking systems, starting with the example of the Grameen Bank in Bangladesh, have been established with the primary goal of breaking the development impasse caused by lack of collateral. They replace capital collateral with what may be called the "collateral of peer pressure."

Traditional banks do not lend to village microentrepreneurs in part because they find it very costly to get the information of who is a high-risk borrower. This creates a niche for the moneylenders, whose local affiliations make it less costly for them to get such information. But unlike the banks, they tend to face a high cost of loanable funds (part of the explanation for their higher interest rates). Village banks trump the advantage of moneylenders by forming voluntary solidarity groups among women who co-sign loans, in order to guarantee repayment. Availability of credit can greatly increase enterprise productivity, and hence incomes, as studies of Grameen and other banks demonstrate.

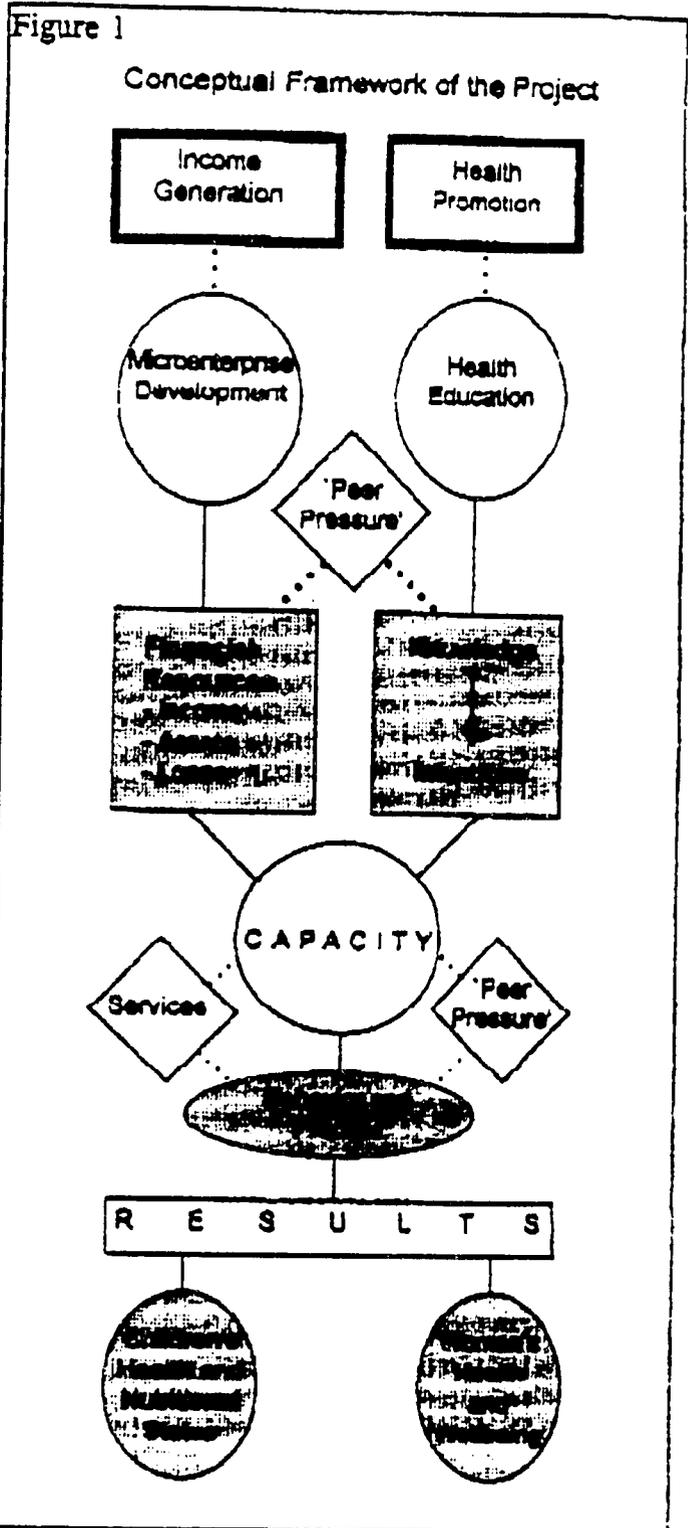
There is no reason to anticipate that access to credit is any less a limiting factor in microenterprise development in Ecuador or Honduras than in other countries. Indeed field visits to Ecuador (March 1994) and Honduras (May 1994) and interviews with borrowers left little room for doubt that the "limiting factor" in the operation of these microenterprises is credit. While borrowers will need to learn bookkeeping and inventory skills as their businesses expand, their present skills are up to starting or expanding their businesses from present levels. They have ideas, energy and business commitment. While they tend to exhibit low productivity, anecdotal evidence from the interviews suggests that this can be traced in most cases to lack of working capital, or in some cases to lack of low-cost capital equipment. One striking fact is how much of the credit is on-lent as consumer credit. Customers may have no savings and can purchase few of their wares without credit extended over at least 2 or 3 weeks. Bank members' previous sources of credit were limited, centering on either family, or high-interest moneylenders or wholesalers, or there was virtually no access at all. While family tended not to charge interest most women seemed delighted to have a chance to borrow from other sources, which freed up more resources and probably freed them from other obligations.

C. Linking Health, Income Generation, and Human Development

Health promotion activities seek to provide individuals with basic health knowledge and access to basic health services. This may include basic hygiene, child survival interventions (ARI, EPI, CDD, breastfeeding, nutrition), maternal health, family planning, and women's preventative health care. Income generation, in this case in the form of microenterprise-driven traditional sector enrichment, provides a means to raise the socioeconomic status of the family by providing women with access to credit which is then invested to produce sustainable improvements in family welfare. The education component of this project, (both business and health education) functions to guide resource utilization, and to reinforce behaviors conducive to sustained improvements in the health status and income of the family.

The conceptual relationship between income generation and improvement of the health status of mothers and children is shown in Figure 1, which depicts the relationships among economic status, health education, and health status, as developed in part in Section A and B of this document.

In this framework, "peer pressure" works on several levels. First, peer pressure may work to influence mothers to become involved in the community bank project to begin with. Peer pressure is exerted on bank members to encourage them to pay back loans in a timely manner. It also works to provide community support and encourage the practice of health-seeking behaviors. In this model, these actions are hypothesized to lead to increased savings and investment, as well as health behavior intentions. Here, "intentions" is used to indicate that an individual knows what



types of behaviors lead to healthier lifestyles, has accepted these behaviors, and fully intends to practice them. Finally, these three factors, financial resources, health knowledge, and intentions, combine in this model to build *capacity*.

Capacity is achieved, individually, as a result of mothers' increase of knowledge, resources, and intentions, as well as by factors exogenous to this project such as the availability of health services. Peer pressure can serve to enhance and reinforce individual and community capacity. These factors together can lead to desired healthy practices and behaviors.

Improved economic resources combine with investments in health and nutrition education should lead to improvements in household food security, children's nutritional status, and women's health.<sup>7</sup> This is achieved by increasing mothers' income and knowledge on how to use this income effectively for health enhancement, such as purchasing improved quantity and quality of foods, practicing breastfeeding, and using health services. Outputs such as improved infant feeding practices, improved management of childhood diseases, immunizations, use of prenatal care and cancer detection services can be quantified using the survey questions developed to evaluate this project. Thus, in this model, better health is a function of financial resources, increased health knowledge, and intentions, neither which is alone sufficient to produce sustainable improvement in health.

The identification of credit for women microentrepreneurs as a logical development strategy leads to questions about the best way this may be integrated with children's health and other health-and-development goals. There are two broad approaches: 1) Health promotion activities are integrated with the banks' activities; and 2) Health promotion activities are separate from bank activities. Project HOPE has chosen to integrate maternal and child health activities directly with the bank. The logic is that the health-bank combination will be better able to foster the linkages necessary for mothers to utilize their increased incomes for improving their health and that of their children, through the mechanisms outlined in the conceptual framework presented above. In addition, the availability of credit can act as an incentive for mothers to participate in MCH programs that they would otherwise not participate in.

On the other hand, there are those who believe that health promotion activities should be separated from financial and banking activities, the rationale being that by loading non-financial responsibilities onto a financial institution, that institution becomes distracted from its primary mission. The logic is that different institutions develop different comparative advantages in the division of labor across the economy. Regulations or incentives which pull an institution away from its core competencies may reduce overall efficiency even as they seem to be helping society to realize certain goals in the short run. *The hypothesis would be that the economic impact of*

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<sup>7</sup> See International Food Policy Research Institute. *1990 Report*. Washington, DC, 1990; Kennelly, Barbara. *The impact of income-generating activities on household nutrition: Literature review and summary*. The Freedom from Hunger Foundation, 1988; and Marek, Tonia. *Ending Malnutrition: Why increasing income is not enough*. World Bank Technical Working Paper No. 5. Washington, DC, 1992.

*conventional village banks is greater than that of village health banks.* Thus the alternative is to keep the health activities of NGOs like Project Hope entirely separate from village banking activities. The argument would be that despite their potential complementarities in outcomes, there are not complementarities in producing their separate health and business outputs. These two arguments are reflected in the choice of control groups as indicated below.

### III. EVALUATION DESIGN

#### A. Conceptual Framework

The conceptual framework that guides this impact evaluation is depicted in figure 1, which hypothesizes that income generation and health promotion activities will positively affect the health of mothers and children in selected rural areas of Ecuador, and peri-urban areas of Honduras.

The standardized survey has been designed to address the following impact evaluation questions:

1. What is the impact of the health-bank approach on women's health?
2. What is the impact of the health-bank approach on mothers' perinatal health?
3. What is the impact of the health-bank approach on children's (under two years of age) nutritional and health status?
4. What is the impact of the health-bank approach on household economy?

#### B. Hypothesis

**H<sub>a</sub>** = There will be a statistically significant and positive relationship between the integrated village health bank approach and the health of women of fertile age, women with children under two, and their children under two years of age, above and beyond that expected from similar Project HOPE health-only or credit-only interventions.

#### C. Study Population

Women of fertile age (aged 15-49) without children under 2 (WFA); and women with children under two years of age, and their children under two (Women w/ < 2's), who participate in Project HOPE's village health bank project (See table 1).

**Table 1: Study population participating in the different cycles of the village health banking and income generation project in Ecuador and Honduras as of May 1994.**

Banks	Ecuador			Honduras		
	Cycles	# Banks	Women w/ < 2's	WFAs	# Banks	Women w/ < 2's
Cycle 1	4	21	81	5	26	126
Cycle 2	8	28	185	6	34	135
Cycle 3	3	28	92	6	25	100
<b>TOTAL</b>	<b>15</b>	<b>77</b>	<b>358</b>	<b>17</b>	<b>85</b>	<b>361</b>

*D. Study and control groups*

1. There are three possible control groups (see table 2).

- Control #1 is composed of individuals who participate in a village bank that has no health component, but a solid loan system, and who meet the established criteria (Women of Fertile Age (WFA); and/or women with children under two years old).
- Control #2 is composed of individuals who meet the study criteria and are taking part in a MCH health promotion program, but who are not involved in any structured program which provides them with credit.
- Control #3 is composed of women who meet the study criteria who take part in neither child survival programs, nor village bank or other credit programs, and who live in conditions which are comparable to those of the study group.

Table 2: Control groups

	Baseline	Intervention		Post-survey
Population	Observation	Health	Bank	Observation
Study	0	X	X	0
Control 1	0	-	X	0
Control 2	0	X	-	0
Control 3	0	-	-	0

2. Limitations

It should be acknowledged that the study population represents a sub-sample of women who choose to participate in the village bank project, and, therefore, contains a self-selection bias.

Given the intensity of NGO and Ministry of Health (MOH) activities, the main difficulty with these control groups will be the absence of a "non-contaminated" group. Local NGOs, MOH and international organization programs cover both countries with child survival activities, and because so many organizations (in Honduras) are working in village banking projects, it would be difficult to locate a population of women with children under two years old who were *neither* part of a child survival project *nor* a village banking project. For these reasons, control # 3 will not be included in this evaluation.

In addition, since child survival programs differ from the health component of Project HOPE's village health banks, in terms of the length and intensity of health promotion efforts, this may lead to a bias in favor of women participating in child survival programs who are likely to show higher levels of health *knowledge*. For this reason, the questionnaire has been carefully designed to emphasize questions of health *practice* and health *outcomes* such as immunization rates, and child weight/age, rather than questions which emphasize health knowledge.

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## *E. Baseline Survey*

The baseline survey will be conducted at the end of the first year of the project (in June 1994), and then will be repeated in October 1995, and finally in June 1997 (the last year of the project). Although the project is already in progress, no village health banks have begun -- nor will they begin the health component -- until after the baseline has been administered. Data will be collected through personal interviews with a standardized survey questionnaire with both closed-ended and open-ended questions. The methodology will be that of a cross-sectional analysis, although to the extent possible, an effort will be made to follow some of the same subjects throughout the course of the study via the surveys, in order to facilitate longitudinal analysis. For the baseline, subjects will be drawn from the 15 banks currently functioning in Ecuador, and the 17 banks currently functioning in Honduras. Participants will have to meet specific criteria.

### **1. Statistical Analysis**

The suggested sample size for stratified sampling of bank records is 96 subjects per control group. This sample size is the result of applying the formula proposed by the WHO/EPI program.<sup>8</sup>

$$n = z^2 (pq)/d^2$$

n = sample size

z = (1- $\alpha$ )/2

p = estimated prevalence and coverage

q = 1-p

d = precision desired

Where  $z^2 = 1.96$  and the statistical certainty desired is set at 95%. The desired precision is set at  $d = .10$ . The value of "p" has been set at 0.5, the value which requires the maximum sample size. The resulting random sample size is  $n = 96$  when it is desired to be 95% sure that the population estimate obtained from the sample be within 10% of the true value for this population 95% of the time. If we wanted to increase the confidence level to 99%, the sample size required would be  $n = 166$ .

### **2. Study Groups**

#### **A. Group A**

Women participating in a Project HOPE sponsored village health bank, with children under two years old (and their children).

Because the size of this population is presently small (77 in Ecuador, and 85 in Honduras - refer to Table 1), all women who meet the established criteria will be interviewed for the baseline

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<sup>8</sup> See Stanley Lemeshow, David W. Hosmer, Janelle Klar and Stephen K. Lwanga. *Adequacy of sample size in health studies*, WHO, 1990.

survey. The target number for these interviews is 96 (see Table 3). New women entering the project who meet the criteria for study group A will be interviewed until a total of 96 women have been interviewed in each country, or until August 31 1994, whichever comes first.

### *B. Group B*

Women of Fertile Age (WFA) aged 15-49, without children under two, who participate in a Project HOPE sponsored village health bank.

Group B will be a stratified sample, to assure that all banks are represented. If possible, an equal number of women of fertile age will be selected from each bank.

## 3. Control Groups

### *A. Honduras (See Table 3)*

- Control #1: Project HOPE will begin five village banks in the peri-urban regions of Tegucigalpa which have no health component. Women with children under two, and women of fertile age, will be interviewed from these banks.

- Control # 2: Individuals can be selected from the 44 "colonias" in Tegucigalpa which have child survival programs. Individuals will be randomly selected using cluster sampling. The total number of respondents will be divided evenly between women of fertile age, and women with children under two.

Control # 3: This population is not currently available in the environment of Tegucigalpa and therefore will not be sampled in the baseline.

### *B. Ecuador (See Table 3)*

- Control #1: Project HOPE will begin five banks which have no health component. Women with children under two, and women of fertile age, will be interviewed from these banks.

- Control #2<sup>9</sup>: Individuals reached by child survival activities, but not by village banking will be randomly selected using cluster sampling. The total number of respondents will be divided evenly between women of fertile age, and women with children under two.

- Control #3: A population similar to that in the village health banks is not currently available in Ecuador and therefore will not be sampled in the baseline.

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<sup>9</sup> In Ecuador, individuals in control #2 will be selected *only* from communities following Project HOPE Child Survival Programs A or B, and *not* from those following Child Survival Program C. These distinctions are based on the intensity of health promotion activities. Programs A and B have health promotion activities comparable to those of village health banks, while program C does not.

Table 3: Baseline sample size

Sample	Ecuador n = 472		Honduras n = 472	
	WFAs	Women with < 2's	WFAs	Women with < 2's
Study	96 <sup>a</sup>	96 <sup>b</sup>	96 <sup>a</sup>	96 <sup>b</sup>
Control 1	20 <sup>c</sup>	50 <sup>c</sup>	20 <sup>c</sup>	50 <sup>c</sup>
Control 2	105 <sup>d</sup>	105 <sup>d</sup>	105 <sup>d</sup>	105 <sup>d</sup>
Control 3	Not possible	Not possible	Not possible	Not possible

a = stratified samples from existing village health banks

b = target of 96 to be sampled from existing village health banks. Will complete sample until a total of 96 is reached, or August 31, 1994, whichever comes first.

c = estimates<sup>10</sup>. The entire population of WFA without children under two, and women with children under two will be sampled from the five village banks with no health component.

d = the total sample of 210 will be evenly divided between WFAs without children under two, and women with children under two.

#### 4. Suggested sampling methodology

Stratified sampling may be the most appropriate sampling methodology for this study. In this sampling technique, banks and health centers will each form a mutually exhaustive and exclusive stratum. Each stratum should be as homogeneous as possible. A random sample is then selected from each stratum using bank and health center records. For example, if 96 subjects are to be sampled from 3 banks, then 32 individuals would be randomly selected from each bank. If 96 individuals were required from 4 health centers, then 24 individuals would be randomly selected from each health center.

n = 96	<u>Bank #1</u>	<u>Bank #2</u>	<u>Bank #3</u>	
Subjects	32	32	32	
n = 96	<u>Health Center #1</u>	<u>HC #2</u>	<u>HC #3</u>	<u>HC #4</u>
Subjects	24	24	24	24

For study group B, for example, to determine how many women will be sampled in each bank, the target number (n=96) will be divided by the number of village health banks. Once the

<sup>10</sup> Due to logistical limitations, these figures will not represent a statistically significant sample. However, data gathered from these individuals will give an indication of the impact of the credit component on health, and will facilitate comparison with the other two groups.

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number of women to be interviewed in each bank is calculated, a list of all women in each bank must be used to randomly select the required number of women from the population of each bank. This can be done by using a random number table with the "cedula" of each bank member; by picking the names of the women out of a hat; or simply by pointing to different places on the list, with one's eyes closed. If a woman selected does not meet the criteria, another woman will be randomly selected. This process will continue until the required number of qualifying women has been selected. This process will be repeated for each bank.

An alternative is to compile a list of all women who meet the criteria, and then randomly select them from this list, using the same methods outlined above. In this way, some selections will not have to be eliminated. If there are not enough qualifying women (that is, if there are less than 96), as many as qualify will be interviewed.

Cluster sampling will be used for control group #2. For a cluster sample, the sample size is approximately doubled from 96 to 210 (Lemeshow, et al. 1990). (See appendix F)

In Honduras, for example, populations can be selected from the 44 colonias in Tegucigalpa. Clusters can be determined easily, since each colonia is divided into quadrants or "manzanas". Each manzana will represent one cluster. 30 clusters must be randomly determined by such methods as computer-generated random numbers, using a random number table, or by drawing the names of the manzanas out of a hat. In each individual cluster, a total of seven respondents will be interviewed. Households are randomly selected within each cluster. Based on the guidelines for selecting participants, interviewers will then determine if each household contains a respondent who is eligible for the study. If so, then they will be interviewed. If not, another household will be selected, until a suitable respondent is located. This procedure will continue until seven respondents are located within each cluster, for a total of 210 respondents in 30 clusters. A similar process will be established in Ecuador.

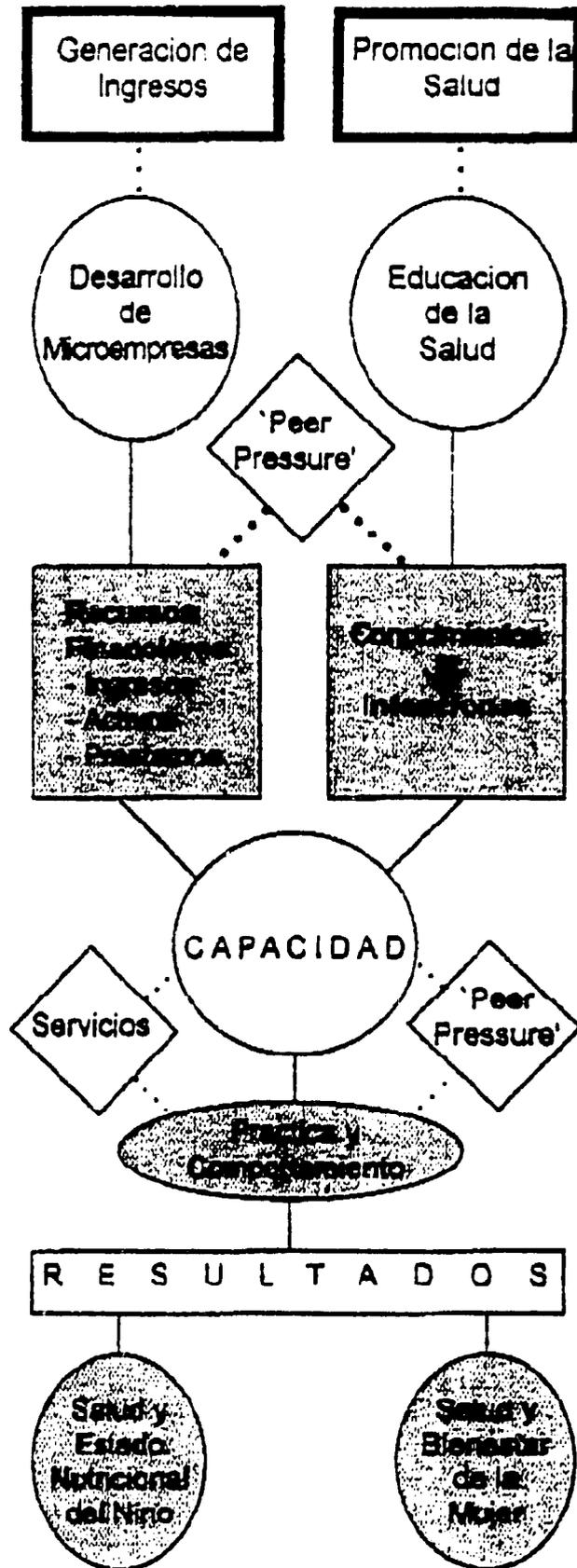
#### IV. Appendices

- A. Conceptual framework (in Spanish)
- B. Letter of Cooperation between Project HOPE and GWU
- C. Questionnaire
- D. Guide for interviewers
- E. Guides for conducting the baseline survey
  - 1. Guide for study groups
  - 2. Guide for control groups
- F. Guide to cluster sampling (WHO/EPI)

1-10-93/WHO/EP/93/001/001/001/001/001

APPENDIX A

Marco Conceptual del Proyecto



"Historical Report of Payment  
to HOPE Program"PROYECT HOPE/HONDURAS  
INCOME GENERATION PROGRAM  
HISTORICAL REPORT OF PAYMENTS BY VILLAGF HEALTH BANKS  
TO HOPE PROGRAM

NO. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER JOLLAR	TOTAL PAYMENT IN DOLLARS
VILLAGF HEALTH BANK #: 607.50400 EBEN-EZER						
N-EZER						
LOAN #: 1						
1 10/08/93	150.00	25.00	0.00	175.00	6.80	25.74
2 24/08/93	150.00	25.00	0.00	175.00	6.80	25.74
3 07/09/93	150.00	25.00	0.00	175.00	6.80	25.74
4 21/09/93	150.00	25.00	0.00	175.00	6.88	25.44
5 05/10/93	150.00	25.00	0.00	175.00	6.88	25.44
6 19/10/93	150.00	25.00	0.00	175.00	6.88	25.44
7 02/11/93	150.00	25.00	0.00	175.00	7.00	25.00
8 16/11/93	150.00	25.00	10000.00	10175.00	7.00	1453.57
subtotal *	1200.00	200.00	10000.00	11400.00		1632.11
N-EZER						
LOAN #: 2						
1 07/12/93	243.75	40.64	0.00	284.39	7.30	38.96
2 22/12/93	243.75	40.64	0.00	284.39	7.25	39.23
3 05/01/94	243.75	40.64	0.00	284.39	7.25	39.23
4 19/01/94	243.75	40.64	0.00	284.39	7.25	39.23
5 02/02/94	243.75	40.64	0.00	284.39	7.25	39.23
6 16/02/94	243.75	40.64	0.00	284.39	7.25	39.23
7 02/03/94	243.75	40.64	0.00	284.39	7.40	38.43
8 16/03/94	243.75	40.52	16250.00	16534.27	7.40	2234.36
subtotal *	1950.00	325.00	16250.00	18525.00		2507.90
N-EZER						
LOAN #: 3						
1 06/04/94	297.75	49.63	0.00	347.38	7.68	45.23
2 21/04/94	297.75	49.63	0.00	347.38	7.92	43.86
3 04/05/94	297.75	49.63	0.00	347.38	7.92	43.86
4 17/05/94	297.75	49.63	0.00	347.38	7.92	43.86
5 06/06/94	297.75	49.63	0.00	347.38	8.35	41.60
6 17/06/94	297.75	49.63	0.00	347.38	8.35	41.60
subtotal *	1786.50	297.78	0.00	2084.28		260.01
total **	4936.50	822.78	26250.00	32009.28		4400.02
VILLAGF HEALTH BANK #: 607.50300 DORCAS						
DORCAS						
LOAN #: 1						
1 30/08/93	145.50	24.25	0.00	169.75	6.80	24.96
2 10/09/93	145.50	24.25	0.00	169.75	6.80	24.96
3 24/09/93	145.50	24.25	0.00	169.75	6.88	24.67
4 08/10/93	145.50	24.25	0.00	169.75	6.88	24.67
5 22/10/93	145.50	24.25	0.00	169.75	7.00	24.25

NO. 2  
/94

PROYECT HOPE/HONDURAS  
INCOME GENERATION PROGRAM  
HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
TO HOPE PROGRAM

NO. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
6 09/11/93	145.50	24.25	0.00	169.75	7.00	24.25
7 19/11/93	291.00	48.50	0.00	339.50	7.00	48.50
8 23/11/93	0.00	0.00	9700.00	9700.00	7.30	1328.77
subtotal *	1164.00	194.00	9700.00	11058.00		1525.03
CAS						
			LOAN #: 2			
1 10/12/93	189.75	31.64	0.00	221.39	7.30	30.33
2 21/12/93	189.74	31.64	0.00	221.38	7.25	30.54
3 02/01/94	189.74	31.64	0.00	221.38	7.25	30.54
4 21/01/94	189.74	31.64	0.00	221.38	7.25	30.54
5 04/02/94	189.74	31.64	0.00	221.38	7.25	30.54
6 18/02/94	189.74	31.64	0.00	221.38	7.25	30.54
7 04/03/94	189.75	31.64	0.00	221.39	7.40	29.92
8 21/03/94	189.75	31.57	12650.00	12871.32	7.68	1675.95
subtotal *	1517.95	253.05	12650.00	14421.00		1888.90
CAS						
			LOAN #: 3			
1 08/04/94	213.75	35.63	0.00	249.38	7.68	32.47
2 22/04/94	213.75	35.63	0.00	249.38	7.92	31.49
3 09/05/94	213.75	35.63	0.00	249.38	7.92	31.49
4 20/05/94	213.75	35.63	0.00	249.38	7.92	31.49
5 02/06/94	213.75	35.63	0.00	249.38	8.35	29.87
6 17/06/94	213.75	35.63	0.00	249.38	8.35	29.87
7 17/06/94	213.75	35.63	0.00	249.38	8.35	29.87
ubtotal *	1496.25	249.41	0.00	1745.66		216.55
total **	4178.20	696.46	22350.00	27224.66		3630.48
VILLAGE HEALTH BANK #: 607.51400 MUJERES ADMINISTRANDO						
RES ADMINISTRANDO						
			LOAN #: 1			
1 13/09/93	168.00	28.00	0.00	196.00	6.80	28.82
2 28/09/93	168.00	28.00	0.00	196.00	6.88	28.49
3 13/10/93	168.00	28.00	0.00	196.00	6.88	28.49
4 26/10/93	168.00	28.00	0.00	196.00	7.00	28.00
5 09/11/93	168.00	28.00	0.00	196.00	7.00	28.00
6 31/08/93	168.00	28.00	0.00	196.00	6.80	28.82
7 23/11/93	168.00	28.00	0.00	196.00	7.30	26.85
8 07/12/93	168.00	28.00	11200.00	11396.00	7.30	1561.10
ubtotal *	1344.00	224.00	11200.00	12768.00		1758.57

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No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
JERES ADMINISTRANDO						
	LOAN #: 2					
1 21/12/93	260.25	43.42	0.00	303.67	7.25	41.89
2 04/01/94	260.25	43.42	0.00	303.67	7.25	41.89
3 17/01/94	260.25	43.42	0.00	303.67	7.25	41.89
4 31/01/94	260.25	43.42	0.00	303.67	7.25	41.89
5 14/02/94	260.25	43.42	0.00	303.67	7.25	41.89
6 01/03/94	260.25	43.42	0.00	303.67	7.40	41.04
7 15/03/94	260.25	43.42	0.00	303.67	7.40	41.04
8 25/03/94	260.25	43.06	17350.00	17653.31	7.68	2298.61
subtotal *	2082.00	347.00	17350.00	19779.00		2590.14
JERES ADMINISTRANDO						
	LOAN #: 3					
1 05/04/94	300.00	50.00	0.00	350.00	7.68	45.57
2 19/04/94	300.00	50.00	0.00	350.00	7.68	45.57
3 03/05/94	300.00	50.00	0.00	350.00	7.92	44.19
4 17/05/94	300.00	50.00	0.00	350.00	7.92	44.19
5 31/05/94	300.00	50.00	0.00	350.00	8.35	41.92
6 28/06/94	300.00	50.00	0.00	350.00	8.60	40.70
7 14/06/94	300.00	50.00	0.00	350.00	8.35	41.92
subtotal *	2100.00	350.00	0.00	2450.00		304.06
total **	5526.00	921.00	28550.00	34997.00		4652.77
VILLAGE HEALTH BANK #: 607.51150 LA UNION						
UNION						
	LOAN #: 1					
1 03/09/93	177.00	29.50	0.00	206.50	6.80	30.37
2 16/09/93	177.00	29.50	0.00	206.50	6.80	30.37
3 05/10/93	177.00	29.50	0.00	206.50	6.88	30.01
4 15/10/93	177.00	29.50	0.00	206.50	6.88	30.01
5 29/10/93	177.00	29.50	0.00	206.50	7.00	29.50
6 12/11/93	177.00	29.50	0.00	206.50	7.00	29.50
7 26/11/93	177.00	29.50	0.00	206.50	7.30	28.29
8 13/12/93	177.00	29.50	11800.00	12006.50	7.30	1644.73
subtotal *	1416.00	236.00	11800.00	13452.00		1852.78
UNION						
	LOAN #: 2					
1 19/12/93	226.50	37.75	0.00	264.25	7.30	36.20
2 14/01/94	226.50	37.75	0.00	264.25	7.25	36.45
3 28/01/94	226.50	37.75	0.00	264.25	7.25	36.45
4 11/02/94	226.50	37.75	0.00	264.25	7.25	36.45
5 28/02/94	226.50	37.75	0.00	264.25	7.40	35.71
6 28/03/94	226.50	37.75	0.00	264.25	7.68	34.41

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No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
7 08/04/94	226.50	37.75	0.00	264.25	7.68	34.41
8 13/04/94	226.50	37.75	15100.00	15364.25	7.68	2000.55
subtotal *	1812.00	302.00	15100.00	17214.00		2250.63
UNION						
			LOAN #: 3			
1 06/05/94	231.00	38.50	0.00	269.50	7.92	34.03
2 20/05/94	231.00	38.50	0.00	269.50	7.92	34.03
3 03/06/94	231.00	38.50	0.00	269.50	8.35	32.28
subtotal *	693.00	115.50	0.00	808.50		100.34
total **	3921.00	653.50	26900.00	31474.50		4203.75
VILLAGE HEALTH BANK #: 607.51050 LA MUJER TRABAJADORA						
MUJER TRABAJADORA						
			LOAN #: 1			
1 20/09/93	177.00	29.50	0.00	206.50	6.80	30.37
2 05/10/93	177.00	29.50	0.00	206.50	6.88	30.01
3 18/10/93	177.00	29.50	0.00	206.50	6.88	30.01
4 02/11/93	177.00	29.50	0.00	206.50	7.00	29.50
5 16/11/93	177.00	29.50	0.00	206.50	7.00	29.50
6 30/11/93	177.00	29.50	0.00	206.50	7.30	28.29
7 11/12/93	354.00	59.00	0.00	413.00	7.30	56.58
8 14/12/93	0.00	0.00	11800.00	11800.00	7.30	1616.44
subtotal *	1416.00	236.00	11800.00	13452.00		1850.70
MUJER TRABAJADORA						
			LOAN #: 2			
1 30/12/93	201.75	33.63	0.00	235.38	7.25	32.47
2 17/01/94	201.75	33.63	0.00	235.38	7.25	32.47
3 31/01/94	201.75	33.63	0.00	235.38	7.25	32.47
4 14/02/94	201.75	33.63	0.00	235.38	7.25	32.47
5 28/02/94	201.75	33.63	0.00	235.38	7.40	31.81
6 15/03/94	201.75	33.63	0.00	235.38	7.40	31.81
7 28/03/94	201.75	33.63	0.00	235.38	7.68	30.65
8 22/04/94	201.75	33.63	13450.00	13685.38	7.92	1727.95
total *	1614.00	269.04	13450.00	15333.04		1952.10
MUJER TRABAJADORA						
			LOAN #: 3			
1 14/05/94	202.50	33.75	0.00	236.25	7.92	29.83
2 01/06/94	202.50	33.75	0.00	236.25	8.35	28.29
3 17/06/94	202.50	33.75	0.00	236.25	8.35	28.29
4 28/06/94	202.50	33.75	0.00	236.25	8.60	27.47
total *						

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HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
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No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
ubtotal **	810.00	135.00	0.00	945.00		113.88
	3840.00	640.04	25250.00	29730.04		3916.68
VILLAGE HEALTH BANK #: 607.50500 ENMANUEL						
MANUEL LOAN #: 1						
1 18/09/93	172.50	28.75	0.00	201.25	6.80	29.60
2 30/09/93	172.50	28.75	0.00	201.25	6.88	29.25
3 14/10/93	172.50	28.75	0.00	201.25	6.88	29.25
4 28/10/93	172.50	28.75	0.00	201.25	7.00	28.75
5 11/11/93	172.50	28.75	0.00	201.25	7.00	28.75
6 25/11/93	172.50	28.75	0.00	201.25	7.30	27.57
7 09/12/93	345.00	57.50	0.00	402.50	7.30	55.14
8 10/12/93	0.00	0.00	11500.00	11500.00	7.30	1575.34
bsubtotal *	1380.00	230.00	11500.00	13110.00		1803.65
MANUEL LOAN #: 2						
1 30/12/93	168.00	28.00	0.00	196.00	7.25	27.03
2 14/01/94	168.00	28.00	0.00	196.00	7.25	27.03
3 28/01/94	168.00	28.00	0.00	196.00	7.25	27.03
4 10/02/94	168.00	28.00	0.00	196.00	7.25	27.03
5 24/02/94	168.00	28.00	0.00	196.00	7.40	26.49
6 11/03/94	168.00	28.00	0.00	196.00	7.40	26.49
7 24/03/94	168.00	28.00	0.00	196.00	7.68	25.52
8 07/04/94	168.00	28.00	11200.00	11396.00	7.68	1483.85
bsubtotal *	1344.00	224.00	11200.00	12768.00		1670.47
MANUEL LOAN #: 3						
1 29/04/94	276.00	46.00	0.00	322.00	7.92	40.66
2 10/05/94	276.00	46.00	0.00	322.00	7.92	40.66
3 03/06/94	276.00	46.00	0.00	322.00	8.35	38.56
4 10/06/94	276.00	46.00	0.00	322.00	8.35	38.56
5 24/06/94	276.00	46.00	0.00	322.00	8.60	37.44
subtotal *	1380.00	230.00	0.00	1610.00		195.88
bttotal **	4104.00	684.00	22700.00	27488.00		3670.00

VILLAGE HEALTH BANK #: 607.51250 LAZOS DE AMISTAD

LAZOS DE AMISTAD LOAN #: 1						
1 26/10/93	157.50	26.25	0.00	183.75	7.00	26.25
2 29/10/93	157.50	26.25	0.00	183.75	7.00	26.25

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No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
3 15/11/93	157.50	26.25	0.00	183.75	7.00	26.25
4 30/11/93	157.50	26.25	0.00	183.75	7.30	25.17
5 13/12/93	157.50	26.25	0.00	183.75	7.30	25.17
6 23/12/93	157.50	26.25	0.00	183.75	7.25	25.34
7 08/01/94	157.50	26.25	0.00	183.75	7.25	25.34
8 22/01/94	157.50	26.25	0.00	183.75	7.25	25.34
9 25/01/94	0.00	0.00	10500.00	10500.00	7.25	1448.28
subtotal *	1260.00	210.00	10500.00	11970.00		1653.39
OS DE AMISTAD						
						LOAN #: 2
1 14/02/94	187.50	31.25	0.00	218.75	7.25	30.17
2 28/02/94	187.50	31.25	0.00	218.75	7.40	29.56
3 14/03/94	187.50	31.25	0.00	218.75	7.40	29.56
4 28/03/94	187.50	31.25	0.00	218.75	7.68	28.48
5 23/04/94	187.50	31.25	0.00	218.75	7.92	27.62
6 07/05/94	187.50	31.25	0.00	218.75	7.92	27.62
7 21/05/94	187.50	31.25	0.00	218.75	8.35	26.20
8 23/05/94	187.50	31.25	12500.00	12718.75	8.35	1523.20
subtotal *	1500.00	250.00	12500.00	14250.00		1722.41
OS DE AMISTAD						
						LOAN #: 3
1 14/06/94	248.25	41.38	0.00	289.63	8.35	34.69
subtotal *	248.25	41.38	0.00	289.63		34.69
total **	3008.25	501.38	23000.00	26509.63		3410.49
VILLAGE HEALTH BANK #:						607.52300 ROSALINDA
ROSALINDA						
						LOAN #: 1
1 27/10/93	132.00	22.00	0.00	154.00	7.00	22.00
2 10/11/93	132.00	22.00	0.00	154.00	7.00	22.00
3 24/11/93	132.00	22.00	0.00	154.00	7.30	21.10
4 08/12/93	132.00	22.00	0.00	154.00	7.30	21.10
6 05/01/94	132.00	22.00	0.00	154.00	7.25	21.24
7 19/01/94	132.00	22.00	0.00	154.00	7.25	21.24
8 02/02/94	132.00	22.00	8800.00	8954.00	7.25	1235.03
subtotal *	924.00	154.00	8800.00	9878.00		1363.71
ROSALINDA						
						LOAN #: 2
1 23/02/94	152.25	25.37	0.00	177.62	7.40	24.00
2 10/03/94	152.25	25.37	0.00	177.62	7.40	24.00
3 23/03/94	152.25	25.37	0.00	177.62	7.68	23.13

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No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
4 06/04/94	152.25	25.38	0.00	177.63	7.68	23.13
5 21/04/94	152.25	25.38	0.00	177.63	7.92	22.43
6 06/05/94	152.25	25.38	0.00	177.63	7.92	22.43
7 20/05/94	152.25	25.38	0.00	177.63	7.92	22.43
8 01/06/94	152.25	25.38	10150.00	10327.63	8.35	1236.84
subtotal *						
	1218.00	203.01	10150.00	11571.01		1398.39
btotal **						
	2142.00	357.01	18950.00	21449.01		2762.10

VILLAGE HEALTH BANK #: 607.52450 SALUD Y SUPERACION

UD Y SUPERACION			LOAN #: 1			
1 13/11/93	226.50	37.75	0.00	264.25	7.00	37.75
3 15/12/93	226.50	37.75	0.00	264.25	7.30	36.20
4 29/12/93	226.50	37.75	0.00	264.25	7.25	36.45
5 12/01/94	226.50	37.75	0.00	264.25	7.25	36.45
6 26/01/94	226.50	37.75	0.00	264.25	7.25	36.45
7 09/02/94	226.50	37.75	0.00	264.25	7.25	36.45
8 23/02/94	226.50	37.75	15100.00	15364.25	7.40	2076.25
subtotal *						
	1585.50	264.25	15100.00	16949.75		2296.00

UD Y SUPERACION			LOAN #: 2			
1 09/03/94	287.25	47.88	0.00	335.13	7.40	45.29
2 23/03/94	287.25	47.88	0.00	335.13	7.68	43.64
3 06/04/94	287.25	47.88	0.00	335.13	7.68	43.64
4 20/04/94	287.25	47.88	0.00	335.13	7.68	43.64
5 04/05/94	287.25	47.88	0.00	335.13	7.92	42.31
6 19/05/94	287.25	47.88	0.00	335.13	7.92	42.31
7 01/06/94	287.25	47.88	0.00	335.13	8.35	40.14
8 16/06/94	287.25	47.88	19150.00	19485.09	8.35	2333.54
subtotal *						
	2298.00	383.04	19150.00	21831.00		2634.51
btotal **						
	3883.50	647.29	34250.00	38780.75		4930.51

VILLAGE HEALTH BANK #: 607.52580 SHALON

LOAN			LOAN #: 1			
1 25/11/93	153.00	25.50	0.00	178.50	7.30	24.45
2 09/12/93	153.00	25.50	0.00	178.50	7.30	24.45
3 23/12/93	153.00	25.50	0.00	178.50	7.25	24.62
4 07/01/94	153.00	25.50	0.00	178.50	7.25	24.62
5 21/01/94	153.00	25.50	0.00	178.50	7.25	24.62
6 04/02/94	153.00	25.50	0.00	178.50	7.25	24.62

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HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
TO HOPE PROGRAM

No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
7 21/02/94	153.00	25.50	0.00	178.50	7.40	24.12
8 03/03/94	153.00	25.50	0.00	178.50	7.40	24.12
9 08/03/94	0.00	0.00	10200.00	10200.00	7.40	1378.38
Subtotal *	1224.00	204.00	10200.00	11628.00		1574.00
BALON						
			LOAN #: 2			
1 24/03/94	227.25	37.88	0.00	265.13	7.68	34.52
2 07/04/94	227.25	37.88	0.00	265.13	7.68	34.52
3 21/04/94	227.25	37.88	0.00	265.13	7.92	33.48
4 05/05/94	227.25	37.88	0.00	265.13	7.92	33.48
5 19/05/94	227.25	37.88	0.00	265.13	7.92	33.48
6 03/06/94	227.25	37.88	0.00	265.13	8.35	31.75
7 17/06/94	227.25	37.88	0.00	265.13	8.35	31.75
8 30/06/94	227.25	37.88	15150.00	15415.09	8.60	1792.45
Subtotal *	1818.00	303.04	15150.00	17271.00		2025.43
Subtotal **	3042.00	507.04	25350.00	28899.00		3599.43
VILLAGE HEALTH BANK #: 607.52700 UNION Y ESFUERZO						
UNION Y ESFUERZO						
			LOAN #: 1			
1 03/12/93	150.00	25.00	0.00	175.00	7.30	23.97
2 17/12/93	150.00	25.00	0.00	175.00	7.30	23.97
3 30/12/93	150.00	25.00	0.00	175.00	7.25	24.14
4 14/01/94	150.00	25.00	0.00	175.00	7.25	24.14
5 28/01/94	150.00	25.00	0.00	175.00	7.25	24.14
6 11/02/94	150.00	25.00	0.00	175.00	7.25	24.14
7 25/02/94	150.00	25.00	0.00	175.00	7.40	23.65
8 11/03/94	150.00	25.00	10000.00	10175.00	7.40	1375.00
Subtotal *	1200.00	200.00	10000.00	11400.00		1543.15
UNION Y ESFUERZO						
			LOAN #: 2			
1 28/03/94	206.25	34.38	0.00	240.63	7.68	31.33
2 08/04/94	206.25	34.38	0.00	240.63	7.68	31.33
3 22/04/94	206.25	34.38	0.00	240.63	7.92	30.38
4 10/05/94	206.25	34.38	0.00	240.63	7.92	30.38
5 20/05/94	206.25	34.38	0.00	240.63	7.92	30.38
6 06/06/94	206.25	34.38	0.00	240.63	8.35	28.82
7 20/06/94	206.25	34.38	0.00	240.63	8.35	28.82
8 07/01/94	206.25	34.38	13750.00	13990.63	7.25	1929.74
Subtotal *	1650.00	275.04	13750.00	15675.04		2141.18
Subtotal **						

55

E NO. 9  
07/94

PROYECT HOPE/HONDURAS  
INCOME GENERATION PROGRAM  
HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
TO HOPE PROGRAM

No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
	2850.00	475.04	23750.00	27075.04		3684.33
VILLAGE HEALTH BANK #: 607.51350 MUJERES UNIDAS						
MUJERES UNIDAS						
	LOAN #: 1					
1 07/12/93	178.50	29.75	0.00	208.25	7.30	28.53
2 21/12/93	178.50	29.75	0.00	208.25	7.25	28.72
3 04/01/94	178.50	29.75	0.00	208.25	7.25	28.72
4 18/01/94	178.50	29.75	0.00	208.25	7.25	28.72
5 01/02/94	178.50	29.75	0.00	208.25	7.25	28.72
6 16/02/94	178.50	29.75	0.00	208.25	7.25	28.72
7 11/04/94	178.50	29.75	0.00	208.25	7.68	27.12
8 15/03/94	178.50	29.75	11900.00	12108.25	7.40	1636.25
subtotal *	1428.00	238.00	11900.00	13566.00		1835.50
MUJERES UNIDAS						
	LOAN #: 2					
1 01/04/94	222.75	37.13	0.00	259.88	7.68	33.84
2 11/04/94	222.75	37.13	0.00	259.88	7.68	33.84
3 16/04/94	222.75	37.13	0.00	259.88	7.68	33.84
4 09/05/94	222.75	37.13	0.00	259.88	7.92	32.81
5 24/05/94	222.75	37.13	0.00	259.88	8.35	31.12
6 08/06/94	222.75	37.13	0.00	259.88	8.35	31.12
subtotal *	1336.50	222.78	0.00	1559.28		196.57
subtotal **	2764.50	460.78	11900.00	15125.28		2032.07
VILLAGE HEALTH BANK #: 607.50420 EL FUTURO DE LA BEHTANIA						
FUTURO DE LA BEHTANIA						
	LOAN #: 1					
1 24/02/94	198.00	33.00	0.00	231.00	7.40	31.22
2 10/03/94	198.00	33.00	0.00	231.00	7.40	31.22
3 24/03/94	198.00	33.00	0.00	231.00	7.68	30.08
4 21/04/94	198.00	33.00	0.00	231.00	7.92	29.17
5 24/04/94	198.00	33.00	0.00	231.00	7.92	29.17
6 06/05/94	198.00	33.00	0.00	231.00	7.92	29.17
7 24/05/94	198.00	33.00	0.00	231.00	8.35	27.66
8 19/05/94	198.00	33.00	13200.00	231.00	7.92	29.17
subtotal *	1584.00	264.00	13200.00	1848.00		236.86
FUTURO DE LA BEHTANIA						
	LOAN #: 2					
1 24/06/94	202.50	33.75	0.00	236.25	8.60	27.47
subtotal *	202.50	33.75	0.00	236.25		27.47

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NO. 10  
17/94

PROYECT HOPE/HONDURAS  
INCOME GENERATION PROGRAM  
HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
TO HOPE PROGRAM

No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
ubtotal **	1786.50	297.75	13200.00	2084.25		264.33
VILLAGE HEALTH BANK #: 607.50410 EL FUTURO DE LA MUJER						
FUTURO DE LA MUJER			LOAN #: 1			
1 01/03/94	186.00	31.00	0.00	217.00	7.40	29.32
2 15/03/94	186.00	31.00	0.00	217.00	7.40	29.32
3 28/03/94	186.00	31.00	0.00	217.00	7.68	28.26
4 12/04/94	186.00	31.00	0.00	217.00	7.68	28.26
5 26/04/94	186.00	31.00	0.00	217.00	7.92	27.40
6 10/05/94	186.00	31.00	0.00	217.00	7.92	27.40
7 24/05/94	186.00	31.00	0.00	217.00	8.35	25.99
8 08/06/94	186.00	31.00	12400.00	12617.00	8.35	1511.02
bsubtotal *	1488.00	248.00	12400.00	14136.00		1706.97
FUTURO DE LA MUJER			LOAN #: 2			
1 22/06/94	244.50	40.75	0.00	285.25	8.60	33.17
bsubtotal *	244.50	40.75	0.00	285.25		33.17
ubtotal **	1732.50	288.75	12400.00	14421.25		1740.14
VILLAGE HEALTH BANK #: 607.50600 FE EN MARCHA						
EN MARCHA			LOAN #: 1			
1 04/03/94	157.50	26.25	0.00	183.75	7.40	24.83
2 17/03/94	157.50	26.25	0.00	183.75	7.40	24.83
3 28/03/94	157.50	26.25	0.00	183.75	7.68	23.93
4 15/04/94	157.50	26.25	0.00	183.75	7.68	23.93
5 28/04/94	157.50	26.25	0.00	183.75	7.92	23.20
6 13/05/94	157.50	26.25	0.00	183.75	7.92	23.20
7 26/05/94	157.50	26.25	0.00	183.75	8.35	22.01
8 09/06/94	157.50	26.25	10500.00	10683.75	8.35	1279.49
bsubtotal *	1260.00	210.00	10500.00	11970.00		1445.42
EN MARCHA			LOAN #: 2			
1 24/06/94	196.50	32.75	0.00	229.25	8.60	26.66
bsubtotal *	196.50	32.75	0.00	229.25		26.66
ubtotal **	1456.50	242.75	10500.00	12199.25		1472.08

NO. 11  
/94

PROYECT HOPE/HONDURAS  
INCOME GENERATION PROGRAM  
HISTORICAL REPORT OF PAYMENTS BY VILLAGE HEALTH BANKS  
TO HOPE PROGRAM

No. AND DATE OF PAYMENT	INTEREST	COMMISSION	CAPITAL	TOTAL PAYMENT IN LEMPIRAS	LEMPIRAS PER DOLLAR	TOTAL PAYMENT IN DOLLARS
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VILLAGE HEALTH BANK #: 607.52260 PUERTA AL PROGRESO

PUERTA AL PROGRESO

LOAN #: 1

1 14/03/94	145.50	24.25	0.00	169.75	7.40	22.94
2 28/03/94	145.50	24.25	0.00	169.75	7.68	22.10
3 11/04/94	145.50	24.25	0.00	169.75	7.68	22.10
4 23/04/94	145.50	24.25	0.00	169.75	7.92	21.43
5 09/05/94	145.50	24.25	0.00	169.75	7.92	21.43
6 21/05/94	145.50	24.25	0.00	169.75	8.35	20.33
7 06/06/94	145.50	24.25	0.00	169.75	8.35	20.33
8 20/06/94	145.50	24.25	9700.00	9869.75	8.35	1182.01

subtotal \*

1164.00	194.00	9700.00	11058.00		1332.67
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total \*\*

1164.00	194.00	9700.00	11058.00		1332.67
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VILLAGE HEALTH BANK #: 607.52751 FE Y ESPERANZA

FE Y ESPERANZA

LOAN #: 1

1 08/04/94	198.00	33.00	0.00	231.00	7.68	30.08
2 22/04/94	198.00	33.00	0.00	231.00	7.92	29.17
3 06/05/94	198.00	33.00	0.00	231.00	7.92	29.17
4 20/05/94	198.00	33.00	0.00	231.00	7.92	29.17
5 06/06/94	198.00	33.00	0.00	231.00	8.35	27.66

subtotal \*

990.00	165.00	0.00	1155.00		145.25
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total \*\*

990.00	165.00	0.00	1155.00		145.25
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VILLAGE HEALTH BANK #: 607.52752 AMOR Y PAZ

AMOR Y PAZ

LOAN #: 1

1 14/06/94	154.50	25.75	0.00	180.25	8.35	21.59
2 28/06/94	154.50	25.75	0.00	180.25	8.60	20.96

subtotal \*

309.00	51.50	0.00	360.50		42.55
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total \*\*

309.00	51.50	0.00	360.50		42.55
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total \*\*\*

51634.45	8606.07	335000.00	382040.44		49889.65
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CONTROL DE CUE' A INTERNA

NO.	FECHA	PAGOS	CAPITAL	INTERES	SALDO	FIRMA TESORERA
		→	→	→	→	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
TOTALES						

Honduras VHB  
Appendix F

"Passbook with Health Messages"

CICLO

2

BANCO COMUNAL: \_\_\_\_\_

NOMBRE DE LA SOCIA: \_\_\_\_\_

COMUNIDAD: \_\_\_\_\_

MONTO DEL PRESTAMO: LPS. \_\_\_\_\_

INTERESES A PAGAR: LPS. \_\_\_\_\_

COMISION: LPS. \_\_\_\_\_

TOTAL: LPS. \_\_\_\_\_

CUOTA QUINCENAL: \_\_\_\_\_

(INTERESES, COMISION) LPS. \_\_\_\_\_

CUOTA QUINCENAL: \_\_\_\_\_

(AHORRO) LPS. \_\_\_\_\_

CUOTA MENSUAL: \_\_\_\_\_

(CAPITAL) LPS. \_\_\_\_\_

**PROJECT HOPE**

PROGRAMA  
GENERACION DE INGRESOS  
HONDURAS C.A.

AHORROS							PRESTAMO							
NO.	FECHA	DEPOSITO	RETIRO	SALDO	FIRMA TESORERA	TOTALES	NO.	FECHA	PAGOS	CAPITAL Y COMISION	INTERES	SALDO	FIRMA TESORERA	TOTALES
		←	←	←	←				←	←	←	←	←	
20							20							
19							19							
18							18							
17							17							
16							16							
15							15							
14							14							
13							13							
12							12							
11							11							
10							10							
9							9							
8							8							
7							7							
6							6							
5							5							
4							4							
3							3							
2							2							
1							1							
		←	←	←	←				←	←	←	←	←	
TOTALES							TOTALES							

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## SALUD DE LA MUJER

LA SALUD DE LAS MUJERES Y DE LOS NIÑOS PUEDE MEJORAR MUCHISIMO SI :

- A) SE ALARGA EL PERIODO ENTRE EL NACIMIENTO DE UN NIÑO Y OTRO A POR LO MENOS 2 AÑOS.
- B) SE EVITAN LOS EMBARAZOS ANTES DE LOS 18 AÑOS Y DESPUES DE LOS 35
- C) SE LIMITAN A 4 EL NUMERO TOTAL DE EMBARAZOS



LA PLANIFICACION FAMILIAR OFRECE A LA MUJER Y/O LA PAREJA LA POSIBILIDAD DE DECIDIR :

- A) CUANDO QUIEREN EMPEZAR A TENER HIJOS
- B) CUANTOS HIJOS QUIEREN TENER
- C) EN QUE ESPACIO DE TIEMPO QUIEREN TENER EL SIGUIENTE HIJO
- D) CUANDO DEJAN DE TENER MAS HIJOS



LA MUJER PUEDE EVITAR LOS RIESGOS DEL PARTO SI ACUDE AL CENTRO DE SALUD MAS CERCANO PARA CONTROLAR DESDE LOS PRIMEROS 3 MESES DE EMBARAZO.



LA MUJER EMBARAZADA NECESITA ALIMENTARSE MAS DURANTE EL EMBARAZO A MENOS QUE YA PRESENTE EXCESO DE PESO.

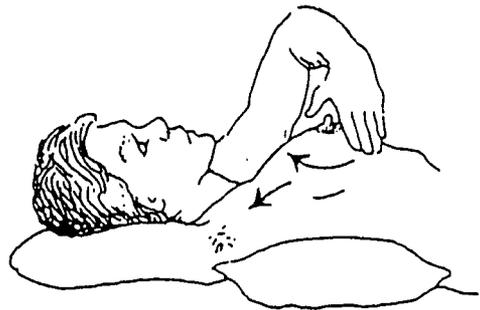
TODA MUJER EMBARAZADA TIENE MAYOR, NECESIDAD DE DESCANSO



TODAS LAS MUJERES DEBEN HACERSE EL EXAMEN DETECTORA DEL CANCER OSEA LA CITOLOGIA CERVICO UTERINA POR LO MENOS UNA VEZ AL AÑO.



CADA MUJER DEBE APRENDER A AUTOEXAMINAR SUS MAMAS.



LA SIFILIS, GONORREA, EL SIDA Y OTRAS SON ENFERMEDADES DE TRANSMISION SEXUAL O MAS CONOCIDAS COMO VENEREAS. SE TRANSMITEN POR CONTACTO SEXUAL.



LA MUJER DE HOY DEBE INFORMARSE E INFORMAR AL RESTO DE SU FAMILIA SOBRE LA FORMA DE PREVENIRSE CONTRA ESTAS ENFERMEDADES. EL OFICIAL DE SALUD O CUALQUIER OTRO PERSONAL DE SALUD PUEDE BRINDARLE ESTA INFORMACION.



CONTROL DE CUENTA INTERNA

Nº	FECHA	PAGOS	CAPITAL	INTERESES	SALDO	FIRMA TESORERA
SALDO INICIAL						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
TOTALES						

CICLO

3

BANCO COMUNAL : \_\_\_\_\_

NOMBRE DE LA SOCIA : \_\_\_\_\_

COMUNIDAD : \_\_\_\_\_

MONTO DEL PRESTAMO : LPS. \_\_\_\_\_

INTERESES A PAGAR : LPS. \_\_\_\_\_

COMISION : LPS. \_\_\_\_\_

TOTAL : LPS. \_\_\_\_\_

CUOTA QUINCENAL : \_\_\_\_\_

(INTERESES, COMISION) : LPS. \_\_\_\_\_

CUOTA QUINCENAL : \_\_\_\_\_

(AHORRO) : LPS. \_\_\_\_\_

CUOTA MENSUAL : \_\_\_\_\_

(CAPITAL) : LPS. \_\_\_\_\_



PROGRAMA  
GENERACION DE INGRESOS  
BONDURAS C.A.

TOTALES									
20	19	18	17	16	15	14	13	12	11
SALDO INICIAL									
No.	FECHA	PAGOS	CAPITAL	INTERESES	COMISION	SALDO	DEPOSITO	RETIRO	SALDO
PRESTAMO						AHORROS			
FIRMA TESORERA									

CONTROL CUENTA EXTERNA

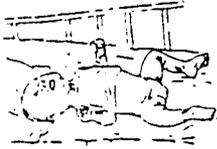
42

# INFECCIONES RESPIRATORIAS AGUDAS

SON AQUELLAS INFECCIONES QUE OCURREN EN EL APARATO RESPIRATORIO YA SEA EN LA NARIZ, GARGANTA, OIDOS, TRAQUEA, BRONQUIOS Y PULMONES

CUANDO UN NIÑO CON INFECCION RESPIRATORIA PRESENTA

RESPIRACION RAPIDA  
HUNDIMIENTO DE LAS  
COSTILLAS



ESTO INDICA QUE EL NIÑO TIENE NEUMONIA

ESTO ES GRAVE, E L NIÑO DEBE RECIBIR ATENCION MEDICA INMEDIATA

LAS INFECCIONES RESPIRATORIAS EN LOS NIÑOS MENORES DE 5 AÑOS ES UNA DE LAS CAUSAS PRINCIPALES DE MUERTE DE NIÑOS EN HONDURAS Y EL MUNDO

PROTEJA SU NIÑO

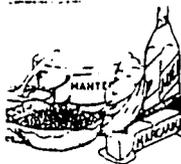


APLICANDOLE TODAS LAS VACUNAS QUE EL NIÑO NECESITA

DAN DOLE LECHE MATERNA EN LOS PRIMEROS SEIS MESES



ALIMENTAN DOLO CON COMIDAS NUTRITIVAS DISPONIBLES EN LA COMUNIDAD



MANTENIENDO UNA BUENA HIGIENE Y UN AMBIENTE LIBRE DE HUMO Y POLVO



SI EL NIÑO PRESENTA TOS Y MOQUERA, ESTO INDICA QUE TIENE GRIPE O RESFRIO COMUN

PARA AYUDAR A QUE EL NIÑO SE RECUPERE, LA MADRE DEBE

MANTENER LIMPIA LA NARIZ DEL NIÑO



APLICAR GOTAS DE MANZANILLA EN LA NARIZ



ABRIGAR AL NIÑO PARA PROTEGERLO DEL FRIO



BAJAR LA FIEBRE CON MEDIOS FISICOS



DARLE ABUNDANTE LIQUIDO



DARLE COMIDA CON MAS FRECUENCIA DE LO ACOSTUMBRADO CUANDO EL NIÑO ESTA ENFERMO Y DURANTE LAS DOS SEMANAS SIGUIENTES DE RECUPERACION



HACIENDO TODO ESTO SE EVITARA QUE EL NIÑO SE COMPLIQUE CON NEUMONIA

**CONTROL DE CUENTA INTERNA**

No.	FECHA	PAGOS	CAPITAL	INTERESES	SALDO	FIRMA TESORERA
<b>SALDO INICIAL</b>						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
<b>TOTALES</b>						

**CICLO**  
**IV**

BANCO COMUNAL: \_\_\_\_\_

NOMBRE DE LA SOCIA: \_\_\_\_\_

COMUNIDAD: \_\_\_\_\_

MONTO DEL PRESTAMO LPS. \_\_\_\_\_

INTERESES A PAGAR LPS. \_\_\_\_\_

COMISION LPS. \_\_\_\_\_

TOTAL LPS. \_\_\_\_\_

CUOTA QUINCENAL  
(INTERESES, COMISION) LPS. \_\_\_\_\_

CUOTA QUINCENAL  
(AHORRO) LPS. \_\_\_\_\_

CUOTA MENSUAL  
(CAPITAL) LPS. \_\_\_\_\_

**PROJECT HOPE**

PROGRAMA  
GENERACION DE INGRESOS  
HONDURAS C.A.

No.	FECHA	PAGOS	CAPITAL	INTERESES	COMISION	SALDO	PROFITO	RETIRO	SALDO	FIRMA TESORERA
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
<b>TOTALES</b>										

**CONTROL CUENTA EXTERNA**

41

# QUE ES LA DESHIDRATACION



CUANDO EL NIÑO TIENE DIARREA PIERDE GRANDES CANTIDADES DE AGUA Y SALES QUE SON NECESARIAS PARA VIVIR A ESTO SE LE LLAMA DESHIDRATACION

LA DIARREA EN EL NIÑO PROVOCA LO SIGUIENTE :

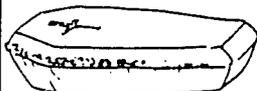
DESHIDRATACION



DESNUTRICION



MUERTE



CUANDO SU NIÑO TENGA DIARREA PONGA EN PRACTICA LOS SIGUIENTES CONSEJOS :

CONTINUE ALIMENTANDOLO NORMALMENTE

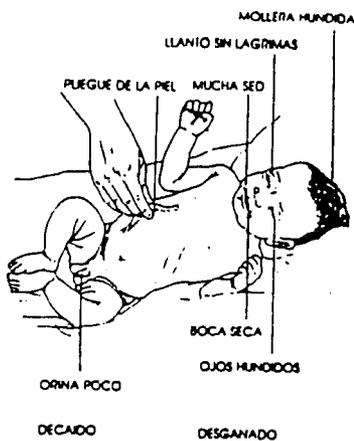


CONTINUE DANDOLE EL PECHO

CUANDO EL NIÑO SE ESTE RECUPERANDO DE LA DIARREA DEJE UNA COMIDA ADICIONAL DIARIA AL MENOS DURANTE DOS SEMANAS



SEÑALES DE LA DESHIDRATACION :



COMO EVITAR QUE EL NIÑO SE DESHIDRATE

EN CUANTO EMPIECE LA DIARREA DEJE ABUNDANTES LIQUIDOS COMO LITROSOL, AGUA DE ARROZ TE DE CANELA, Y TE DE MANZANILLA

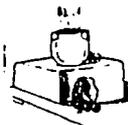


COMO EVITAR LA DIARREA EN EL NIÑO

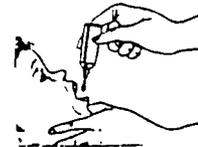
DANIXO LACTANCIA MATERNA EXCLUSIVA DURANTE LOS PRIMEROS 6 MESES DE VIDA



APLICANDO AL NIÑO TODAS LAS VACINAS QUE NECESITA



DANDOLE AGUA Y ALIMENTOS LIMPIOS



LAVANDOSE LAS MANOS ANTES DE TOCAR LOS ALIMENTOS

QUEMANDO O ENTERRANDO LA BASURA



MANTENIENDO LIMPIA LA LETRINA Y USANDO LA ADECUADAMENTE

EN LOS SIGUIENTES CASOS LLEVE INMEDIANTE AL NIÑO AL MEDICO

- SI OBSERVA ALGUNA SEÑAL DE DESHIDRATACION
- SI LA DIARREA PERSISTE POR MAS DE DOS SEMANAS
- SI OBSERVA SANGRE EN LAS HECES

## **D. ECUADOR VILLAGE HEALTH BANKS**

The Ecuador Program situated in Portoviejo, is the first VHB program in Ecuador. Since it has had no other village bank programs in the country to learn with and share experiences, the Ecuador VHB Program has had a more challenging start than Honduras. Despite its rural setting and more complicated economy with 25.78% inflation and 14.3% devaluation, it has achieved the following:

### **A. Health Education**

#### **Achievements:**

All VHB's selected two Health Officers to be a part of the management committee and be in charge of health statistics surveillance (immunization cards, child growth monitoring cards), coordinate creative health education activities, and provide talks on the health theme of each cycle. As of the second cycle the Health Officer is responsible for providing talks and inciting reflection on the child survival issue of that cycle: i.e. in the second cycle maternal health, in the third cycle Acute Respiratory Infection (ARI), in the fourth cycle Diarrhea, and so on. To prepare the health officers for their educational duties, two workshops were held in May 1994 providing training on all child survival issues. A further workshop was held to define the role of the Health Officer.

#### **Integration of Child Survival health education and Credit activity.**

The integration of the two programs is of primary importance for Project Hope since this is a Maternal Child Health activity that has been wed to a village bank approach in order to enlarge the impact of the MCH education.

The Union of the two approaches requires that the staffs of each program coordinate their scheduled activities at the VHB's. In Ecuador, coordination takes extra effort since the Child Survival and Income Generation offices are physically separate. This requires the two teams to make special efforts to be in communication with each other in order for their schedules and activities to blend, i.e. a CS nurse can go to a VHB meeting and help the health officer give a talk on maternal health.

Since the initial target VHB towns have on-going Child Survival activities, the VHB participants have shared in the CS events such as parades, health posts, activities and workshops in each of the towns where they both work (Calceta, 24 de Mayo, Junin, Montecristi, and Portoviejo.)

#### **Concerns**

Training to Health Officers on all Child Survival health messages in two workshops is

overly ambitious. HOPE Center will help them create a streamlined curriculum to reinforce each theme through periodic retrainings.

**B. Credit Provision**

- 1. VHB Implementation**
- 2. Portfolio Systems Design and Management**
- 3. Sustainability Tracking Systems Design and Management**

**1. VHB Implementation**

**Achievements**

Of the twenty banks targeted for inauguration this year, 13 new banks were formed. This reduction was decided on in order to consolidate the existing banks, re-train the management committees, and install community promoters to help the program promoters, before further expansion of the program. Growth without strengthening the staff capacity was seen as unwise.

The 13 new banks increased the membership by 345. Added to previous members, the total program membership is 490 members. In accordance with the DIP, individual credit levels have been allowed to increase by 20% in relation to the amount borrowed in the previous cycle, as long as the members have saved at least 10% of their loan.

To July 20, 1994, 38 VHB loans have been disbursed: 929 individual loans have been disbursed valued at 150,656,000 Sucres. Member savings rise to 14,797,113.18 Sucres. (Please see Ecuador Appendix B for portfolio details).

**VHB Promotion and Monitoring by Promoters** Program promoters perform a series of motivational and pre-credit training to the group before it becomes an official VHB and is inaugurated with the first loan cycle. During the first cycle of a new VHB, staff promoters visit every entrepreneur to verify use of the credit and monitor each VHB meeting so that bookkeeping practices are reinforced in the Management Committee. Also, promoters have the responsibility to execute a financial statement and balance sheet for each VHB meeting so that each bank can track its capitalizing and its payment responsibilities to the Program. (The Management Committees will ultimately be responsible for executing the Financial Statement and Balance Sheet for their VHB.) As the VHB's mature in later cycles, the promoters' visits can taper off, but strict follow up of the financial statement, the bookkeeping practices, and health education are imperative supervisory practices that have to continue.

Preventative measures of retraining Management Committees, slowing down growth, re-enforcing the Promoter staff through a 2nd year training, selecting and hiring community promoters to supplement the staff promoters are being taken in order that

the program grow at a rate consistent with good quality operations.

Priority has been placed on incrementing membership in existing VHB's instead of necessarily having a greater number of small VHB's. As explained in the DIP, geographic coverage of the VHB activity is restricted to areas that are within 40 mins. driving distance of Portoviejo. Other criteria include peri-urban areas with commercial activity. This has forced the VHB program to go to areas not necessarily in CS regions. Given the need to have "control" VHB's for the impact evaluation, this has not presented a problem.

**Internal Cycle and Capitalization of VHB's** Consistent with the DIP, all VHB's have been trained on implementation of the Internal Account, created policies (5% monthly with a maximum of 200,000 in the second cycle and 300,000 in the third cycle), and to understand the importance of this activity. While the internal account allows entrepreneurs access to a higher level of credit to supplement their external account loan, and the VHB its own revenue source of interest income, if improperly managed it can become a source of arrears problems to the VHB and the program.

### Concerns

**Internal Account Management Problems** While the internal account can be the primary source of a VHB's own capital, Ecuador has found various problems with its implementation. First, the management committees work is overloaded when the internal account starts to function. Second, the VHB's are not clear on analyzing the feasibility of the internal of loans they allocate. Furthermore, since internal account loans are for higher levels with shorter intervals, they find the entrepreneur falling into serious and frequent arrears in the interval account payments. Although Internal Account arrears may not directly affect External Account responsibilities, the discipline of village banking hinges on that no arrears (in either account) exist before recapitalization. At one point in March and April 1994, the Ecuador team saw three VHB's persisted with IA and EA arrears, yet recapitalized one of them. In good faith they did not want to bring the enterprises of a whole group to a halting stop therefore the banks closed their loan to the program by using members savings, but the debt remained outstanding to the bank from the delinquent members. So they recapitalized the banks but the discipline of the VHB methodology was compromised. Since then they never recapitalize a group without bringing both balances to a zero. Analysis of the situation has only been done sporadically on an "as needed" basis because there are no formal records of arrears levels from each meeting. As of July 1, 1994 the promoters began tracking internal and external account arrears during each meeting so that they can be properly reported in the FMIS.

Remedial action including studying an escalated method of arrears disciplinary action, investigating with a lawyer what can be done to recover debt, and installing a form for each VHB meeting to track arrears, has been taken. At the second year training,

credit policy revisions may be addressed and training on business feasibility analysis for individual enterprises, will be provided to the staff.

High arrears inside the cycles, lack of solidarity group activities, and lax management procedures were observed by HOPE Center in some VHBs in July. Due to this situation all management committees were retrained in July and August 1994 placing emphasis on the importance of transactions and practices in cash box closing at the end of the meetings. An internal audit of all VHB's was also initiated, in order to acquire better data for the computerized FMIS. This results of this audit will be reviewed by HOPE Center and program meetings in September 1994 and the necessary corrective actions will be taken.

## **2. Portfolio Systems Design and Management**

### **Achievements**

**Financial Management Information System (FMIS)** A computerized FMIS has been put into practice. Using three sources of data (VHB loan application, individual borrowers' loan applications, and bi-monthly VHB financial statements), the Ecuador and Honduras teams created reports to measure: 1. Credit Portfolio status (including volumes, arrears, and VHB capitalization levels), 2. Impact, and 3. Sustainability. The reports that are coming out of the Ecuador program are:

#### **Portfolio**

Historical Summary External Account (**Ecuador Appendix B1**)

Inflows Summary External and Internal Account (**Ecuador Appendix B2**)

Outflows VHB's (**Ecuador Appendix B3**)

Monthly Portfolio Report (**Ecuador Appendix C**)

#### **Impact**

MEMS by hand (**Ecuador Appendix D**)

#### **Sustainability**

Sustainability Report (**Ecuador Appendix E**)

### **Concerns**

**Reliability of Data** Until the internal audit is completed in September, the computerized FMIS can only produce estimated data. This reaffirms the need for Management Committees to be extremely careful and efficient, in order that all VHB books reconcile and financial management practices be transparent, thereby ensuring the trust of participants.

**Administrative Systems** Extensive work has been needed in Ecuador in order to set

up administrative systems that meet the needs of a Financial Services/Health Education Activity. To date the Ecuador IG Program has a tiered structure between the actual VHB operation taking place in Portoviejo and the Director and some administrative work being done in Cuenca. Since January 1994, the Ecuador program has implemented some reforms including: opening a dollars bank account in Portoviejo to receive the credit fund disbursements and therefore keep them separate from operations disbursements from HC; buying a fax for the Portoviejo IG office, hiring an administrator and scheduling an appropriate transfer of administrative duties from Cuenca to Portoviejo.

### **3. Sustainability Tracking Systems**

#### **Achievements**

Sustainability Tracking systems unite **portfolio management and cost-centered management** in order to monitor the growth of the credit enterprise, control costs, and thereby reach the "break-even" point where an "enterprise" covers its costs. Proper tracking of this relies on 1) timely and accurate portfolio reports that interpret loan volumes and program revenue (interest income, commission, and late fines), and 2) timely and accurate pipeline analysis of the operations expenses and credit subsidy provided by the Grant.

To track this cost-centered tracking, systems have been installed in each program. All administrative staff has been trained on reporting expenses according to **institutional development and operations costs**. Once operations costs are divided from institutional development costs, credit capital, and impact evaluation expenses, they are compared to program revenue for that period and a sustainability rate can be derived from these. (Please see **Ecuador Appendix E** for Ecuador's sustainability tracking from August 1993 when the official credit activity began, to the present.)

#### **Concerns**

Given the heavy workload at the Portoviejo office: including the internal audit, the retraining of Management Committees, and the execution of the baseline of the impact evaluation the cost tracking exercise to disaggregate institutional development and operational costs has been temporarily delegated to the Cuenca office. This should only be temporary, because the Portoviejo office needs to master the follow up of costs and calculation of sustainability on its own.

#### **C. Training at all Levels**

##### **1. IG Personnel**

IG Personnel followed up their initial training of April, with:

Financial Management workshop directed by Dr. Cheryl Lassen in October 1993.

Financial information systems, directed by Ing. Jesus Torres and Dr. Cheryl Lassen in Nov. 1993.

Dr. Cheryl Lassen also conducted an on-site evaluation visit in February 1994 and technical assistance on arrears management, FMIS reporting, Sustainability Management, and produced and implemented the PEE Training module of "Laying the Golden Egg - How to Build the Economic Activity that Provides a Livable Wage" for the staff and three VHB's.

## **2. VHB Management Committees.**

The IG personnel provides a 4 day Pre-Credit training to Management Committees to teach VHB bookkeeping practices, roles and duties of each VHB Management Committee member, income generating activities of a VHB including the internal account, and organizational development issues to consolidate a disciplined group. Over time the team has modified and perfected these training modules. In July lax Management Committee practices and the obvious disregard for closing the cash box at the end of the VHB meeting, caused the team to realize that the existing MC's had to be re-trained to re-enforce their rules and duties. Since the cash box was not getting closed due to time constraints, they trained MC members on speeding up their transaction time for each borrower, in order to leave enough time to close the cash box and verify the four methods of recordkeeping: external and internal account books, summary sheet, cash book, and financial statement.

## **3. VHB Member training**

VHB member training includes everything from motivational training to organize a VHB, to training on VHB rules and credit policies, to Popular Economic Education (PEE) training and Child Survival training. Despite the systems development, personnel training and credit capital that could be invested in this model, the root of success or failure lies in the individual entrepreneur's ability to succeed with their loan and eventually apply their revenue sources to the health related activities they learn about in the VHB meetings.

For this reason Popular Economic Education Modules and Health Education Modules are of primary importance. To date the Ecuador Child Survival staff have developed socio-dramas that help illustrate important issues such as breastfeeding, prenatal care, and health surveillance for infants and children. Some of these are practiced by VHB members, and CS nurses or promoters can coordinate with Health Officers to help them develop these educational activities.

To date, no PEE training has been implemented despite the hands-on training provided

for the team in Feb 1994 by Technical Advisor Dr. Lassen. Further PEE training is awaited and a primary need of the participants. All problems in a poverty lending mechanism (arrears, bad business choices, misuse etc.) can be traced back to individual entrepreneur's inability to manage her individual business. Furthermore improved individual management allows them to grow and flourish so that their savings and credit levels do not stagnate.

Difficulties in working with a population that has low reading, writing, and arithmetic skills can be overcome with Popular Economic Education methods explained above.

#### **D. Impact evaluation**

One priority focus for Project HOPE is the assessment of the health impact of its "village health banks" on the health status of mothers and their young children. Because of Project HOPE's mission of "helping people to help themselves" in the area of health, pure poverty lending programs, as implemented by the Grameen Bank and FINCA, do not fall under this mission statement. It is, however, expected that the hybrid model of village banking combined with education in maternal and child health will afford long-term health benefits to the bank members and their young children. To assess this hypothesis, a work group of Project HOPE headquarters staff and faculty of the George Washington University developed an impact assessment model that will compare health knowledge, practices, and coverage levels of Project HOPE's village health bank members (experimental group) to those of two control groups: women and their children participating in village banks without health and women and their children living in the same geographical areas that are exposed to maternal and child health education (see **Appendix F** for the design of this component). Positive results of the "village health banks" on health status is crucial for the continual and expansion of such activities under Project HOPE's mission.

Ecuador initiated the baseline data collection for the impact assessment component on July 14, 1994 and has completed the necessary number of surveys for the experimental group, 96 bank members with children under two and 96 bank members who are women of fertile age.

#### **Concerns**

Because of delays in the development of the impact assessment strategy, some of the baseline data may be positively affected by women's exposure to health information in their passbooks and health education talks given by the health officers.

\$20,000 each has been allocated to the impact assessment component of the Honduras and Ecuador IG project. Because additional staff were hired to conduct the KPC surveys, this amount may not cover the cost of this component for the duration of the project. Project HOPE and the participating faculty from the George

Washington University are committed to identify other sources of funding to successfully complete this activity.

### Variations from plan

#### ONG Meeting

Until the Ecuador activity is further consolidated, it would be premature to hold this meeting. Individual visits by interested parties such as CRS, Ayuda en Accion, Fundacion DONUM and AID/Ecuador Mission have been hosted. However, until some of the current re-training and re-affirming of basic concepts have been accomplished, the Ecuador Program should postpone the hosting of this meeting.

#### Nutrition VHBs

A proposal for Nutrition VHBs was submitted to AID/Washington. Although AID/Ecuador Mission has shown interest in this approach, expansion of the model should wait for further refinement to access another source of funding of the Village Health Bank methodology. Given the VHB Financial management issues that have to be addressed in the Ecuador program, the replication of the model should be delayed.

### Ecuador Annual plan - Sept. 94-Aug. 95

1. Improve monitoring and evaluation of VHBs and individual member's businesses. Continue retraining Management committees in order that they produce the financial statement, shorten transaction times, and reinforce discipline at every VHB. The Second Year Training slated for November 1994 will provide much needed reinforcement of VHB promoter productivity, financial management, and sustainability management training for the promoters to improve their monitoring and evaluation of VHB's .
2. Ensure the adequate recruitment, training, and implementation of Community Promoters before moving to expand.
3. Pending use of Community Promoters, consolidation of VHB Management Committees, and reconciling of books through the internal audit, create 18 new banks with 450 members and increase the number of members at each existing bank. Growth of 1.5 banks per month.
5. Provide PEE training to IG staff and VHB members for better management of their business.
6. Improve training in popular health education techniques to Health Officers.

Monitor health surveillance to be performed by Health Officers.

7. Continue slow shift of accounting responsibility for IG program to Portoviejo, in order that the IG program have complete responsibility for sustainability tracking.

8. Finish the FMIS system.

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**ECUADOR-INCOME GENERATION (IG)**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	393,227	105,877	287,350
Travel	119,197	30,284	88,913
Credit Funds	416,195	8,574	407,621
Other Direct Costs	189,762	35,670	154,092
Procurement Costs:			
Supplies/Equipment	79,750	62,228	17,522
Services	35,167	20,086	15,081
Evaluation	139,040	0	139,040
Indirect Costs	217,649	58,977	158,672
<b>GRAND TOTAL</b>	<b>1,589,987</b>	<b>321,696</b>	<b>1,268,291</b>

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MATCHING GRANT ANNUAL REPORT

SEPTEMBER 1, 1993 - AUGUST 31, 1994

BUDGET NOTES

COOPERATIVE AGREEMENT NO: FAO-0158-A-002071-00

This note is to formally document the budget reallocation that was made from the Swaziland MCH/AIDS program to the Guatemala MCH project and to the Village Health banks in Honduras and Ecuador. These changes were made at the time of the first annual report of the above referenced cooperative agreement.

The net effect of the change was to transfer \$70,000 dollars from the Swaziland MCH/AIDS project to the following projects:

Guatemala MCH for the purpose of developing an income generation strategy	\$30,000.
Honduras/Ecuador Village Health Bank project for a monitoring and evaluation strategy	<u>\$40,000</u>
Total transferred	\$70,000

These changes are reflected in the budget reports included in this annual report.



RESUMEN HISTORICO DE LOS BANCOS COMUNALES  
 CUENTA EXTERNA

NOMBRE DEL BANCO	SOCIAS	CICLO		MONTO PRESTADO	INTERES	COMISION
		#	INICIO FIN			
BANKIA AUXILIADORA	19	1	04/08/93 02/12/93	2,850,000.00	570,000.00	28,500.00
	26	2	26/11/93 26/03/94	3,427,000.00	685,400.00	34,270.00
	22	3	25/03/94 23/07/94	4,394,000.00	878,800.00	43,940.00
PROMEDIO:	22		TOTALES:	10,671,000.00	2,134,200.00	106,710.00
BANKIA UNIDAS	31	1	05/08/93 03/12/93	4,650,000.00	930,000.00	46,500.00
	31	2	30/11/93 30/03/94	5,354,000.00	1,070,800.00	53,540.00
	49	3	29/03/94 27/07/94	9,338,000.00	1,867,600.00	93,380.00
PROMEDIO:	37		TOTALES:	19,342,000.00	3,868,400.00	193,420.00
BANKIA ANZANA Y PROGRESO	17	1	17/08/93 15/12/93	2,550,000.00	510,000.00	25,500.00
	23	2	09/12/93 08/04/94	3,543,000.00	708,600.00	35,430.00
	33	3	08/04/94 06/08/94	4,664,000.00	932,800.00	46,640.00
PROMEDIO:	24		TOTALES:	10,757,000.00	2,151,400.00	107,570.00
BANKIA MONSERRATE	19	1	19/08/93 17/12/93	2,850,000.00	570,000.00	28,500.00
	26	2	17/12/93 16/04/94	4,238,000.00	847,600.00	42,380.00
	28	3	06/06/94 04/10/94	4,841,000.00	968,200.00	48,410.00
PROMEDIO:	24		TOTALES:	11,929,000.00	2,385,800.00	119,290.00
BANKIA ANZANA Y PROGRESO	23	1	23/09/93 21/01/94	3,350,000.00	670,000.00	33,500.00
	24	2	18/01/94 18/05/94	2,731,000.00	546,200.00	27,310.00
PROMEDIO:	24		TOTALES:	6,081,000.00	1,216,200.00	60,810.00
BANKIA GEMA	22	1	27/09/93 25/01/94	3,300,000.00	660,000.00	33,000.00
	19	2	24/01/94 24/05/94	3,099,000.00	619,800.00	30,990.00
PROMEDIO:	21		TOTALES:	6,399,000.00	1,279,800.00	63,990.00
BANKIA ANZANA Y DESARROLLO	34	1	01/10/93 29/01/94	5,100,000.00	1,020,000.00	51,000.00
	25	2	17/02/94 17/06/94	3,605,000.00	721,000.00	36,050.00
PROMEDIO:	30		TOTALES:	8,705,000.00	1,741,000.00	87,050.00
BANKIA EL FUTURO DE LA	26	1	18/11/93 18/03/94	3,750,000.00	750,000.00	37,500.00
	26	2	16/03/94 14/07/94	2,895,000.00	579,000.00	28,950.00
PROMEDIO:	26		TOTALES:	6,645,000.00	1,329,000.00	66,450.00
BANKIA NUEVA UNION	20	1	19/11/93 19/03/94	2,850,000.00	570,000.00	28,500.00
	18	2	31/03/94 29/07/94	2,811,000.00	562,200.00	28,110.00
PROMEDIO:	19		TOTALES:	5,661,000.00	1,132,200.00	56,610.00
BANKIA INGRESO PARA EL FUT	25	1	19/11/93 19/03/94	3,450,000.00	690,000.00	34,500.00
	18	2	12/04/94 10/08/94	2,903,000.00	580,600.00	29,030.00

RESUMEN HISTORICO DE LOS BANCOS COMUNALES  
CUENTA EXTERNA

NOMBRE DEL BANCO	SOCIAS	CICLO		MONTO PRESTADO	INTERES	COMISION
		#	INICIO FIN			
PROMEDIO:	22		TOTALES:	6,353,000.00	1,270,600.00	63,530.00
ROGRESO	31	1	19/11/93 19/03/94	4,650,000.00	930,000.00	46,500.00
	32	2	23/03/94 21/07/94	4,788,000.00	957,600.00	47,880.00
PROMEDIO:	32		TOTALES:	9,438,000.00	1,887,600.00	94,380.00
ES P' FUTURO MEJ	24	1	22/02/94 22/06/94	3,450,000.00	690,000.00	34,500.00
PROMEDIO:	24		TOTALES:	3,450,000.00	690,000.00	34,500.00
RACION DE LA MUJ	22	1	22/02/94 22/06/94	3,000,000.00	600,000.00	30,000.00
PROMEDIO:	22		TOTALES:	3,000,000.00	600,000.00	30,000.00
AS POR LA SUPERA	21	1	06/05/94 03/09/94	3,000,000.00	600,000.00	30,000.00
PROMEDIO:	21		TOTALES:	3,000,000.00	600,000.00	30,000.00
ACION HACE LA FUE	31	1	16/05/94 13/09/94	4,350,000.00	870,000.00	43,500.00
PROMEDIO:	31		TOTALES:	4,350,000.00	870,000.00	43,500.00

COD	NOMBRE DEL BANCO	CICLO	ENTRADAS DE CUENTA EXTERNA			ENTRADAS DE CUENTA INTERNA					
			CAPITAL	INTERES	COMISION	CAPITAL	INTERES	MORA	MULTAS	AHORROS	GANANCIAS
1	MARIA AUXILIADORA	1	2,850,000.00	566,250.00	28,306.50	0.00	0.00	0.00	10,000.00	649,691.50	125,935.00
		2	3,427,000.00	685,400.00	34,164.25	3,846,905.00	350,995.00	30,025.00	6,500.00	672,949.73	135,672.00
		3	3,188,000.00	659,100.00	32,958.00	2,458,885.00	330,315.00	400.00	3,500.00	552,792.00	62,382.00
		TOTAL	9,465,000.00	1,910,750.00	95,428.75	6,305,790.00	681,310.00	30,425.00	20,000.00	1,875,433.23	323,989.00
2	MADRES UNIDAS	1	4,588,687.50	930,000.00	46,500.00	0.00	0.00	0.00	0.00	702,450.50	34,239.90
		2	5,359,448.00	1,066,250.00	52,642.00	5,411,700.00	533,439.00	0.00	4,000.00	1,001,463.00	149,403.33
		3	4,621,122.00	933,750.00	46,720.00	464,000.00	233,250.00	0.00	0.00	880,078.00	116,064.88
		TOTAL	14,569,257.50	2,930,000.00	145,862.00	5,875,700.00	766,689.00	0.00	4,000.00	2,583,991.50	299,708.11
3	ESPERANZA Y PROGRESO	1	2,550,036.00	510,000.00	25,499.50	0.00	0.00	0.00	4,500.00	468,806.50	54,461.10
		TOTAL	2,550,036.00	510,000.00	25,499.50	0.00	0.00	0.00	4,500.00	468,806.50	54,461.10
4	MARIA MONSERRATE	1	2,850,000.00	570,000.00	28,500.00	0.00	0.00	0.00	7,000.00	727,992.50	34,110.08
		2	4,336,544.64	914,248.00	45,446.00	3,554,001.18	322,554.00	105,122.60	3,500.00	944,008.02	139,042.81
		TOTAL	7,186,544.64	1,484,248.00	73,946.00	3,554,001.18	322,554.00	105,122.60	10,500.00	1,672,000.52	173,152.89
5	UNION Y PROGRESO	1	3,350,000.00	670,000.00	33,500.00	0.00	0.00	0.00	6,400.00	493,243.50	214,912.00
		2	1,235,085.00	323,650.00	16,182.50	766,228.00	102,500.00	560.00	6,100.00	303,169.61	183,738.00
		TOTAL	4,585,085.00	993,650.00	49,682.50	766,228.00	102,500.00	560.00	12,500.00	796,413.11	398,650.00
6	SANTA GEMA	1	3,300,000.00	660,000.00	33,000.00	0.00	0.00	0.00	10,050.00	378,920.70	131,395.00
		2	1,065,988.88	379,100.00	18,967.00	969,884.64	223,356.00	69,188.00	0.00	222,708.84	30,538.00

08/07/94

Programa Generacion de Ingresos  
Reporte en SUCRES

COD	NOMBRE DEL BANCO	CICLO	ENTRADAS DE CUENTA EXTERNA			ENTRADAS DE CUENTA INTERNA					
			CAPITAL	INTERES	COMISION	CAPITAL	INTERES	MORA	MULTAS	AHORROS	GANANCIAS
	TOTAL		4,365,988.88	1,039,100.00	51,967.00	969,884.64	223,356.00	69,188.00	10,050.00	601,629.54	161,933.00
8	PARA EL FUTURO DE LA	1	3,750,000.00	750,000.00	37,500.00	0.00	0.00	0.00	9,500.00	601,785.00	206,609.00
		2	2,149,525.00	499,625.00	24,983.00	2,908,746.00	317,994.00	0.00	2,500.00	549,406.00	133,692.00
	TOTAL		5,899,525.00	1,249,625.00	62,483.00	2,908,746.00	317,994.00	0.00	12,000.00	1,151,191.00	340,301.00
9	LA NUEVA UNION	1	2,357,002.00	551,250.00	28,312.50	0.00	0.00	30,819.00	18,000.00	399,177.80	110,019.00
	TOTAL		2,357,002.00	551,250.00	28,312.50	0.00	0.00	30,819.00	18,000.00	399,177.80	110,019.00
10	PROGRESO PARA EL FUT	1	2,916,146.88	637,500.00	31,875.00	0.00	0.00	1,797.50	14,000.00	477,712.00	111,145.00
	TOTAL		2,916,146.88	637,500.00	31,875.00	0.00	0.00	1,797.50	14,000.00	477,712.00	111,145.00
12	MADRES P' FUTURO MEJ	1	3,450,000.00	690,000.00	30,605.00	63,700.00	0.00	0.00	1,500.00	436,959.00	194,989.00
	TOTAL		3,450,000.00	690,000.00	30,605.00	63,700.00	0.00	0.00	1,500.00	436,959.00	194,989.00
13	SUPERACION DE LA MUJ	1	2,195,682.00	517,500.00	25,944.00	0.00	0.00	0.00	0.00	431,463.00	48,900.00
	TOTAL		2,195,682.00	517,500.00	25,944.00	0.00	0.00	0.00	0.00	431,463.00	48,900.00
14	8 DE NOVIEMBRE	1	450,000.00	97,500.00	4,888.00	0.00	0.00	0.00	0.00	88,612.00	12,500.00
	TOTAL		450,000.00	97,500.00	4,888.00	0.00	0.00	0.00	0.00	88,612.00	12,500.00
15	UNIDAS POR LA SUPERA	1	862,500.00	210,000.00	10,528.00	0.00	0.00	0.00	2,000.00	205,174.50	45,831.00

08/07/94

AV

Programa Generación de Ingresos  
Reporte en SUCRES

COD	NOMBRE DEL BANCO	CICLO	ENTRADAS DE CUENTA EXTERNA			ENTRADAS DE CUENTA INTERNA						
			CAPITAL	INTERES	COMISION	CAPITAL	INTERES	MORA	MULTAS	AHORROS	GANANCIAS	REC.
	TOTAL		862,500.00	210,000.00	10,528.00	0.00	0.00	0.00	2,000.00	205,174.50	45,831.00	
16	LA UNION HACE LA FUE	1	1,005,461.00	213,750.00	10,716.00	0.00	0.00	0.00	0.00	235,188.00	35,628.00	
	TOTAL		1,005,461.00	213,750.00	10,716.00	0.00	0.00	0.00	0.00	235,188.00	35,628.00	

08/07/94



Programa Generación de Ingresos  
Reporte en SUCRES

COD	NOMBRE DEL BANCO	CICLO	PRESTAMOS CI	RET.AHARR.SOC.	RET.AHO.NO SOC	PAGOS A HOPE	PAGOS A PFOMOT	GASTOS ADMINIS	PAG.CTA.INCOBR	COMPRA	INVENTA	COMPRA	ACT.FIJI
1	MARIA AUXILIADORA	1	0.00	9,937.50	0.00	3,448,500.00	0.00	31,016.50	0.00	0.00	0.00	0.00	0.00
		2	3,895,000.00	0.00	0.00	4,146,670.00	0.00	56,871.00	0.00	0.00	0.00	0.00	0.00
		3	5,803,000.00	15,000.00	0.00	0.00	0.00	36,950.00	0.00	0.00	0.00	0.00	0.00
		TOTALES:	9,698,000.00	24,937.50	0.00	7,595,170.00	0.00	124,837.50	0.00	0.00	0.00	0.00	0.00
2	MADRES UNIDAS	1	0.00	61,312.50	0.00	5,626,500.00	0.00	33,200.00	0.00	0.00	0.00	0.00	0.00
		2	5,411,700.00	26,378.00	0.00	6,478,340.00	0.00	43,564.00	0.00	0.00	0.00	0.00	0.00
		3	9,575,000.00	0.00	0.00	0.00	0.00	14,440.00	0.00	0.00	0.00	0.00	0.00
		TOTALES:	14,986,700.00	87,690.50	0.00	12,104,840.00	0.00	91,204.00	0.00	0.00	0.00	0.00	0.00
3	ESPERANZA Y PROGRESO	1	0.00	0.00	0.00	3,085,500.00	0.00	14,800.00	8,600.00	0.00	0.00	0.00	
		TOTALES:	0.00	0.00	0.00	3,085,500.00	0.00	14,800.00	8,600.00	0.00	0.00	0.00	
4	MARIA MONSERRATE	1	0.00	254,065.00	0.00	3,448,500.00	0.00	6,000.00	0.00	0.00	0.00	0.00	
		2	4,581,500.00	487,174.62	0.00	5,135,900.00	0.00	54,500.00	0.00	0.00	0.00	0.00	
		TOTALES:	4,581,500.00	741,239.62	0.00	8,584,400.00	0.00	60,500.00	0.00	0.00	0.00	0.00	
5	UNION Y PROGRESO	1	0.00	40,507.50	0.00	4,053,500.00	0.00	15,740.00	0.00	0.00	0.00	0.00	
		2	2,880,000.00	0.00	0.00	0.00	0.00	78,000.00	0.00	0.00	0.00		
		TOTALES:	2,880,000.00	40,507.50	0.00	4,053,500.00	0.00	93,740.00	0.00	0.00	0.00		
6	SANTA GEMA	1	0.00	52,349.50	0.00	3,993,000.00	0.00	28,800.00	0.00	0.00	0.00	0.00	
		2	1,580,000.00	8,990.00	0.00	0.00	0.00	32,400.00	0.00	0.00	0.00		
		TOTALES:	1,580,000.00	61,339.50	0.00	3,993,000.00	0.00	61,200.00	0.00	0.00	0.00		
8	PARA EL FUTURO DE LA	1	0.00	6,500.00	0.00	4,537,500.00	0.00	30,800.00	0.00	0.00	0.00	0.00	
		2	3,171,000.00	159,225.00	0.00	0.00	0.00	41,450.00	0.00	0.00	0.00		
		TOTALES:	3,171,000.00	165,725.00	0.00	4,537,500.00	0.00	72,250.00	0.00	0.00	0.00		
9	LA NUEVA UNION	1	0.00	42,857.00	0.00	3,448,500.00	0.00	15,200.00	0.00	0.00	0.00		
		TOTALES:	0.00	42,857.00	0.00	3,448,500.00	0.00	15,200.00	0.00	0.00	0.00		
10	PROGRESO PARA EL FUT	1	0.00	55,000.00	0.00	4,177,480.00	0.00	17,000.00	0.00	0.00	0.00		

	TOTALES:	0.00	55,000.00	0.00	4,177,480.00	0.00	17,000.00	0.00	0.00	0.00
12 MADRES P' FUTURO MEJ	1	0.00	18,500.00	0.00	4,174,500.00	0.00	55,000.00	0.00	0.00	0.00
	TOTALES:	0.00	18,500.00	0.00	4,174,500.00	0.00	55,000.00	0.00	0.00	0.00
13 SUPERACION DE LA MUJ	1	0.00	19,500.00	0.00	0.00	0.00	41,500.00	0.00	0.00	0.00
	TOTALES:	0.00	19,500.00	0.00	0.00	0.00	41,500.00	0.00	0.00	0.00
14 8 DE NOVIEMBRE	1	0.00	0.00	0.00	0.00	0.00	11,200.00	0.00	0.00	0.00
	TOTALES:	0.00	0.00	0.00	0.00	0.00	11,200.00	0.00	0.00	0.00
15 UNIDAS POR LA SUPERA	1	0.00	2,000.00	0.00	0.00	0.00	28,500.00	0.00	0.00	0.00

Programa Generación de Ingresos  
 Reporte en SUCRES

COD	NOMBRE DEL BANCO	CICLO	PRESTAMOS CI	RET.AHORR.SOC.	RET.AHO.NO SOC	PAGOS A HOPE	PAGOS A PROMOT	GASTOS ADMINIS	PAG.CTA.INCOBR	COMPRA INVENTA	COMPRA ACT.FIJ
		TOTALES:	0.00	2,000.00	0.00	0.00	0.00	28,500.00	0.00	0.00	0.00
16	LA UNION HACE LA FUE	1	0.00	0.00	0.00	0.00	0.00	12,300.00	0.00	0.00	0.00
		TOTALES:	0.00	0.00	0.00	0.00	0.00	12,300.00	0.00	0.00	0.00

9/6

2008

REPORTE MENSUAL DE LA CARTERA

A. Número de Bancos	Período 1	Período 2	Período 3	Período 4	Período 5	Período 6
	Ago 1-Dic 20	Dic 21-Abr 20	Abr 21-May 20	May 21-Jun 20	Jun 21-Jun 3	Ji 1-Jul 20
1. Número de bancos al inicio del período	0	11	13	17	17	17
2. Número de nuevos bancos este período	11	2	4	0	0	0
3. Número de bancos disueltos este período	0	0	0	0	0	0
4. Total de bancos al final del período (1+2-3)	11	13	17	17	17	17

B. Número de Miembros	Período 1	Período 2	Período 3	Período 4	Período 5	Período 6
	Ago 1-Dic 20	Dic 21-Abr 20	Abr 21-May 20	May 21-Jun 20	Jun 21-Jun 3	Ji 1-Jul 20
1. Total de Miembros al Inicio del Período	0	255	343	470	470	481
2. Número de miembros nuevos este período	300	97	129	0	12	9
3. Número de miembros retirados este período	45	9	2	0	1	0
4. Total de miembros al final del período (1+2-3)	255	343	470	470	481	490
5. Porcentaje de Mujeres	100%	100%	100%	100%	100%	100%

C. Desembolzos	Período 1	Período 2	Período 3	Período 4	Período 5	Período 6
	Ago 1-Dic 20	Dic 21-Abr 20	Abr 21-May 20	May 21-Jun 20	Jun 21-Jun 3	Ji 1-Jul 20
1. Número préstamos iniciales (primer préstamo) este período	263	44	116	0	0	0
2. Número de segundos o más préstamos este período (préstamo #2, #3, ...)	99	233	30	28	84	32
3. Total de préstamos este período (1+2)	362	277	146	28	84	32
4. Monto en préstamos iniciales del período	20.160,53	3.071,43	8.048,11	0,00	0,00	0,00
5. Monto en segundos o más préstamos en el período (préstamo #2, #3, ...)	8.207,14	19.521,69	2.458,83	2.225,75	6.254,57	2.665,45
6. Monto Total prestado en este período (4+5)	28.367,67	22.593,12	10.506,94	2.225,75	6.254,57	2.665,45
7. Tamaño promedio de préstamo a socias nuevas (4/1)	76,66	69,81	69,38	0,00	0,00	0,00
8. Tamaño promedio de préstamo a socias antiguas (5/2)	82,90	83,78	81,96	79,49	74,46	83,30
9. Tamaño promedio de préstamos en total (6/3)	78,36	81,55	71,97	79,49	74,46	83,30

D. Portafolio Cuenta Externa	Período 1	Período 2	Período 3	Período 4	Período 5	Período 6
	Ago 1-Dic 20	Dic 21-Abr 20	Abr 21-May 20	May 21-Jun 20	Jun 21-Jun 3	Ji 1-Jul 20
1. Balance de préstamos no recuperados al inicio del período	0,00	21.975,20	24.063,71	33.303,99	31.068,13	5.745,92
2. Cantidad de dinero desembolzada este período (c6)	28.367,67	22.593,12	10.506,94	2.225,75	6.254,57	2.665,45
3. Cantidad de dinero recuperado este período (solo capital)	6.392,47	20.504,61	1.266,66	4.461,61	1.576,78	2.611,44
4. Nuevo balance de préstamos no recuperados al final del período (1+2-3)	21.975,20	24.063,71	33.303,99	31.068,13	35.745,92	5.799,93
5. Saldo Chequera (sucres)	343,80	5.535,78	4.108,57	1.169,44	484,04	2.077,77
6. Subtotal Cartera Sucres (4+5)	22.324,00	29.699,49	37.412,56	32.237,57	36.229,96	7.877,70
7. Balance reconciliado en cuenta \$ al inicio del período						
8. Total transferencias HOPE/Center a Cuenta Crédito \$						
9. Total transferencias Cuenta Crédito \$ - Cuenta crédito sucres		21.066,67	3.500,00	5.000,00	0,00	2.658,00
10. Nuevo balance en la cuenta de capital dólares (7+8-9)	0,00	21.066,67	3.500,00	5.000,00	0,00	2.658,00
11. Subtotal Cartera \$ (Saldo de Chequera \$ al final del período)						
12. Total Cartera (d6+d11)	22.324,00	29.699,49	37.412,56	32.237,57	36.229,96	7.877,70

Ecuador VHB  
 Appendix C  
 "Monthly Portfolio Report"

Aug. 17 1994 05:25PM P04  
 Proyecto HOPE-GI  
 PHONE NO. : 632550

**E. Morosidad Cuenta Externa**

1. Número de bancos con morosidad al inicio del período	0	0	1	0	0	0
2. Número de bancos con morosidad este período	0	3	0	1	0	0
3. Número de pagos sobre morosidad este período	0	2	1	1	0	0
4. Número de bancos con morosidad al final del período (1+2-3)	0	1	0	0	0	0
5. Monto total de Morosidad al inicio del período	0,00	0,00	3,48	3,00	0,00	0,00
6. Monto total de Morosidad este período	0,00	136,07	0,00	34,85	0,00	0,00
7. Monto total de pagos sobre cuentas morosas este período	0,00	132,59	3,48	34,85	0,00	0,00
8. Nuevo monto total de morosidad al final del período (5+6-7)	0,00	3,48	0,00	3,00	0,00	0,00
9. Monto total de morosidad sobre el ciclo						

**F. Portafolio Cuenta Interna**

1. Balance de préstamos no recuperados al inicio del período	0,00	1.164,52	7.238,41	11.226,95	12.311,08	13.395,21
2. Cantidad de dinero desembolsada este período	1.164,52	13.705,95	6.713,23	4.101,35	4.101,35	3.654,46
3. Cantidad de dinero recuperado este período	0,00	7.532,06	2.724,69	3.017,22	3.017,22	11.492,48
4. Nuevo balance de préstamos no recuperados al final del período (1+2-3)	1.164,52	7.238,41	11.226,95	12.311,08	13.395,21	5.557,19

**G. Morosidad Cuenta Interna**

1. Número de bancos con morosidad al inicio del período						
2. Número de bancos con morosidad este período						
3. Número de pagos sobre morosidad este período						
4. Número de bancos con morosidad al final del período (1+2-3)	0	0	0	0	0	0
5. Monto total de Morosidad al inicio del período						
6. Monto total de Morosidad este período						
7. Monto total de pagos sobre cuentas morosas este período						
8. Nuevo monto total de morosidad al final del período (5+6-7)	0,00	0,00	0,00	0,00	0,00	0,00
9. Monto total de morosidad sobre el ciclo						

**H. Ahorros**

1. Balance al inicio del período	0,00	1.981,05	4.410,56	5.249,31	6.115,94	6.459,16
2. Monto de nuevos ahorros este período	2.145,48	3.165,05	989,61	1.057,53	478,66	855,83
3. Retiros de ahorros este período	164,43	735,54	150,86	190,90	135,44	217,88
4. Nuevo balance de ahorros al final del período (1+2-3)	1.981,05	4.410,56	5.249,31	6.115,94	6.459,16	7.097,11

**I. Costo por Sucre/Dólar prestado**

1. Gastos Operacionales en el período	27.667,52	22.048,14	4.825,85	5.817,64	4.107,77	2.494,28
2. Monto desembolsado este período (d2)	28.367,67	22.593,12	10.506,94	2.225,75	6.254,57	2.665,45
3. Costo por Sucre/Dólar prestado (1/2)	0,98	0,93	0,46	2,61	0,66	0,94

**J. Autosuficiencia**

1. Inter. comis. ganadas y mora sobre los préstamos este período	1.342,42	4.312,13	265,46	938,32	351,13	548,40
2. Gastos operacionales en el período	27.667,52	22.048,14	4.825,85	5.817,64	4.107,77	2.494,28
3. Porcentaje de autosuficiencia (1/2)	4,85%	19,56%	5,50%	16,13%	8,06%	21,99%

REPORTE MEMS

	P5	P6
	Jun 21-Jun 30	Jul 1-Jul 20
	Ecuador	Ecuador
1 Nombre del País		
2 Tasa de cambio este período		
3 # bancos acumulados hasta la fecha	17	17
4 # miembros acumulados hasta la fecha	481	490
5 # prestatarías acumuladas		
6 Porcentaje de miembros que son mujeres	100%	100%
7 # préstamos a empresas comunitarias	0	0
8 Valor de préstamos a empresas comunitarias	0	0
9 # préstamos individuales de cuenta externa este período	84	32
10 # préstamos individuales de cuenta interna este período	NO DATOS	NO DATOS
11 Valor de la cartera de CE prestada a individuos este período	6.254,57	2.665,54
12 Valor de la cartera de CI prestada a individuos este período	1.534,73	3.654,46
13 # acumulado de préstamos de cuenta externa individuales	897	929
14 Número acumulado de préstamos de cuenta interna individuales	NO DATOS	NO DATOS
15 Valor acumulado de préstamos de cuenta externa individuales	69.948,05	72.613,59
16 Valor acumulado de préstamos de cuenta interna individuales	27.219,78	30.874,24
17 Tamaño promedio de préstamos individuales de cuenta externa acumulado	77,98	78,16
Tamaño promedio de préstamos individuales de cuenta interna acumulado	NO DATOS	NO DATOS
18 Tamaño promedio de préstamos individuales de cuenta externa este período	74,46	83,30
Tamaño promedio de préstamos individuales de cuenta interna este período	NO DATOS	NO DATOS
19 Porcentaje de autosostenibilidad acumulada a la fecha	11,15%	11,56%
Ingresos acumulados a la fecha	7.191,02	7.739,42
Relación a gastos operacionales acumuladas	54.465,92	66.961,20
20 Cantidad de ahorro a la fecha (ahorros acumulados-retiros acumulados)	6.459,16	7.097,11
21 Promedio de ahorros por socia	13,43	14,48
Ahorros a la fecha (22)	6.459,16	7.097,11
Número de socias a la fecha	481	490
22 Capital propio de los bancos comunales acumulados	NO DATOS	NO DATOS
23 Tasa de Interés por ciclo	20%	20%
24 Tasa de comisión por ciclo	1%	1%
25 Cantidad (porcentaje) de préstamos en		
Comercio General	NO DATOS	NO DATOS
Comercio Agrícola	NO DATOS	NO DATOS
Animales	NO DATOS	NO DATOS
Artesanías	NO DATOS	NO DATOS
Alimentos	NO DATOS	NO DATOS
Fabricación/Producción	NO DATOS	NO DATOS
Servicios	NO DATOS	NO DATOS

Ecuador VHB  
Appendix D  
"Impact of MEMS"

REPORTE MEMS

	P1	P2	P3	P4
	Ago 1 Dic 20	Dic 21-Abr 20	Abr 21 May 20	May 21 Jun 20
	Ecuador	Ecuador	Ecuador	Ecuador
1 Nombre del País				
2 Tasa de cambio este período				
3 # bancos acumulados hasta la fecha	11	13	17	17
4 # miembros acumulados hasta la fecha	255	343	470	470
5 # prestatarías acumuladas				
6 Porcentaje de miembros que son mujeres	100%	100%	100%	100%
7 # préstamos a empresas comunitarias	0	0	0	0
8 Valor de préstamos a empresas comunitarias	0	0	0	0
9 # préstamos individuales de cuenta externa este período	362	277	146	28
10 # préstamos individuales de cuenta interna este período	NO DATOS	NO DATOS	NO DATOS	NO DATOS
11 Valor de la cartera de CE prestada a individuos este período	28.367,67	22.593,12	10.506,94	2.225,75
12 Valor de la cartera de CI prestada a individuos este período	1.164,52	13.705,95	6.713,23	4.101,35
13 # acumulado de préstamos de cuenta externa individuales	362	639	785	813
14 Número acumulado de préstamos de cuenta interna individuales	NO DATOS	NO DATOS	NO DATOS	NO DATOS
15 Valor acumulado de préstamos de cuenta externa individuales	28.367,67	50.960,79	61.467,73	63.693,48
16 Valor acumulado de préstamos de cuenta interna individuales	1.164,52	14.870,47	21.583,70	25.685,05
17 Tamaño promedio de préstamos individuales de cuenta externa acumulado	78,36	79,75	78,30	78,34
Tamaño promedio de préstamos individuales de cuenta interna acumulado	NO DATOS	NO DATOS	NO DATOS	NO DATOS
18 Tamaño promedio de préstamos individuales de cuenta externa este período	78,36	81,56	71,97	79,49
Tamaño promedio de préstamos individuales de cuenta interna este período	NO DATOS	NO DATOS	NO DATOS	NO DATOS
19 Porcentaje de autosostenibilidad acumulada a la fecha	4,85%	11,37%	10,85%	11,36%
Ingresos acumulados a la fecha	1.342,42	5.654,60	5.920,06	6.858,38
Relación a gastos operacionales acumuladas	27.667,52	49.715,66	54.541,51	60.359,15
20 Cantidad de ahorro a la fecha (ahorros acumulados-retiros acumulados)	1.981,05	4.410,56	5.249,31	6.115,94
21 Promedio de ahorros por socia	7,77	12,86	11,17	13,01
Ahorros a la fecha (22)	1.981,05	4.410,56	5.249,31	6.115,94
Número de socias a la fecha	255	343	470	470
22 Capital propio de los bancos comunales acumulados	NO DATOS	NO DATOS	NO DATOS	NO DATOS
23 Tasa de Interés por ciclo	20%	20%	20%	20%
24 Tasa de comisión por ciclo	1%	1%	1%	1%
25 Cantidad (porcentaje) de préstamos en				
Comercio General	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Comercio Agrícola	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Animales	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Artesanías	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Alimentos	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Fabricación/Producción	NO DATOS	NO DATOS	NO DATOS	NO DATOS
Servicios	NO DATOS	NO DATOS	NO DATOS	NO DATOS

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NIVEL DE SOSTENIBILIDAD

	Período 1		Período 2		Período 3	
	Ago/1-Dic/20		Dic/21-Abr/20		Abr/21-May/20	
	Sucres	Dólares	Sucres	Dólares	Sucres	Dólares
Número Bancos	11		13		17	
Número Bancos Nuevos	11		2		4	
Número Bancos Desembolzados	11		12		5	
Número Total de Prestamos a socias	362		277		146	
Volumen	55.912.000	28.367,67	47.678.000	22.593,12	22.716.000	10.506,94
Capital Nuevo	41.037.000	21.066,67	7.168.000	3.500,00	10.800.000	5.000,00
Deuda Incobrable	0	0,00	288.480	136,06	7.519	3,48
Ingresos por Intereses	2.580.000	1.278,50	8.602.400	4.101,63	546.200	252,64
Ingresos por comisión	129.000	63,92	430.120	205,07	27.310	12,63
Ingresos de Prestamos Grupales	0	0,00	0	0,00	0	0,00
Otros Ingresos	0	0,00	11.599	5,48	401	0,19

<b>Total Ingresos</b>	<b>2.709.000</b>	<b>1.342,42</b>	<b>9.044.119</b>	<b>4.312,18</b>	<b>573.911</b>	<b>265,46</b>
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**Total Ingresos del año en dolares**

**Gastos Operativos**

Serie 70 (Salarios)	32.296.357	14.336,77	25.060.256	12.055,44	6.121.011	2.831,18
Serie 76	2.740.265	1.399,18	3.017.221	1.468,53	254.999	119,27
Serie 78	2.363.207	1.139,26	2.553.563	1.210,46	929.487	429,92
Serie 80	39.997	19,82	300.901	145,76	0	0,00
Serie 82	360.750	183,66	433.226	206,87	101.744	47,06
Serie 86	108.907	55,32	91.958	44,31	35.154	16,26
Serie 87	363.247	182,36	330.338	158,35	145.654	67,37
Serie 88 (Vehiculos)	9.655.251	4.885,83	5.474.294	2.632,84	1.316.701	609,02
Serie 8823 (Viaticos Localca)	8.801.561	4.465,91	3.971.133	1.891,88	896.408	414,62
Serie 90 (Telefonos)	1.850.000	919,60	4.650.977	2.217,19	615.975	284,91
Serie 96 (Cargos del Banco)	58.827	29,81	34.274	16,31	13.491	6,24

<b>Total Gastos Operacionales</b>	<b>58.638.367,73</b>	<b>27.667,52</b>	<b>45.917.742,45</b>	<b>22.048,14</b>	<b>10.430.625,22</b>	<b>4.825,85</b>
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**Total Gastos Operacionales al año en dolares**

<b>Perdida o Ganancia</b>	<b>(58.929.367,73)</b>	<b>(26.325,10)</b>	<b>(36.873.623,45)</b>	<b>(17.735,96)</b>	<b>(9.856.714,22)</b>	<b>(4.560,39)</b>
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<b>Nivel de Sostenibilidad</b>	<b>4,62%</b>	<b>4,85%</b>	<b>19,73%</b>	<b>19,56%</b>	<b>5,50%</b>	<b>5,50%</b>
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**Nivel de Sostenibilidad al año en dolares**

Ecuador VHB  
 Appendix E  
 "Sustainability Report"

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NIVEL DE SOSTENIBILIDAD

	Período 4		Período 5		Período 6	
	May/21-Jun 20		Jun/21-Jun30		Jul/1-Jul/30	
	Sucres	Dólares	Sucres	Dólares	Sucres	Dólares
Número Bancos	17		17		17	
Número Bancos Nuevos	0		0		0	
Número Bancos Desembolizados	1		4		1	
Número Total de Prestamos a socios	28		84		32	
Volumen	4341000	2.225,75	13685000	6.254,57	5824000	2.665,45
Capital Nuevo	0	0,00	5807730	2.658,00	0	0,00
Deuda Incobrable	75.790	35,06	0	0,00	0	0,00
Ingresos por Intereses	1940800	892,32	690000	315,36	1141200	522,29
Ingresos por comisión	97040	44,61	34500	15,77	57060	26,11
Ingresos de Prestamos Grupales	0	0,00	0	0,00	0	0,00
Otros Ingresos	3032	1,39	0	0,00	0	0,00
<b>Total Ingresos</b>	<b>2.040.872</b>	<b>938,32</b>	<b>724.500</b>	<b>331,13</b>	<b>1.198.260</b>	<b>545,40</b>

**Total Ingresos del año en dolares** 7.189,51

Gastos Operativos

Serie 70 (Salarios)	7.476.280	3.437,37	7.656.018	3.515,16	528.049	241,67
Serie 76	319.508	146,90	99.360	45,62	1.578.357	722,36
Serie 78	775.583	336,59	179.990	82,64	588.858	269,50
Serie 80	20.010	9,20	0	0,00	30.000	13,73
Serie 82	104.966	48,26	108.051	49,61	18.791	8,60
Serie 86	34.648	15,93	0	0,00	17.109	7,83
Serie 87	80.910	37,20	19.994	9,18	26.810	12,27
Serie 88 (Vehiculos)	1.212.497	557,47	467.094	214,46	829.601	375,68
Serie 8823 (Viajes Locales)	1.367.923	628,93	369.100	169,47	876.688	401,23
Serie 90 (Telefonos)	1.270.831	584,29	44.105	20,25	942.806	431,49
Serie 96 (Cargos del Banco)	33.713	15,50	3.000	1,38	12.935	5,92

**Total Gastos Operacionales** 12.696.866,90 5.817,64 8.946.723,00 4.107,77 5.450.001,80 2.494,28

**Total Gastos Operacionales al año en dolares** 64.466,92

**Perdida o Ganancia** (10.655.994,90) (4.879,32) (8.222.223,06) (3.776,64) (4.251.741,80) (1.945,88)

**Nivel de Sostenibilidad** 16,07% 16,13% 8,10% 8,06% 21,99% 21,99%

**Nivel de Sostenibilidad al año en dolares** 11,15%

THE GWU CENTER FOR INTERNATIONAL HEALTH

**Project HOPE / GW Center for International Health  
Village Health Banking and Income Generation Project  
IMPACT EVALUATION PROTOCOL**

by

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## I. PROJECT BACKGROUND

### A. Goal and Rationale

Project HOPE's village banking and income generation project began in Ecuador and Honduras in August of 1993. The project was developed on the premise that maternal and child health programs have often been limited in providing sustained improvements in health and nutrition because of constraints due to poverty. Simply put, poor families many times cannot afford the nutritious foods, medicines, health services, or environmental conditions they need for protecting their health and participating fully in their development status. Consequently, the goal selected for this project was: *to improve the health status of low-income women, mothers, and their infants and young children in Ecuador and Honduras, by creating "village health banks" that combine loans and popular economic education with maternal and child health promotion activities.*

The approach used by Project HOPE consists of integrating maternal and child health with village banking, and is based upon lessons learned in previous child survival and village banking experiences. The strengths of the health-bank approach over the traditional child survival approach include: 1) Village health banks seek to supply the *means* as well as the knowledge necessary to improve nutrition and health service utilization, and to promote health seeking behaviors; 2) Peer pressure and group solidarity are used as a means to encourage the practice of health seeking behaviors; and 3) Village health banks contain an element of financial sustainability.

### B. Interventions

1. Provision of credit and basic business skills to low-income women for use in productive activities. Banks are divided into loan cycles each of which lasts for 16 weeks.

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<sup>3</sup> Project HOPE

2. Provision of health promotion activities focusing on maternal and child health (MCH). Village health banks, designed under the Project HOPE model, incorporate health promotion efforts with credit in order to improve the health of women participating in the project and their children. These health interventions take place in the form of 15 minute health talks and other activities at each biweekly meeting of the bank lead by the health officer of each bank. All bank members are required to attend. Health messages for each cycle are printed on the reverse of each borrower's account booklet. The health promotion component begins with the second cycle of each bank. Topics change each bank cycle.

- Cycle 1: No health-related activities
- Cycle 2: Maternal and women's health
- Cycle 3: Management of Acute Respiratory Infections (ARI)
- Cycle 4: Control of Diarrheal Diseases (CDD) and basic hygiene
- Cycle 5: Nutrition and management of child illnesses
- Cycle 6: Expanded Programme on Immunization (EPI)
- Cycle 7: Determined by the health needs/priorities of each bank.

In addition, the health officer of each bank monitors immunizations of children and women, records births/deaths, weighs children under two on a quarterly basis, and refers members to local health services for care.

## II. CONCEPTUAL FRAMEWORK FOR THE IMPACT EVALUATION

### A. Background

The theoretical basis of this project stems from the recent series of Human Development Reports, by the United Nations Development Program, especially the 1993 report on broadening participation in development; and the 1990 and 1993 World Bank World Development Reports on poverty and health, respectively. These reports in turn have synthesized some of the most important theoretical and empirical contributions from the fields of development economics and international health during the past 15 years.

The Human Development Reports and the 1993 World Development Report: Investing in Health have cited convincing evidence on the interrelationships between health and income. Taken together this evidence shows that we cannot automatically expect income to rise among the absolutely poor without improvements in their health status; and on the other hand, increases in income do not automatically result in improved health status.

The Human Development Reports have proposed a framework in which the level of a country's development is dependent not just on per capita income but equally on benefits from health (H), education (E) and (weighted) per capita income (Y). Thus, the human development index, HDI, is a function of all three elements,  $HDI=f(H,E,Y)$ . Increases in income are always assumed to positively affect welfare, though at a steeply declining rate after a given point. Health is measured by life expectancy. Education is measured by a combination of the level of literacy and years of schooling according to world norms. The Human Development Index and the

theory behind it provides the rationale and framework for the evaluation of the village bank projects.

One weakness of the HDI is that it focuses on averages across countries and fails to acknowledge the impact of the distribution of income and welfare within a country.<sup>4</sup> Here we may supplement the HDI with ideas found in the 1990 World Development Report by stipulating that income benefits in turn depend on the average level of income (Y), the level of absolute poverty (P) and inequality (I). For the purposes of this framework we may define *absolute poverty* as "the resources needed to keep one's level of health and the health of one's family from falling, given one's age and using standard inexpensive technology." Of course, this level does not stand still as knowledge improves, but for the period of this evaluation, the absolute poverty line may be taken as fixed. In practice, we may define the absolute poverty line at a given level of real income. *Inequality* can be defined as the share of national income held by the top 20%, or by other measures such as the Gini coefficient, which summarizes income-share measures.<sup>5</sup>

In Ecuador, the UNDP estimates that 56% of the population lives in absolute poverty. In Honduras, 46% of the population is estimated to be absolutely poor. Inequality is also high in both countries. In Honduras the highest 20% of the population possess 63.5% of all income. Official figures are not available for Ecuador, but given the level of absolute poverty and a GNP per capita of US \$1,000 (nearly twice that of Honduras) inequality is also expected to be quite high.<sup>6</sup>

To develop a more complete framework for the village health banking and income generation project and its evaluation, we may expand the ideas in the previous paragraphs as follows: Welfare from health is defined broadly as life expectancy, but for our purposes it is perhaps more relevant and useful to be defined in terms of improvements in MCH, and consequently, in measures such as the nutritional status of infants and small children. With a further analogy, we may seek a measure of "absolute health deprivation," such as the number of people with no access to preventive MCH care. For consistency with the other HDI components and to incorporate the health and education aspects of the project, we may expand this idea further by supposing that welfare from education will depend not just on its average level, but on how equally distributed are years of schooling, and how many people fall below a threshold level of education, which in most cases can be taken as functional literacy and numeracy.

Within this context, three broad strategies for socio-economic development may be identified:

1. *Modern sector enrichment*, in which the incomes of those who already have modern jobs

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<sup>4</sup> Rodriguez-Garcia, R. and Goldman, A. (eds.) *The health-development link*. Pan-American Health Organization, 1994.

<sup>5</sup> For a full development of the ideas in this paragraph, see Gary Fields. *Poverty, inequality and development*, Cambridge University Press, 1980.

<sup>6</sup> Data from the *Human Development Report 1993*, UNDP, Oxford University Press.

increases; this will not directly benefit the target population and evidence for trickle-down effects is very sparse.

2. *Modern sector enlargement*, in which more of those from the traditional sector are absorbed into modern jobs; this process has many advantages, including a reduction of poverty and eventual reduction of inequality, but it tends to be very slow, and hence will not affect the majority of the target population for possibly many decades.

3. *Traditional sector enrichment*, in which incomes of those without modern jobs increases. This includes the relatively new strategy of development represented by village banking and microenterprise development. While it may not quickly lift the level of incomes of participants over the threshold target, it has the advantage of increasing incomes of many, in principle, a large majority, toward the threshold target.

Implicitly, this project has accepted the traditional sector enrichment framework as a feasible way to proceed within the health and development framework. Thus, the next step is to examine microenterprise development strategies, the way in which village banking works, and their relation to health.

#### *B. Microenterprise Development Strategies*

Throughout the world, the tendency for the average size of enterprises to increase, measured by the number of employees, has reversed in the last decade. In the US, where half of all employees work in firms with less than 100 employees, and self-employment is growing rapidly, a growing percentage of small businesses are owned by women. In fact, women own over one-third of small businesses in the US, compared to less than one-quarter a decade ago. These trends are mirrored in Latin America and elsewhere in the industrialized and developing world. In Ecuador, more than half the working population is self-employed. A majority of entrepreneurs in Honduras are women, as are about one-third in Latin America as a whole.

The potential role of women is extremely important from the point of view of our development framework. First, women tend to have much lower incomes and wealth than men, thus attention to their development potential is weighted more heavily. So-called "trickle-across" of income and education from husbands to wives has proven surprisingly small in practice. Second, women have the primary role in caring for children. Mothers are more likely to spend extra resources on children than fathers. The poor tend to have higher birth rates, and poor nutrition and other factors tends to cause poverty to be transmitted across generations. The health and economic productivity of children, both now and after they become adults, will be dependent on the mother's health and development status and their own nutritional status, more than on most other factors.

The gap between very small and larger enterprise productivity is vastly greater in developing countries than in developed countries. This provides significant opportunities for raising

productivity and hence incomes. For example, given two people of equal native ability, it is easier to raise the productivity of a low-productivity person than to raise the productivity of a high-productivity person. This may be understood as an effect of the law of diminishing returns. Providing more capital, education and other resources to those working with fewer of those factors can be expected to produce larger productivity gains than when provided to those already working with more of such resources, other things held constant. In developing countries, microenterprises, especially those run by women have, in fact, tended to exhibit extremely low productivity. Empirical studies have shown that microenterprise development strategies have been able to raise productivity of microentrepreneurs when implemented effectively.

The question, then, is what factors have been most important in preventing microenterprises from raising their levels of productivity. A large and growing body of evidence from around the world suggests that *the most important factor is lack of access to credit*; this lack of credit particularly, though certainly not exclusively, affects women borrowers, for reasons ranging from lack of property rights to local cultural prejudice, but of which lack of collateral is arguably the most important. Village banking systems, starting with the example of the Grameen Bank in Bangladesh, have been established with the primary goal of breaking the development impasse caused by lack of collateral. They replace capital collateral with what may be called the "collateral of peer pressure."

Traditional banks do not lend to village microentrepreneurs in part because they find it very costly to get the information of who is a high-risk borrower. This creates a niche for the moneylenders, whose local affiliations make it less costly for them to get such information. But unlike the banks, they tend to face a high cost of loanable funds (part of the explanation for their higher interest rates). Village banks trump the advantage of moneylenders by forming voluntary solidarity groups among women who co-sign loans, in order to guarantee repayment. Availability of credit can greatly increase enterprise productivity, and hence incomes, as studies of Grameen and other banks demonstrate.

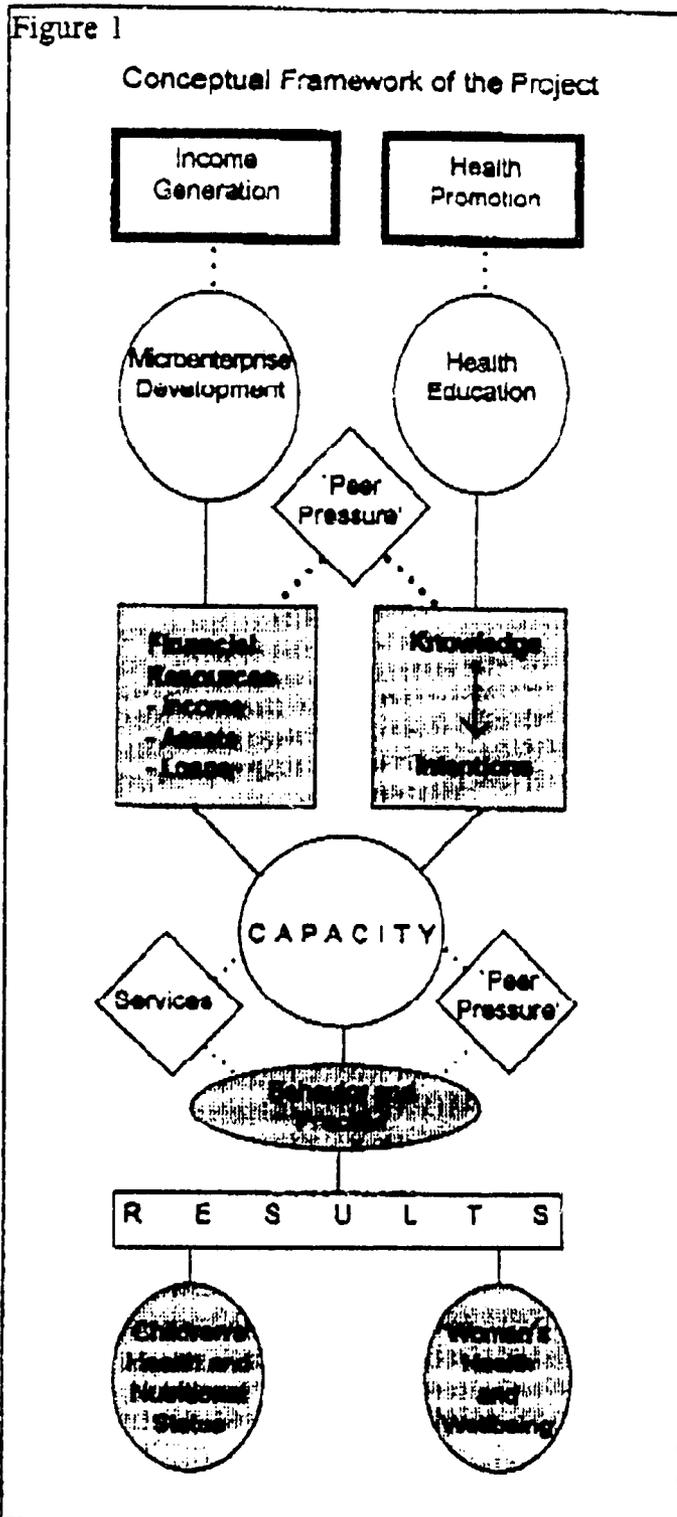
There is no reason to anticipate that access to credit is any less a limiting factor in microenterprise development in Ecuador or Honduras than in other countries. Indeed field visits to Ecuador (March 1994) and Honduras (May 1994) and interviews with borrowers left little room for doubt that the "limiting factor" in the operation of these microenterprises is credit. While borrowers will need to learn bookkeeping and inventory skills as their businesses expand, their present skills are up to starting or expanding their businesses from present levels. They have ideas, energy and business commitment. While they tend to exhibit low productivity, anecdotal evidence from the interviews suggests that this can be traced in most cases to lack of working capital, or in some cases to lack of low-cost capital equipment. One striking fact is how much of the credit is on-lent as consumer credit. Customers may have no savings and can purchase few of their wares without credit extended over at least 2 or 3 weeks. Bank members' previous sources of credit were limited, centering on either family, or high-interest moneylenders or wholesalers, or there was virtually no access at all. While family tended not to charge interest most women seemed delighted to have a chance to borrow from other sources, which freed up more resources and probably freed them from other obligations.

### C. Linking Health, Income Generation, and Human Development

Health promotion activities seek to provide individuals with basic health knowledge and access to basic health services. This may include basic hygiene, child survival interventions (ARI, EPI, CDD, breastfeeding, nutrition), maternal health, family planning, and women's preventative health care. Income generation, in this case in the form of microenterprise-driven traditional sector enrichment, provides a means to raise the socioeconomic status of the family by providing women with access to credit which is then invested to produce sustainable improvements in family welfare. The education component of this project, (both business and health education) functions to guide resource utilization, and to reinforce behaviors conducive to sustained improvements in the health status and income of the family.

The conceptual relationship between income generation and improvement of the health status of mothers and children is shown in Figure 1, which depicts the relationships among economic status, health education, and health status, as developed in part in Section A and B of this document.

In this framework, "peer pressure" works on several levels. First, peer pressure may work to influence mothers to become involved in the community bank project to begin with. Peer pressure is exerted on bank members to encourage them to pay back loans in a timely manner. It also works to provide community support and encourage the practice of health-seeking behaviors. In this model, these actions are hypothesized to lead to increased savings and investment, as well as health behavior intentions. Here, "intentions" is used to indicate that an individual knows what



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types of behaviors lead to healthier lifestyles, has accepted these behaviors, and fully intends to practice them. Finally, these three factors, financial resources, health knowledge, and intentions, combine in this model to build *capacity*.

Capacity is achieved, individually, as a result of mothers' increase of knowledge, resources, and intentions, as well as by factors exogenous to this project such as the availability of health services. Peer pressure can serve to enhance and reinforce individual and community capacity. These factors together can lead to desired healthy practices and behaviors.

Improved economic resources combine with investments in health and nutrition education should lead to improvements in household food security, children's nutritional status, and women's health.<sup>7</sup> This is achieved by increasing mothers' income and knowledge on how to use this income effectively for health enhancement, such as purchasing improved quantity and quality of foods, practicing breastfeeding, and using health services. Outputs such as improved infant feeding practices, improved management of childhood diseases, immunizations, use of prenatal care and cancer detection services can be quantified using the survey questions developed to evaluate this project. Thus, in this model, better health is a function of financial resources, increased health knowledge, and intentions, neither which is alone sufficient to produce sustainable improvement in health.

The identification of credit for women microentrepreneurs as a logical development strategy leads to questions about the best way this may be integrated with children's health and other health-and-development goals. There are two broad approaches: 1) Health promotion activities are integrated with the banks' activities; and 2) Health promotion activities are separate from bank activities. Project HOPE has chosen to integrate maternal and child health activities directly with the bank. The logic is that the health-bank combination will be better able to foster the linkages necessary for mothers to utilize their increased incomes for improving their health and that of their children, through the mechanisms outlined in the conceptual framework presented above. In addition, the availability of credit can act as an incentive for mothers to participate in MCH programs that they would otherwise not participate in.

On the other hand, there are those who believe that health promotion activities should be separated from financial and banking activities, the rationale being that by loading non-financial responsibilities onto a financial institution, that institution becomes distracted from its primary mission. The logic is that different institutions develop different comparative advantages in the division of labor across the economy. Regulations or incentives which pull an institution away from its core competencies may reduce overall efficiency even as they seem to be helping society to realize certain goals in the short run. *The hypothesis would be that the economic impact of*

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See International Food Policy Research Institute. *1990 Report*. Washington, DC, 1990; Kennelly, Barbara. *The impact of income-generating activities on household nutrition: Literature review and summary*. The Freedom from Hunger Foundation, 1988; and Marek, Tonia. *Ending Malnutrition: Why increasing income is not enough*. World Bank Technical Working Paper No. 5. Washington, DC, 1992.

*conventional village banks is greater than that of village health banks.* Thus the alternative is to keep the health activities of NGOs like Project Hope entirely separate from village banking activities. The argument would be that despite their potential complementarities in outcomes, there are not complementarities in producing their separate health and business outputs. These two arguments are reflected in the choice of control groups as indicated below.

### III. EVALUATION DESIGN

#### A. Conceptual Framework

The conceptual framework that guides this impact evaluation is depicted in figure 1, which hypothesizes that income generation and health promotion activities will positively affect the health of mothers and children in selected rural areas of Ecuador, and peri-urban areas of Honduras.

The standardized survey has been designed to address the following impact evaluation questions:

1. What is the impact of the health-bank approach on women's health?
2. What is the impact of the health-bank approach on mothers' perinatal health?
3. What is the impact of the health-bank approach on children's (under two years of age) nutritional and health status?
4. What is the impact of the health-bank approach on household economy?

#### B. Hypothesis

**H<sub>a</sub>** = There will be a statistically significant and positive relationship between the integrated village health bank approach and the health of women of fertile age, women with children under two, and their children under two years of age, above and beyond that expected from similar Project HOPE health-only or credit-only interventions.

#### C. Study Population

Women of fertile age (aged 15-49) without children under 2 (WFA); and women with children under two years of age, and their children under two (Women w/ <2's), who participate in Project HOPE's village health bank project (See table 1).

**Table 1: Study population participating in the different cycles of the village health banking and income generation project in Ecuador and Honduras as of May 1994.**

Banks	Ecuador			Honduras		
	Cycles	# Banks	Women w/ < 2's	WFAs	# Banks	Women w/ < 2's
Cycle 1	4	21	81	5	26	126
Cycle 2	8	28	185	6	34	135
Cycle 3	3	28	92	6	25	100
<b>TOTAL</b>	<b>15</b>	<b>77</b>	<b>358</b>	<b>17</b>	<b>85</b>	<b>361</b>

#### D. Study and control groups

1. There are three possible control groups (see table 2).

- Control #1 is composed of individuals who participate in a village bank that has no health component, but a solid loan system, and who meet the established criteria (Women of Fertile Age (WFA); and/or women with children under two years old).

- Control #2 is composed of individuals who meet the study criteria and are taking part in a MCH health promotion program, but who are not involved in any structured program which provides them with credit.

- Control #3 is composed of women who meet the study criteria who take part in neither child survival programs, nor village bank or other credit programs, and who live in conditions which are comparable to those of the study group.

Table 2: Control groups

	Baseline	Intervention		Post-survey
Population	Observation	Health	Bank	Observation
Study	O	X	X	O
Control 1	O	-	X	O
Control 2	O	X	-	O
Control 3	O	-	-	O

#### 2. Limitations

It should be acknowledged that the study population represents a sub-sample of women who choose to participate in the village bank project, and, therefore, contains a self-selection bias.

Given the intensity of NGO and Ministry of Health (MOH) activities, the main difficulty with these control groups will be the absence of a "non-contaminated" group. Local NGOs, MOH and international organization programs cover both countries with child survival activities, and because so many organizations (in Honduras) are working in village banking projects, it would be difficult to locate a population of women with children under two years old who were *neither* part of a child survival project *nor* a village banking project. For these reasons, control # 3 will not be included in this evaluation.

In addition, since child survival programs differ from the health component of Project HOPE's village health banks, in terms of the length and intensity of health promotion efforts, this may lead to a bias in favor of women participating in child survival programs who are likely to show higher levels of health *knowledge*. For this reason, the questionnaire has been carefully designed to emphasize questions of health *practice* and health *outcomes* such as immunization rates, and child weight/age, rather than questions which emphasize health knowledge.

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## E. Baseline Survey

The baseline survey will be conducted at the end of the first year of the project (in June 1994), and then will be repeated in October 1995, and finally in June 1997 (the last year of the project). Although the project is already in progress, no village health banks have begun -- nor will they begin the health component -- until after the baseline has been administered. Data will be collected through personal interviews with a standardized survey questionnaire with both closed-ended and open-ended questions. The methodology will be that of a cross-sectional analysis, although to the extent possible, an effort will be made to follow some of the same subjects throughout the course of the study via the surveys, in order to facilitate longitudinal analysis. For the baseline, subjects will be drawn from the 15 banks currently functioning in Ecuador, and the 17 banks currently functioning in Honduras. Participants will have to meet specific criteria.

### 1. Statistical Analysis

The suggested sample size for stratified sampling of bank records is 96 subjects per control group. This sample size is the result of applying the formula proposed by the WHIO/EPI program.<sup>8</sup>

$$n = z^2 (pq)/d^2$$

n = sample size

z = (1- $\alpha$ )/2

p = estimated prevalence and coverage

q = 1-p

d = precision desired

Where  $z^2 = 1.96$  and the statistical certainty desired is set at 95%. The desired precision is set at  $d = .10$ . The value of "p" has been set at 0.5, the value which requires the maximum sample size. The resulting random sample size is  $n = 96$  when it is desired to be 95% sure that the population estimate obtained from the sample be within 10% of the true value for this population 95% of the time. If we wanted to increase the confidence level to 99%, the sample size required would be  $n = 166$ .

### 2. Study Groups

#### A. Group A

Women participating in a Project HOPE sponsored village health bank, with children under two years old (and their children).

Because the size of this population is presently small (77 in Ecuador, and 85 in Honduras - refer to Table 1), all women who meet the established criteria will be interviewed for the baseline

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<sup>8</sup> See Stanley Lemeshow, David W. Hosmer, Janella Klar and Stephen K. Lwanga, *Adequacy of sample size in health studies*, WHO, 1990.

survey. The target number for these interviews is 96 (see Table 3). New women entering the project who meet the criteria for study group A will be interviewed until a total of 96 women have been interviewed in each country, or until August 31 1994, whichever comes first.

### *B. Group B*

Women of Fertile Age (WFA) aged 15-49, without children under two, who participate in a Project HOPE sponsored village health bank.

Group B will be a stratified sample, to assure that all banks are represented. If possible, an equal number of women of fertile age will be selected from each bank.

## 3. Control Groups

### *A. Honduras (See Table 3)*

- Control #1: Project HOPE will begin five village banks in the peri-urban regions of Tegucigalpa which have no health component. Women with children under two, and women of fertile age, will be interviewed from these banks.

- Control # 2: Individuals can be selected from the 44 "colonias" in Tegucigalpa which have child survival programs. Individuals will be randomly selected using cluster sampling. The total number of respondents will be divided evenly between women of fertile age, and women with children under two.

Control # 3: This population is not currently available in the environment of Tegucigalpa and therefore will not be sampled in the baseline.

### *B. Ecuador (See Table 3)*

- Control #1: Project HOPE will begin five banks which have no health component. Women with children under two, and women of fertile age, will be interviewed from these banks.

- Control #2<sup>9</sup>: Individuals reached by child survival activities, but not by village banking will be randomly selected using cluster sampling. The total number of respondents will be divided evenly between women of fertile age, and women with children under two.

- Control #3: A population similar to that in the village health banks is not currently available in Ecuador and therefore will not be sampled in the baseline.

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<sup>9</sup> In Ecuador, individuals in control #2 will be selected *only* from communities following Project HOPE Child Survival Programs A or B, and *not* from those following Child Survival Program C. These distinctions are based on the intensity of health promotion activities. Programs A and B have health promotion activities comparable to those of village health banks, while program C does not.

Table 3: Baseline sample size

Sample	Ecuador n = 472		Honduras n = 472	
	WFAs	Women with < 2's	WFAs	Women with < 2's
Study	96 <sup>a</sup>	96 <sup>b</sup>	96 <sup>a</sup>	96 <sup>b</sup>
Control 1	20 <sup>c</sup>	50 <sup>c</sup>	20 <sup>c</sup>	50 <sup>c</sup>
Control 2	105 <sup>d</sup>	105 <sup>d</sup>	105 <sup>d</sup>	105 <sup>d</sup>
Control 3	Not possible	Not possible	Not possible	Not possible

a = stratified samples from existing village health banks

b = target of 96 to be sampled from existing village health banks. Will complete sample until a total of 96 is reached, or August 31, 1994, whichever comes first.

c = estimates<sup>10</sup>. The entire population of WFA without children under two, and women with children under two will be sampled from the five village banks with no health component.

d = the total sample of 210 will be evenly divided between WFAs without children under two, and women with children under two.

#### 4. Suggested sampling methodology

Stratified sampling may be the most appropriate sampling methodology for this study. In this sampling technique, banks and health centers will each form a mutually exhaustive and exclusive stratum. Each stratum should be as homogeneous as possible. A random sample is then selected from each stratum using bank and health center records. For example, if 96 subjects are to be sampled from 3 banks, then 32 individuals would be randomly selected from each bank. If 96 individuals were required from 4 health centers, then 24 individuals would be randomly selected from each health center.

n = 96	<u>Bank #1</u>	<u>Bank #2</u>	<u>Bank #3</u>
Subjects	32	32	32

n=96	<u>Health Center #1</u>	<u>HC #2</u>	<u>HC #3</u>	<u>HC #4</u>
Subjects	24	24	24	24

For study group B, for example, to determine how many women will be sampled in each bank, the target number (n=96) will be divided by the number of village health banks. Once the

<sup>10</sup> Due to logistical limitations, these figures will not represent a statistically significant sample. However, data gathered from these individuals will give an indication of the impact of the credit component on health, and will facilitate comparison with the other two groups.

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number of women to be interviewed in each bank is calculated, a list of all women in each bank must be used to randomly select the required number of women from the population of each bank. This can be done by using a random number table with the "cedula" of each bank member; by picking the names of the women out of a hat; or simply by pointing to different places on the list, with one's eyes closed. If a woman selected does not meet the criteria, another woman will be randomly selected. This process will continue until the required number of qualifying women has been selected. This process will be repeated for each bank.

An alternative is to compile a list of all women who meet the criteria, and then randomly select them from this list, using the same methods outlined above. In this way, some selections will not have to be eliminated. If there are not enough qualifying women (that is, if there are less than 96), as many as qualify will be interviewed.

Cluster sampling will be used for control group #2. For a cluster sample, the sample size is approximately doubled from 96 to 210 (Lemeshow, et al. 1990). (See appendix F)

In Honduras, for example, populations can be selected from the 44 colonias in Tegucigalpa. Clusters can be determined easily, since each colonia is divided into quadrants or "manzanas". Each manzana will represent one cluster. 30 clusters must be randomly determined by such methods as computer-generated random numbers, using a random number table, or by drawing the names of the manzanas out of a hat. In each individual cluster, a total of seven respondents will be interviewed. Households are randomly selected within each cluster. Based on the guidelines for selecting participants, interviewers will then determine if each household contains a respondent who is eligible for the study. If so, then they will be interviewed. If not, another household will be selected, until a suitable respondent is located. This procedure will continue until seven respondents are located within each cluster, for a total of 210 respondents in 30 clusters. A similar process will be established in Ecuador.

#### **IV. Appendices**

##### **A. Conceptual framework (in Spanish)**

##### **B. Letter of Cooperation between Project HOPE and GWU**

##### **C. Questionnaire**

##### **D. Guide for interviewers**

##### **E. Guides for conducting the baseline survey**

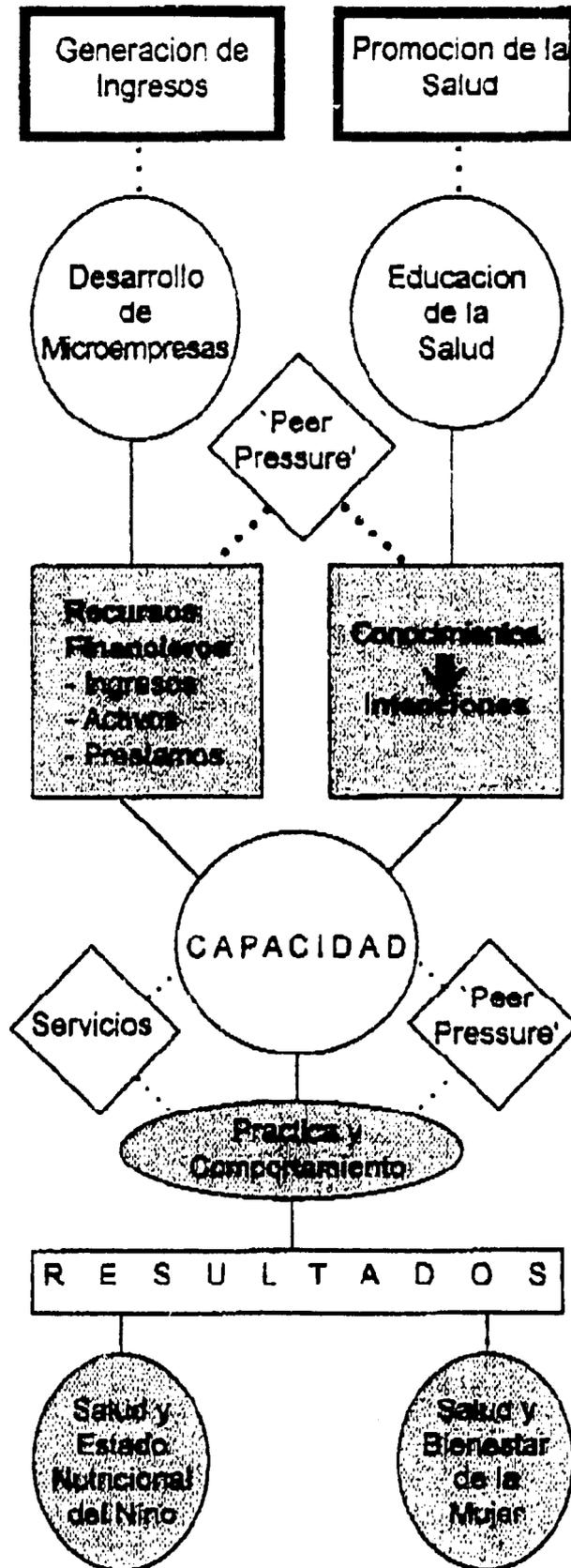
- 1. Guide for study groups**
- 2. Guide for control groups**

##### **F. Guide to cluster sampling (WHO/EPI)**

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APPENDIX A

Marco Conceptual del Proyecto



## **E. VILLAGE HEALTH BANKS CONCLUSION**

### **Country Programs**

*The country VHB programs are operational. They have functional knowledge of management of a credit and education mechanism. Now the crucial part as they go into their third year of the grant and second year of operation, is how to grow prudently but steadily. The staffs want to reply to a growing demand for their services, and to the need to put the credit capital to work.*

*The current challenge is to acquire community promoters to ease their load and allow for prudent expansion, and to strengthen their knowledge base in micro-enterprise credit, business feasibility, VHB management, and popular economic education so that they can better service their clientele. For the above, the team looks forward to the Second Year Training, to exchange experiences, test new ground and prepare for the consolidation year of their operation.*

### **Project HOPE Headquarters**

*For Project HOPE, as a health education organization, the goal of the grant is to lead them to create and support self sustaining health education enterprises. Although it is still early, the vision of HOPE is to see its Credit/Health Education activities reach operational sustainability and be able to continue health education provision past the end of the grant.*

*To ensure that these health/credit enterprises continue past the life of the grant, HOPE leadership in the Program and Finance Divisions have taken measures to safeguard the permanence of these health and credit institutions. For one, they are considering that the HOPE Site offices become NGO's with their own board of directors and legal status, but retaining a linkage to HOPE in order to keep ongoing relationship and the opportunity for research alive. Furthermore, the Finance Department has allowed for procedures to treat interest income so that it remains the asset of the country of the health and credit programs.*

*HOPE's renewed openness to seeing Income Generation as a viable part of its activity portfolio has clarified for leadership that development priorities for the poor... people do not only lie in adequate education for methods on how to lead their lives, but it lies in the opportunities and monetary access they acquire so that they have the means to lead healthier and happier lives.*

**F. SWAZILAND  
MCH/HIV/AIDS**

**I. EXECUTIVE SUMMARY**

The AIDS Information and Support Centre (TASC) received USAID/Project HOPE Matching Grant funding for the current grant activities in October, 1993. The goals of the Swaziland Matching Grant are to decrease the vulnerability of women to STD/HIV/AIDS and implement financial sustainability strategies into the management of TASC, the only local AIDS non-governmental organization. The goals will be accomplished by increasing the organization's financial and management capability to provide on-going training, counseling and information services including gender-specific strategies for reducing the risk of AIDS.

The three principle objectives and accomplishments during the first year are:

1. **Encourage women to become active participants in the development of AIDS prevention strategies at the community level through the application of the Study Circle Model.**

Objective one involves working with the Ministry of Agriculture and Cooperatives (MOAC), Home Economics Division, to train all 236 of the staff in STD/HIV/AIDS prevention. This staff (herein referred to as Agriculture Extension Workers (AEWs), are responsible for the supervision of rural women's groups, the primary targets of the training. In order for the AEWs to assist TASC in the training and supervision of these groups, the MOAC requested that the AEWs be trained first. Activities related to the planning stage of the project - Memorandum of Understanding, Needs Assessment, curriculum and materials development preceded the training. Thirty-four of the 36 staff attended a five-day workshop, May 22-37, 1994, conducted by TASC. The concept of using Study Circles as a training methodology was introduced at that time. A significant outcome of the training was the development of regional action plans for incorporating STD/HIV/AIDS activities into existing AEW responsibilities.

A Study Circle consultant, Dr. Leonard P. Oliver, trained 18 participants, including TASC staff and volunteers and selected Ministry of Health (MOH) and MOAC personnel. As a part of this experience, one of the TASC staff conducted a HIV/AIDS study circle with 28 participants from a rural women's group. During October and November 1994, the second and final workshop for the 34-36 AEWs and five, one-day workshops for two rural women's groups will be conducted. There have been no problems with the implementation of this

objective, but scheduling must be done around the agricultural shows and income-generating projects of the MOAC and women's groups. Re-scheduling of meetings and workshops has been a common occurrence.

2. **Strengthen existing Maternal and Child (MCH) activities to include STD/HIV/AIDS prevention and control by development of curricular materials and training selected MCH staff.**

The primary output for objective two is the training of 48 Maternal Child Health (MCH) nurses in STD/HIV/AIDS prevention, diagnosis, treatment and care management. The DIP provides for two, ten-day workshops for nurses with beginning skills in this area, and two, five-day workshops for nurses with more advanced skills. Most of the pre-training activities for this component have been completed; selection of advisory committee; identification of participating clinics/nurses; and development of curriculum/training materials that can be adapted to meet the needs of the target group. The needs assessment tool designed for the MOAC group is being adapted for use with this group and the survey is targeted for November, 1994. The five MOH staff who attended the Study Circle workshop on July 13, 1994, are assisting with the planning and implementation of the MCH workshops scheduled for January, 1995.

3. **Strengthen TASC's organizational capability, financial sustainability and staff productivity through implementation of management policies and business-oriented practices.**

The strategy for strengthening TASC's capabilities to function as a free-standing, non-governmental organization includes the following sustainability component; developing general and project management structures; marketing the products and services of the organization; planning and implementing income-generation strategies; and establishing a functioning Board of Directors to assist TASC in its mission. Changing from a grant supported to an income generating organization was a new concept for the organization. Time has been spent trying to get a reality base and accomplishments include; management policy and procedures development in some priority areas; fee for service training/counseling sessions for organizations that can afford to pay; obtaining donor funding for workshops and meetings; establishing a Board of Directors with skills to assist in fund raising and other sustainability ventures; and establishing a fund raising subcommittee of the Board.

Modest income has been generated from the sale of materials and one fee for service training/counseling contract. A fund raising plan of the magnitude to support the operations

and services of the organization is still in the exploration state. From a meeting with the Minister of Health and a subsequent meeting on Government subventions (subsidies) to NGOs, it seems that some assistance from government is a possibility. This avenue will be vigorously pursued through the National AIDS Programme (NAP). It is anticipated that the Board fund raising committee and the Financial Manager, (new position) to be hired in October, 1994, will assist with a definitive income-generation plan. Assistance and guidance in this area is also being sought from HOPE headquarters.

## **II. DIP Objectives and Progress**

### **Objective 1**

To provide women the opportunity to become active participants in the development of AIDS prevention strategies at the community level through the application of the study circle mode.

#### **1.1 Identify women's organizations/groups from which study circle leaders and organizers will be recruited.**

The Ministry of Agriculture and Cooperative (MOAC), Home Economics (HE) Division was chosen to work cooperatively with TASC to implement this project component. The MOAC has responsibility for supervising and developing community women's organizations throughout the country. The groups are PHC providers who make home visits, carry out nutrition and sanitation assessments and many are breastfeeding counsellors. The project's goal is to integrate STD/HIV/AIDS prevention as a component of existing PHC activities.

Preliminary meetings with the Principal Home Economics Officer (PHEO), MOAC, during the concept paper state of the project revealed a high degree of interest for the Ministry to participate in the project. The PHEO suggested that the 36 MOAC in the HE Division be trained first in order to sustain the project within the MOAC and so that the field staff could assist TASC with the follow-up and supervision of the groups.

In consultation with the PHEO and the Manzini Regional Home Economics Officers and field staff responsible for the direct supervision of women's groups, the Esikhaleli and Ludzeludze were the two groups chosen for participation in the training. The criteria for selection included: proximity to TASC; active membership; receptivity to previous training; and previous participation in focus group discussions and community surveys.

**1.2 Obtain concurrence or Memorandum of Understanding from MOAC**

A Memorandum of Understanding between the MOAC and TASC/Project HOPE was signed on May 30, 1994. Prior to the signing of the formal agreement, MOAC had made a commitment to participate and had cooperated in accomplishing many of the planning activities.

**1.3 Specify the population to be trained as leaders/observers**

The 36 MOAC, HE Division, staff including the PHEO, Regional Home Economic Officers (Supervisors), Assisting Home Economic Officers (AHEO) and two Rural women's group (30 Trainees) are the training people.

**1.4 Meet with Manzini Regional Supervisors and AEW's responsible for the targeted women groups.**

Planning and implementation meetings between TASC and the Manzini MOAC staff are ongoing. The last meeting took place on August 2, 1994, to follow-up on the Study Circle training and to plan for the next phase of project implementation which includes community leaders' orientation and the scheduling of training for the women's groups.

**1.5 Meet with identified community leaders to discuss the project and receive necessary clearance.**

The Manzini Regional Home Economic Officer and staff who know the community leaders and women's groups decided that they would introduce the project and receive necessary clearances after they themselves had been trained. Clearance was received from the community leader for the group that was trained during the Study Circle consultant's visit. Both the community leaders and the women's groups have been told informally by the RHEO that the training will take place.

**1.6 Formulate Advisory Committee**

The proposed members of the Advisory Committee suggested by MOAC and TASC include: one member from each of the participating women's groups; Principal Home Economics Officer; Manzini Regional Home Economics Officer; TASC Representative; and a representative of another women's organization.

**1.7 Identify survey design consultant to develop needs assessment tools (KABP) for all project training groups. (AEWs, Women's Groups, Nurses)**

The project hired a short term consultant, Thini Dlamini,

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Research Assistant with the Institute for Educational Research (SIER), University of Swaziland, to develop the needs assessment tool, conduct the survey, analyze the data and submit a report.

**1.8 Conduct training needs assessment (KABP) survey for AEWs and Women Groups.**

Thirty-three of the 36 MOAC staff responded to the needs assessment survey which was conducted February 8-22, 1994. A report of preliminary findings was prepared by the consultant using data from 12 respondents so that the curriculum planning for the training could begin. Data from the 33 respondents shows that the majority have a high knowledge of course, transmission, and prevention aspects of STDs/AIDS. As a group they were not clear on the difference between HIV and AIDS. On the risk of acquiring HIV/AIDS, most felt that their own behavior and that of their partner did not put them at risk. They thought the high risk groups were teenagers and prostitutes. A draft report of the findings was submitted by the consultant for review by TASC and the final report is now being written. Copies of the questionnaire, the preliminary report based on data from 12 respondents and the draft report of the 33 respondents have been submitted to HOPE Center. Needs assessment findings were used as the basis for the development of the training curriculum.

**1.9.1 Materials Developed**

Using TASC IEC materials, curricula and reports, the consultant developed a Leader's Guide, Introductions to Study Circle Series; content for five study circle sessions; including discussion questions for each session; and a Training Agenda. A TASC Volunteer has translated into siSwati the booklet, "Living with AIDS in the Community" for use with the women's groups.

**1.9.2 Observation of Rural Women's Group Meeting**

As part of the consultant's orientation to TASC and the kind of groups that are the beneficiaries of the training, TASC made arrangements for the Consultant to observe a meeting of the Bonisanani Yasekuzukekeni Women's Group. The TASC Coordinator of the training, Rejoice Nxumalo cleared with the AEW and appropriate community leaders that an educational session on AIDS prevention could be given at their regularly meeting of the BONISANANI YASEKUZUKEKENI women's group.

### **1.9.3 Study Circle Training**

Thirty-four of the 36 MOAC personnel attended a workshop conducted by TASC, May 22-27, 1994 which included an introductory session on study circles. Eighteen (18) participants received Study Circle training by Dr. Oliver in a one day workshop held on June 13, 1994. TASC invited 20 participants, including those who will be involved in the training of MCH nurses. The trainees included: TASC professional staff-4; TASC volunteers-2; Ministry of Health, Public Health matrons, Supervisors and MCH nurses-5; Ministry of Education-2; MOAC-4, and the School HIV/AIDS Project Education (SHAPE), Program Officer-1. TASC considers these 18 persons to be an adequate resource pool for training the two women's groups and the MCH nurses. In spite of communication problems and meetings that resulted in the training starting late, the objectives were accomplished.

### **1.9.4 Testing the Study Circle Model with a Rural Women's Group**

June 14, 1994 - TASC Counsellors/Trainer, Thabani Matsa conducted a HIV/AIDS prevention study circle with the Bonisanani Yeasekuzukekeni Women's Group mentioned above. Twenty-seven members of the women's group, the male community leader and the MOAC, AHEO, who supervises the group attended the session.

### **1.9.5 Reporting/Recording Instrument**

The consultant developed a recording form, (Study Circle Discussion Survey) for documenting study circle training sessions.

### **Summary - Objective 1**

The cooperative relationship between the MOAC and TASC has been well established to successfully achieve this objective. Activities in the planning phase - required meetings, Memorandum of Understanding, Needs Assessment, curriculum and training materials development have been completed. The latter three, needs assessment, curriculum and materials need refinement and further development.

Implementation - Workshops: STD/HIV/AIDS Prevention - 34 MOAC Staff - May 22-27, 1994

Study Circle Training - 18 Participants - June 13, 1994

The enthusiasm of the MOAC staff for this project has exceeded expectations. Some of the Regional Home Economics

Officers have already begun to integrate AIDS Awareness Talks into their other activities as described in action plans they developed during the workshop. The Manzini region HEO reported that 20 Rural Development Officers attended a session, while Hhohho region reported that approximately 500 farmers attending regional and sub-regional agricultural shows had attended sessions.

### **Priority Objectives For the Coming Year**

1. In cooperation with the Manzini Regional Home Economics Officer and Field staff, train 30 women from the Ludzeludze and Esikaleni women's groups. Five training sessions for one day each for six members each session will be conducted in October 1994. In consultation with the RHEO, a detailed training plan is being developed.
2. Conduct the second training workshop for the 34-36 MOAC staff.
3. Refine the study circle materials, needs assessment questionnaire and training curriculum.
4. Initiate Advisory committee meetings.

### **Objective 2**

Strengthen existing Maternal and Child Health (MCH) activities to include HIV/AIDS/STD Prevention and control.

The Ministry of Health (MOH), represented by the chief Nursing Officer, Deputy Nursing Officer and the Maternal-Child health Coordinator endorsed this project component during the concept paper stage. The DIP as approved was sent to the Chief Nursing Officer in November 1993. Since that time, TASC communication has been with the following MOH personnel who will be directly involved in the planning and implementation of the project activities: the Public Health Matron, the MCH/UNFPA Physician the MCH coordinator, and the Manzini Region Matrons/Supervisors and clinic nurses. TASC is also closely coordinating the project with the MOH STD/AIDS Medical Clinician based at Mbabane Government Hospital. In consultation with these personnel, a number of pre-training activities have been accomplished.

#### **2.1. Selection of Ministry of Health Advisory Committee**

Proposed members of the Advisory Committee are: Deputy Chief Nursing Officer; National AIDS Programme representative; Public Health Matron; MCH/UNFPA physician; and MOH STD/AIDS Medical Clinician.

**2.2 Identification of Manzini Region clinics and nurses to be trained by the project**

King Sobhuza II (KS II) Public Health Unit (PHU) which has 16 nursing staff was chosen as one of the groups to be trained on June 29, 1994. The purpose of the meeting was to give an overview of TASC services, explain the details of the project including the use of study circle training methodology. The other clinics are still to be identified.

**2.3 Meet with Advisory committee to cross-check targeted clinics, propose strategies for training and curriculum and revise according to input.**

Preliminary discussions have been held with those members of the Advisory Committee who are posted in the Manzini sub-region. The committee as a whole has not met. The Manzini Regional Matron has greatly assisted TASC with planning activities.

**2.4 Develop updated list of nurses who have been trained in AIDS/STDs as counsellors, educators or trainers.**

TASC's computerized list of nurses who have been trained by TASC in the various aspects of STD/HIV/AIDS prevention has been updated. Additionally, lists of nurses, who have been trained by other projects have been obtained. There are at least six nurses in the country who were trained as STD specialists in Zambia that TASC will also add to its roster.

**2.5 Conduct training needs assessment survey for nurses using tools developed by survey design consultant.**

The needs assessment developed for the MOAC trainees is being adapted by the consultant for use with the nurses and the target is to conduct the survey end of September 1994.

**2.6 Identify curriculum design consultant and resources.**

Based on the results of the needs assessment with the nurses group, the curriculum that was designed for the MOAC training will be modified/adapted for use with the nurses group. The MOH STD/AIDS Medical Clinician, Dr. Thembisa Khanya, has agreed to assist TASC review the curriculum and resource materials and design the clinic management protocols. The budget narrative (Project HOPE Annual Report, October, 1993) states that the Maternal Child Health curriculum consultancy would take place in Year 3 of the project (p. 135) while the workshops were projected to take place in year 2. (p.136). The curriculum consultancy must take place before the training, therefore TASC is attempting to accomplish this objective without hiring a consultant.

**2.7 Identify resources for supervision of and support for clinic nurses.**

The five nurses listed below who were trained in Study Circles will assist TASC with the training:

Public Health Matron	- Gladys Matsebula
Manzini Matron	- Mary Magwaza
Manzini Supervisor	- Girlie Magwaza
Staff Nurses	- Theresa Mncina
	- Lonkhululeko Khumalo

The other participants trained in study circles expect to assist as requested.

**2.8 Develop module on behavior change using the study circles methodology for clinic nurses**

TASC developed content in this area for the training of the MOAC held on May 22-27, 1993, and for the Support Group workshop conducted on June 24-26, 1994. There is in-country expert in the topic who assists TASC in presenting the topic.

**2.9 Conduct training for MCH nurses**

The project will train 48 MCH nurses in STD/HIV/AIDS prevention, diagnosis, treatment and care management focusing on women and children. Two groups of nurses differentiated on the basis of levels of previous knowledge and experience in the content areas are designated as level I - those who need more training and Level II - those with previous training and experience. The results of the needs assessment as well as input from Matrons and Supervisors will be used to help identify nurses who fit in each category. Matrons and supervisors will also assist in identifying participants for each category.

Workshops to be Conducted:

Level I - 24 nurses - 2 workshops, 10 days each  
Level II - 24 nurses - 2 workshops, 5 days each

An advisory committee meeting is planned for the end of August 1994, to develop a detailed training plan.

**Summary - Objective 2**

Most of the pre-training activities for this component have been completed. Five (5) nurses attended the Study Circles workshop on June 13, 1994, and are expected to assist with the MCH workshops.

## Priority Objectives for the Coming Year

1. Convene meeting of Advisory committee
2. Identify remaining clinics and participants
3. Conduct Needs Assessment
4. Develop a training plan for the four (4) workshops
5. Conduct workshops.

### Objective 3

Strengthening TASC's organizational capability, financial sustainability and staff productivity through implementation of management policies and business-oriented policies and practices.

#### 3.1 Management Structure

- 3.1.1 Develop job descriptions
- 3.1.2 Review and discuss job descriptions with individual staff members.

These activities were completed during Dr. Souder's visit in September/October 1993, when the DIP was finalized. Follow-up discussions were held with individuals in the process of assigning individual responsibilities for the DIP activities.

#### 3.1.3. Develop workplans for each staff

Staff developed and submitted individual workplans for the 1993/94 year which were discussed at team meetings November/December 1993. Due to the resignation of the IEC Coordinator, Zanele Hlatshwayo in December 1993, activities were added to the workload of remaining staff. Rejoice Nxumalo also resigned in July 1994, resulting in another redistribution of activities. Workplans for 1994/95 are being developed.

#### 3.1.4 Develop administrative policy and procedures manual.

Policy Manuals for the Government of Swaziland and Project HOPE have been obtained and specific policies are being reviewed for their relevance to TASC. The following procedures have been developed: Utilization of project vehicles and office equipment (telephone, FAX, photocopier, computers) ; authorization for use of petty cash, purchase of supplies and other procurement; lending/dubbing/borrowing of IEC materials, especially videos; and a draft leave policy.

#### 3.1.5 Develop training plan for upgrading the skills of TASC staff based on the needs of the organization

**3.1.6 Develop criteria for attendance at in-country, and out-of country meetings including appropriate staff to attend.**

A training plan and criteria for attendance at meetings still needs to be developed. At the present time, available training opportunities are discussed at team meetings and decisions about attendance are made at that time. TASC staff and volunteers have attended a number of national and international workshops. Most of these have been funded by other organizations.

**3.1.7 Establish mechanism for obtaining/sharing information and materials with other HIV/AIDS organizations and revise as needed.**

Through the national and international network activities of the TASC staff and volunteers exchanging information with other organizations are well established. The Swaziland National AIDS Programmed (SNAP) and Managers of all AIDS organizations have scheduled meetings for in-country communication. The TASC Services Manager is active in the Southern African Network of AIDS Service Organizations (SANASO) and the local counterpart Swaziland Network of Aids Service Organization (SWANASO) TASC also has links with other organizations that have HIV/AIDS support groups.

**3.2 Managing Programs & Products**

Project activities in this component relate to establishing the financial sustainability of the organization and includes identifying funding sources from corporations and individuals; public fund raising, government funding and income-generation projects; preparing proposals highlighting program and funding needs; and marketing the materials and counselling and educational services of TASC. The grant that was funded September 1991 to September 1993, also had a sustainability component "the development of a strategy for establishing an operational and sustainable AIDS counselling and support center." Efforts at soliciting funds during that period were not successful.

A fund-raising plan of the magnitude needed to support the current operations of TASC still has not been developed, no proposals have been submitted to donors, and no local fund-raising events have taken place. Solicitation letters written to potential donors have not yielded results. This is an area where the organization needs a lot of assistance and the Financial Manager to be hired in October, 1994, will have this responsibility included as a part of his or her job description. A priority area for that person is to develop a systematic plan of fund raising strategies with

projected amounts of money each activity is expected to generate. Some progress, however, has been made towards this objective as indicated by the activities below..

- 3.2.1 TASC has managed to raise about E7,000 (about US\$ 2,000) from a fee for service education/counselling session for one of the UN agencies and from the sale of videos and educational material. An additional E2,200 was donated by a religious organization for support group activities.
  - 3.2.2. TASC staff along with other the staff NGO's have attended seminars sponsored by the Coordinating Assembly of NGO's (CANGO) on income generation and other sustainability issues. Workshops: Income Generating Activities for NGO's, October 21-22, 1993. NGO Funding Crisis, December 3, 1993
- The outcome of the above workshops was the formation of an advisory committee to study the feasibility of joint fund raising ventures.
- 3.2.3 Consultations with other organizations who have been successful in generating funds for large projects. (TransWorld Radio and Swazi Business Growth Trust).
  - 3.2.4 Discussions with the Department of Commerce and the Department of Taxes regarding some of the statutory requirements involved in income-generation.
  - 3.2.5 In a courtesy meeting with the recently appointed Minister of Health, Dr. Derek von Wissel, on April 21, 1994, the possibility of TASC receiving a government subvention (subsidy) was mentioned briefly. The percent of funding a NGO could receive and still remain autonomous and other criteria are to be developed. The Minister, however, did state a number of conditions that NGOs must meet in order to be considered for funding.
  - 3.2.6 TASC attended a meeting on June 16, 1994 between the Ministry of Health and NGOs to review a draft policy on Government subvention to NGO's. An advisory committee established at the meeting has circulated the revised policy which is the only follow-up thus far. TASC will continue dialogue with the Ministry of Health through NAP on government financial support.
  - 3.2.7 The recently formed TASC Board of Directors has appointed a fund raising subcommittee.

- 3.2.8 Through the National AIDS Programme Annual Resource Mobilization Meeting, TASC received pledges of donations from two companies that have not been received as yet.
- 3.2.9 TASC has been successful in obtaining funding from other organizations to fund national and international workshops, conferences, and meetings for staff and volunteers as listed below.
  - 3.2.9.1 The British Council - Managing Relationships between donors, NGOs and Government. Harare, Zimbabwe, November 14-17, 1993. Thandi Nhlengethwa and Rejoice Nxumalo.
  - 3.2.9.2 Unicef - Africa Region Conference for PLWH/A. Zambia. Two TASC Support Group members
  - 3.2.9.3 Netherlands - Management of NGOs - Feb. 28 - March 31, 1994. Thandi Nhlengethwa
  - 3.2.9.4. Southern Africa Network of AIDS service Organizations (SANASO). Home-Based AIDS Care. Zambia, April 25-29, 1994. Mandla Mazibuko, Volunteer/Counsellor.
  - 3.2.9.5 Swaziland National AIDS Programme. Workshop for Support Group. June 24-26, 1994.
  - 3.2.9.6 International Conference on AIDS. Yokohoma, Japan. August 4-12, 1994. Organizing Committee sponsored Thandi Nhlengethwa.
- 3.3 **Organizing a Functioning Board of Directors**
  - 3.3.1 **Devise plan for determining board roles and responsibilities.**
  - 3.3.2 **Plan board's composition**
  - 3.3.3 **Identify prospective board members**

TASC devoted several team meetings to the task of identifying potential board members who would bring the skills necessary to move the organization toward sustainability. An orientation program for prospective members was held on May 6, 1994, and included an overview of the Swaziland AIDS situation; Project HOPE's role in HIV/AIDS prevention activities; funding issues; and the role of a Board of Directors in an AIDS organization. The following subsequent meetings have been held:

May 13, 1994 - Election of Board members. Among the 10 members elected are legal, medical, management, accounting, political, religious, youth/volunteers, and

support group representatives. The Ministry of Health has an ex-officio member.

May 20, 1994 - Election of officers.

June 4, 1994 - Selection of fund-raising and constitution review subcommittees.

**3.3.4 Prepare TASC overview material including an organizational budget and financial statement for potential board members.**

The Chairman of the Board has been given the DIP, budget and job descriptions. The accountant member of the board is to have a detailed orientation to the financial reporting requirements of the project.

**3.3.5 Prepare a board orientation manual**

Materials presented at the orientation session are available to be included in a manual. In addition, resource materials, such as Robert's Rules of Order, and relevant publications from the National Centre for Non Profit Boards, Washington D.C. are being organized to assist the board in its functioning.

**3.4. Volunteers**

**DIP Activities**

- 3.4.1 Determine needs for volunteers in each program area;
- 3.4.2 Establish recruitment, orientation and training procedures
- 3.4.3 Recognize and acknowledge volunteer service

The counsellor/trainer responsible for developing and coordinating the volunteer programme, Rejoice Nxumalo, resigned in July 1994, to assume the position of NAP counsellor coordinator. There is a system in place for the recruitment, orientation and training and monitoring of volunteers.

Currently, there are four active volunteers. Two of them are trained as counsellors and carry a case load, greatly assisting TASC with the ever increasing demand for these services. They also handle most of the IEC activities and give AIDS awareness talks. The other two volunteers are seropositive and assist TASC with education library tasks, answering hotline and support

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group activities. Two of the four volunteers were trained in study circles and will assist with the training of the women's groups.

TASC acknowledges the service of the volunteers by seeking funding for them to attend national and international workshops and meetings. Two of them have attended workshops in Zambia.

### **Summary - Objective 3**

The time-consuming tasks of establishing and orienting a Board of Directors have been completed. The Board was formed in May 1994, and still must receive direction and support in getting firmly established. Resources are being obtained to assist with this.

The movement from a grant supported to an income generating organization is conceptually in the early stages. Many data gathering and brainstorming activities have occurred, but the indepth analysis of the future programming and accompanying financial needs have not been addressed. It is anticipated that the newly formed Board of Directors and the Financial Manager who will assume some responsibility for this area, will assist with identifying and implementing specific fund raising activities. TASC has been able to generate a small amount of income by marketing its materials and services. Financial assistance from the government will continue to be sought.

### **Priority Objectives for the Upcoming Year**

1. Continue to support the development and strengthening of the Board of Directors.
2. Recruit for the Financial Management Position
3. Develop an annual fund raising plan based on budget forecasts of annual expenses.
4. Submit proposals to prospective donor agencies.
5. Through the NAP, submit a formal request/proposal to the Ministry of Health for a government subvention
6. Develop a staff training plan.
7. Continue the work on the policy and procedure manual.

### **III. On-Going Information, Education, Communication (IEC) Counseling, Testing Training and Support Group Services**

The current grant does not make budgetary provisions for TASC's on-going services. One of the sustainability directives is that plans be made for income generation and cost recovery strategies for these services. Under the previous grant, TASC became well established as a center for these activities and with the increasing awareness of the seriousness of the AIDS situation in the country, the demand for these services has increased. Clients cannot afford to pay, therefore user fees are not

feasible. TASC has been successful in implementing some cost-recovery strategies, such as charging for training/counseling sessions for companies and organizations that can afford to pay and selling videos and other IEC materials. TASC is also seeking funding to finance another position as well as appealing to institutions with trained counsellors to second a person to TASC.

TASC is only managing to meet the increased demand for these services through the use of the small core of committed volunteers. Two of the volunteers are trained as counsellors and carry a full case load even though one of them is still in school. Likewise, walk in education sessions, AIDS awareness talks and hotline calls are handled by the volunteers.

TASC receive numerous requests to conduct counsellor training workshops which cannot be honored at this time because of the small staff and lack of financial resources. Ways to make this an income generating area are being explored.

Summary reports for the counselling services and the support group activities, October 1993 to August 1994 are attached.

#### Support Group Activities - October 1993 - August 1994

##### Objective

**"Develop plans for and coordinate the organization of HIV/AIDS support groups, rules and guidelines for support group facilitators and recruitment and training of volunteer support group facilitators."**

A plan for developing HIV/AIDS support groups was developed with the help of two HIV positive people who had attended a workshop in Zambia. Rules and guidelines for support group members and facilitators were developed. HIV/AIDS positive clients were organized from the four regions and a support group was established on the 18th of December 1993 with eight people. Clients came from Manzini region except for two who came from other regions. Five meetings have been held since then and the number has increased up to twenty-one people. TASC has 89 HIV/AIDS positive clients but only a few showed interest in joining the support group. The support group meets once a month on a Saturday since some members are working during the week.

An interim committee composed of three females and one male was elected and has met seven times with the support group coordinator discussing issues of the support group and work on a project proposal to be sent to donors and companies.

A workshop sponsored by the National AIDS Programme for people who are HIV/AIDS positive was held on the 24th of June up to the

26th of June 1994. The workshop aimed at providing participants with more information on HIV/AIDS and on how to live positively with the virus.

Support group members are actively providing HIV/AIDS education in their communities and some of them supply condoms to community members.

A local newspaper (The Times of Swaziland) reporter came to TASC to interview two support group members about living with HIV/AIDS. The interview was well done and the article was published Sunday July 17, 1994. One support group member was interviewed about her experience on living with HIV and the interview was broadcast on the radio broadcasting station five times at the request of the public.

Some group members are unemployed, others have lost their jobs through ill-health. Since members meet every month and others live far away from the meeting venue, a need for providing refreshments was identified. Donations from communities and churches were sought and the International Ministries donated food (rice, mealier meal and tea).

#### HIV/AIDS Counselling - October 1993 - August 1994

##### **Pre-test Counselling**

The number of clients who received pre-test counselling from October 1993 up to August 16, 1994 is 258. Out of the 258 who received pre-test counselling 228 decided to test for HIV/AIDS/ Fifty four (54) of these clients returned for more than one counseling session before deciding to test. Cumulative pre-test counselling from October 1993 to August 16, 1994 is 258.

##### **Post-test Counselling**

There are 186 clients who received post-test counselling from October 1993 up to August 16, 1994. One hundred and sixty of the clients are HIV negative and 62 are HIV positive. Cumulative HIV positive clients from October 193 up to August 16, 1994 are 62. HIV positive clients since the inception of TASC up to August 16, 1994 are 89.

##### **Return/Ongoing Counselling**

The number of clients who visited TASC for ongoing counselling is approximately 85. Thirty-two clients visited the centre more often, about three times a month. HIV positive clients tend to visit TASC soon after receiving their results just after the initial shock has subsided. Later on they come when they have health-related problems.

### **Referrals**

It has taken a long time for doctors to send their patients who are HIV positive to TASC for counselling. However, during the past three months eight HIV positive clients have been referred to TASC for on-going counselling by private doctors.

### **Deaths**

The total number of TASC clients who have died is 6.

### **IV. Notable Successes**

The project has been extremely well received and supported by the central, regional and local level of the Ministry of Agriculture and Cooperatives (MOAC) and the Ministry of Health. This is the first Project HOPE/TASC project with the MOAC and the enthusiasm with which trainees participated in the workshop far exceeded expectations. The project-supported training of rural women's groups will only take place in the Manzini sub-region, but there are already reports from other regions that such training is being implemented.

Although support group activities are not in the DIP, they are included in the job description of the counsellor/trainer, Thabani Motsa. TASC was the first organization in Swaziland to organize HIV/AIDS infected clients into a support group. There has been excellent media coverage of this activity. TASC services manager, Thandi Nhlegethwa has established an extensive networking component for this activity.

Sustainability progress may be considered modest by some standards, but for the first time in history, the organization was able to earn some income from some of the services. The organization has begun to think conceptually about costs of operating a NGO and some cost-saving measures have been instituted.

### **V. Notable Problems and Solutions**

There were three resignations during the year - IEC Coordinator, Zanele Hlatshwayo; counsellor trainer, Rejoice Nxumalo; and the driver, Paulos Dlamini. The positions are still vacant with the exception of a temporary driver. With these resignations there are only two regular professional TASC staff remaining. This situation will be rectified with the recruitment of replacement staff. Replacement of IEC Coordinator, and recruitment of Financial Manager (new position) had been delayed by HOPE Headquarters until September/October 1994, because of budgetary constraints.

TASC has expected the study Circle consultant to be available for two full weeks instead of the seven working days allotted. This necessitated many readjustments to the original training plan and

created a conflict with other scheduled events of MOAC staff. An internal problem was also that the TASC staff who coordinated the training, failed to follow-up on communication regarding the changes. Although the objectives were achieved, neither TASC nor the consultant realized the full benefits from the activity.

Headquarters Report  
Swaziland

The Swaziland program continued to receive full attention and support from Project HOPE Headquarters during the report period.

Dr. Marilyn Edmondson visited HOPE Center in February 1994 to review progress and to develop strategies for fund-raising and income generation from the sale of services by TASC. This meeting was important to Project HOPE and its NGO counterpart institute in Swaziland, TASC, to insure our targets for self sustenance are achieved by the program end date, September 1996.

Also, during the grant year in November 1993, Robert Burastero was appointed as Regional Director of Africa. His previous field experience as a health care administrator in Africa in field and home office posts will strengthen program support at the Headquarters level. Although Dr. Marjorie Souder left Project HOPE in June 1994, she has been replaced in her technical role by Dr. George Gellert a physician with experience in the AIDS prevention program.

During the report period field visits were made by Mr. Burastero and Dr. Souder. Mr. Burastero's visit in July resulted in meetings with the MOH in the interest of fostering closer collaboration with the Swaziland National AIDS Task Force and the commitment of the Minister of Health for annual funding subsidy for TASC to offset, at least partially, some of the running costs.

Drs. Souder and Gellert as well as other headquarters personnel have provided technical support to the field for the development of teaching and educational materials and methodology to insure a high standard of quality in our educational efforts. To assure an orderly TASC transition to self sufficiency, we have extended Dr. Edmondson's contract until June 30, 1995 so that she might have adequate time to finalize income generation capabilities, assist the TASC Board to achieve independent operation and to complete staff training and organization changes.

During the next year, further headquarters assistance will be provided in income generation methodologies and techniques which have been developed and tested in other geographical areas where Project HOPE has operations.

Matching Grant Workplan  
September 1, 1994 - August 31, 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
<p>Decrease the vulnerability of women to STD/HIV AIDS</p>	<p>Provide community women the opportunity to become active participants in AIDS prevention at the community level.</p>	<p>Convene Meeting of advisory committee.</p> <p>Conduct 2nd, 5-day STD/HIV/AIDS Study Circle workshop for 34-36 MOAC, ABWs.</p> <p>Adapt curriculum content.</p> <p>Pre-post test.</p> <p>Follow up/Evaluation.</p> <p>Group reporting instrument.</p> <p>Conduct five, one-day workshops for two community women's groups, participants each session.</p> <p>In cooperation with MOAC: Meet community and women's leaders groups to formally introduce and get clearance for project. Conduct needs assessment.</p>	<p>Advisory Committee meeting as scheduled.</p> <p>Core of 34-36 MOAC who can train, supervise and support rural women's groups in AIDS prevention activities and study circles.</p> <p>Supervisory visits and results reported.</p> <p>30 members of two rural women's groups trained in study circle AIDS prevention.</p> <p>Trainees conducted training for other community groups.</p> <p>Results reported using survey tool developed by consultant.</p>	<p>September 1994</p> <p>February 1995</p> <p>October-November 1994</p>

Matching Grant Workplan  
September 1, 1994 - August 31, 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
	<p>Strengthen existing MCH activities to include STD/HIV/AIDS prevention and control.</p>	<p>Adapt curriculum based on needs assessment.            Arrange worksh.op venue/ logistics.            Observe trainees conduct study circles AIDS prevention sessions.            Follow up/Evaluation.</p> <p>Convene Meeting of advisory committee.</p> <p>Complete selection of clinics/nurses to participate in project.</p> <p>Conduct needs assessment.</p> <p>Adapt curriculum based on needs assessment.</p> <p>Structure two, 10-day 48 nurses trained STD/HIV/AIDS prevention, diagnosis, treatment and care management for 24 Level 1 Nurses (beginning skills) and two, five-day workshops for Level 2 Nurses (advanced).</p>	<p>Advisory Committee meeting as scheduled.</p> <p>Protocols developed and used in clinics.</p> <p>Evaluation data analyzed.</p> <p>Supervisory visits using checklist.</p>	<p>September 1994</p> <p>September 1994</p> <p>November 1994</p> <p>January-April 1995</p>

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Matching Grant Workplan  
September 1, 1994 - August 31, 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
<p>Sustainability of TASC as a free-standing, non-profit, non-governmental organization.</p>	<p>Strengthen TASC's organizational capacity, financial sustainability, staff productivity through implementation of management policies and business-oriented practices.</p>	<p>Develop clinic management protocols.</p> <p>Develop performance evaluation tool.</p> <p>Integrate STD/HIV/AIDS assessment in current supervisors checklist.</p> <p>Continue work on policies/procedures manual.</p> <p>Review/adapt government and Project HOPE policies.</p> <p>Support strengthening development of Board of Directors by providing resource/local consultation.</p> <p>In cooperation with Board and Financial Manager (new position): Develop annual fund-raising plan.</p> <p>Submit funding proposals to potential donors. Formally seek government subsidy through NAP.</p>	<p>Prioritize policies and procedures implemented.</p> <p>Board orientation manual incorporating initial materials.</p> <p>Board meetings as scheduled.</p> <p>Board minutes reflect activities fully supporting TASC's mission.</p> <p>Specific income-generating project implemented.</p> <p>Proposal submitted.</p> <p>Written response on TASC's eligibility for financial support.</p>	<p>April 1995</p> <p>December 1994</p> <p>November 1994-Ongoing</p>

Matching Grant Workplan  
September 1, 1994 - August 31, 1995

Goal	Principal DIP Objectives	Major Activities	Expected Results	Time Frame for Completion
		<p>Follow up on resource mobilization pledges, and fee for service request.</p> <p>Market TASC's counselling/training service.</p> <p>Develop staff training plan.</p> <p>Establish criteria for workshop/meetings attendance.</p>	<p>Income obtained.</p> <p>Developed marketing strategies fee for service contracts.</p> <p>Written staff development plan based on organizational needs.</p> <p>Written criteria established.</p>	<p>Ongoing</p> <p>Ongoing</p> <p>November 1994</p> <p>November 1994</p>

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**SWAZILAND-MCH/AIDS**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	263,345	85,107	178,238
Travel	79,425	13,832	65,593
Other Direct Costs	106,810	39,065	67,745
Procurement Costs:			
Supplies/Equipment	36,997	31,836	5,161
Services	21,746	431	21,315
Evaluation	34,171	0	34,171
Indirect Costs	144,840	46,809	98,031
<b>GRAND TOTAL</b>	<b>687,334</b>	<b>217,080</b>	<b>470,254</b>

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MATCHING GRANT ANNUAL REPORT

SEPTEMBER 1, 1993 - AUGUST 31, 1994

BUDGET NOTES

COOPERATIVE AGREEMENT NO: FAO-0158-A-002071-00

This note is to formally document the budget reallocation that was made from the Swaziland MCH/AIDS program to the Guatemala MCH project and to the Village Health banks in Honduras and Ecuador. These changes were made at the time of the first annual report of the above referenced cooperative agreement.

The net effect of the change was to transfer \$70,000 dollars from the Swaziland MCH/AIDS project to the following projects:

Guatemala MCH for the purpose of developing an income generation strategy	\$30,000.
Honduras/Ecuador Village Health Bank project for a monitoring and evaluation strategy	<u>\$40,000</u>
Total transferred	\$70,000

These changes are reflected in the budget reports included in this annual report.

III. FINANCIAL REPORT

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**MATCHING GRANT  
REVISED BUDGET SUMMARY**

**SUMMARY BY BUDGET CATEGORIES**

**PVO: PROJECT HOPE**

	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		ALL YEARS		TOTAL
	AID	PVO	AID	PVO									
<b>I. Program Elements</b>	298,861	79,414	666,712	236,255	730,697	270,578	251,782	416,904	92,914	382,865	2,040,966	1,386,016	3,426,982
<b>II. Ongoing Monitoring/Evaluation</b>	0	0	47,937	21,960	114,917	0	57,644	34,813	0	32,170	220,498	88,943	309,441
<b>III. Procurement</b>	0	78,012	0	220,976	0	99,229	0	52,279	0	17,630	0	468,126	468,126
<b>IV. Indirect Costs</b>	36,564	73,403	97	211,493	63,532	166,757	103,837	37,927	34,506	67,335	238,536	556,915	795,451
<b>TOTAL PROGRAM COSTS</b>	<b>335,425</b>	<b>230,829</b>	<b>714,746</b>	<b>690,684</b>	<b>909,146</b>	<b>536,564</b>	<b>413,263</b>	<b>541,923</b>	<b>127,420</b>	<b>500,000</b>	<b>2,500,000</b>	<b>2,500,000</b>	<b>5,000,000</b>

Minor computational differences may occur due to rounding.

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC. (PROJECT HOPE)**  
**MATCHING GRANT**  
**COOPERATIVE AGREEMENT NO. FAO-0158-00-2071-00**  
**GRANT LIFE: 9/30/92 - 9/30/97**

**PROGRAM PHASE OVER**

BUDGET CATEGORIES	REVISED GRANT BUDGET	ACTUAL EXPENSES THRU JUN'94	BALANCE REMAINING
Program Costs:			
Personnel	89,706	89,706	0
Travel	22,641	22,641	0
Other Direct Costs	45,193	45,193	0
Procurement Costs:			
Supplies/Equipment	7,672	7,672	0
Services	8,924	8,924	0
Evaluation	0	0	0
Indirect Costs	49,338	49,338	0
<b>GRAND TOTAL</b>	<b>223,474</b>	<b>223,474</b>	<b>0</b>

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