

STATUS REPORT  
RURAL HEALTH SYSTEMS PROJECT  
AID/LAC-C-1397, YEAR IV

July 1984  
Project #504-0066

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## I. INTRODUCTION

For three years, from 1976 to 1979, the University of Hawaii provided periodic short-term technical assistance to the Ministry of Health in Guyana. The main objectives of this assistance were to help adapt the prototype mid-level health worker, or medex, curriculum developed by the University of Hawaii, establish a training center for medex in Guyana, and prepare the teaching staff for the training center. The assistance was provided through a contract with the International Development Research Centre (IDRC) of Canada.

In August of 1980, the present Rural Health Systems Project contract (AID/LAC-C-1397) was signed by AID and the University of Hawaii. The contract continued the provision of both manpower development and health management systems assistance to the Ministry of Health. In the nearly four years of the contract, despite severe financial difficulties facing Guyana, close collaboration between the Ministry of Health and the University of Hawaii specialists has resulted in remarkable achievements in both manpower development and health management systems. In this fourth and final report, we review these achievements in strengthening management systems and manpower development during the four years (August 1980-July 1984) of the Rural Health Systems Project. Following each subsection, there are recommendations for further action to consolidate gains or to resolve problems that have arisen. These recommendations are rather more detailed than the account of accomplishments of the project. We want to emphasize that in looking ahead to future action we do not mean to undervalue the very significant achievements made by the many people who have worked so hard and well over the past four years to strengthen and extend primary health care in Guyana.

## II. REVIEW OF MANAGEMENT SYSTEMS STRENGTHENING

1. Programming and Budgeting. While programming by Department Heads has been carried out for several years, the Ministry's present budget relates to programmed activities to a limited degree only. However, the Ministry realizes that the best use of resources can be achieved only by making careful choices between competing program demands. The programming and budgeting process was reviewed under this contract, and a how-to-do-it programming and budgeting manual was written. The National Budget Committee has shown interest in the budget process being used within the Ministry of Health.

In September and October 1983, Regional staff as well as Department Heads were trained to apply the new system in preparing the 1984 programs and budget. However, there was insufficient time and insufficient disaggregated historical expenditure data (the financial management information system was not yet providing financial reports) to enable budgeting to clearly relate to the programs developed. The 1984 budget had to be formulated largely on the basis of prior years' macro expenditure. Additional constraints were that the National Budget Committee was unable to provide expenditure guidelines or a tentative budget level, and that program evaluation input from 1983 was limited.

For the 1985 programming and budgeting exercise, the Ministry has established a smaller, and, it is hoped, more efficient, programming and budgeting team. Senior level Ministry officials appear determined to fully implement the programming and budgeting process developed during the contract period.

### Recommendations:

- a) The Ministry of Health should fully implement the programming and budgeting process for the 1985 exercise, and the programs devised should be the basis for budget formulation.
  - b) A short-term consultant may be needed to conduct further training and to give assistance to fully implement the programming and budgeting process.
2. Financial Management Information System. The purpose of the FMIS is to provide data on how Ministry manpower and material resources are being used by program and by unit. It appears likely that the use of resources can be considerably improved. For example, it has been observed on a number of occasions that the occupancy in District Hospitals is approximately 10-20%, yet these facilities are provided the basic staff complement.

Accomplishments include design of the FMIS system, writing of a manual, holding of workshops to train data entry staff, and working through various implementation problems. The Data Processing Unit of the Ministry of Finance wrote the computer program, and it enters and processes the data.

The FMIS produces quarterly reports showing overall allocation and detailed expenditures, and some utilization data for programs and institutions. Five types of reports are produced:

- a. Health Centres and Health Posts by region
- b. Each hospital
- c. Summary of each program and institution expenditure by region
- d. Detailed expenditure of each program
- e. Total expenditure for MOH as a whole

When the FMIS is in full operation, the Health Centre/Health Post reports and hospital reports will show some service utilization data, e.g., inpatient and outpatient visits. For hospitals the extremely useful expenditure and utilization indicator of average cost per inpatient day will be calculated. This will be particularly useful in comparing costs between hospitals providing similar services, e.g., between District Hospitals.

The first financial report processed for May-June 1983 was a trial run to test the accuracy and comprehensiveness of collected data. The subsequent reports reviewed for July-September 1983 and October-December 1983 have demonstrated that reporting for facilities and for specific expenditure items is increasing. However, four areas have presented problems:

- a) Salaries are processed by a separate computer program, and many problems have impeded their entry. Salaries for January-March 1984 are being calculated manually. The Ministry plans to enter salary data by computer for the April-June 1984 quarter.
- b) Up to the end of 1983, drug and medical supplies expenses were not included. However, staff have been employed for this task, and data entry is underway.
- c) While verbal agreement was given by the Ministry's Statistics Unit in 1983 to provide the required statistical data, the data is not yet being collected from the regions. The Statistics Unit is planning to train staff in the Regions so that data can be collected.
- d) Budget figures have not yet been included in the program.

Recommendations:

- a) As an urgent matter, the Ministry of Health should complete the implementation of the FMIS.

- b) The Ministry should ensure that salaries are entered into the system beginning with salaries for the January-March 1984 quarter, and that subsequent quarters be entered through the payroll computer program.
  - c) Training of staff responsible for submitting statistical data should proceed as soon as possible, as should the subsequent collection of data for the FMIS.
  - d) A financial analysis of the reports has not been worthwhile so far, as none of the reports have contained salaries, full drugs/medical supply expenses or any statistical data. A financial analysis of the reports should be done when the data is complete. The Management Specialist is willing to do such an analysis on a voluntary basis after his departure from Guyana, if a complete quarterly report is forwarded to him.
  - e) Should entry or processing of the FMIS reports by the Data Processing Unit be significantly delayed, the use of a Ministry microcomputer for this task should be considered.
3. Supply System. Study and design efforts to strengthen the Ministry of Health's Supply System were made by PAHO consultants prior to the start of the University of Hawaii contract in 1980. All supply items, including drugs, medical supplies, general supplies, dietary supplies, and furniture/equipment, are incorporated in the system, which is conceptualised in a cycle of programming - procurement - distribution - storage - issue - programming, etc., with controls at each point in the cycle. Authorised stock lists for all items at each level, and the submission of consumption reports, are essential features of the system. When the system design was finalized in May 1982, manuals were completed for health posts, health centres, hospitals and regional supply units. The system design and manuals were submitted to the Policy Committee in May 1982, and the Committee agreed to proceed with the necessary implementation steps.

A field test of the system was conducted in Region Six during September and October 1982. Commencing in December, workshop training was provided to over 200 persons, including Regional Health Officers, Government Medical Officers, Public Health Nurses, Medex, Community Health Workers, clerks, and others. Manuals for hospitals, health centres, and health posts were distributed as part of this workshop training.

In May 1983, the Chief Supplies Officer position and other Central Supply Unit (CSU) positions were filled, and the Central Supply Unit commenced limited operations, beginning with general and dietary supplies. A Central Supply Unit implementation team was formed with representatives from pharmacy and accounting to define CSU policies and procedures. However, the team was able to accomplish only a few items on its agenda. At present, only a limited amount of centralised purchasing is being undertaken, particularly as no CSU storage space

is yet available. This storage problem will be overcome in 1984 with renovations to the basement of the Liliendaal Ministry building. This will become the CSU storage bond.

In June/July 1983, a survey of 23 persons at fifteen health facilities was conducted, to collect base-line data for future evaluation purposes.

In 1983 it became apparent that resistance had developed to the inclusion of drugs and medical supplies within the new system. In April 1984 a decision was made by the Ministry to delete all references to drugs and medical supplies in the manuals as they were to be handled separately. The revisions have been completed.

Implementation of the new supply system has been only partially accomplished:

- a. Drug and medical supplies are not part of the system.
- b. Formulation of authorised stock lists is incomplete.
- c. Quarterly consumption reports are generally not being submitted.
- d. The Central Supply Unit is only partially functioning, and has insufficient staff and transport.
- e. Regional Supply Units have not been phased in (with the exception of Region 2 for drugs and medical supplies). Regional Supply Units will constitute a more efficient distribution network which is closer to the user. However, a one-time increase in funding will be required to build up adequate stocks in the Regional Supply Units.

Recommendations:

- a. One supply system with a unified distribution network should handle all types of supplies.
- b. Authorised stock lists for all types of supplies should be completed as soon as possible for all levels.
- c. Consumption reports should be completed by all units and forwarded to the Chief Pharmacist and Chief Supplies Officer.
- d. Overseas training of a practical nature should be provided for the Chief Supplies Officer.
- e. Central Supply Unit staffing should be increased, as the current staff is too small to operate the system and its controls. The Chief Supplies Officer has requested a staff increase.
- f. The CSU policies and procedures, including procurement methods, should be finalized and agreed upon. This should be undertaken

by a team of persons, perhaps with assistance from an outside consultant.

- g. Improved transport arrangements for the CSU are essential. The Unit needs at least one-two motorcycles, one car, and a two-ton truck for now, as well as better transport planning and management. The truck could be shared with the transport unit if an efficient system can be worked out.
- h. When the new supplies system is fully implemented, it would be useful to repeat the June/July 1983 survey to obtain comparable data for an evaluation.

The most pervasive problem with the supply system is insufficient stock, the result of inadequate foreign exchange. While the supply system itself cannot address funding, it should increase the availability of supplies through careful purchasing, elimination of theft, wastage and spoilage, elimination of excess stock, and so forth. Therefore, the Ministry of Health should not delay in implementing the new supply system.

- 4. Transportation System. One of the most frequently heard complaints at the Ministry of Health concerns the inadequacy of transport. Among the problems are inadequate transport organization, frequent vehicle and boat break-downs, lack of spare parts, and irresponsible drivers. In September 1981 and January 1982, a short-term consultant analyzed the transport system and concluded that poor organization is the root cause of the problem. He formulated proposals for creating a Transport Unit and made recommendations which were accepted by the Policy Committee in 1982.

A part-time chief of the Transport Unit was designated in February 1982. However, little progress was made until a full-time head of transport was designated in March 1984. He appears to be making progress in organizing the transport components into a cohesive unit. Many severe problems remain to be resolved.

Recommendations:

- a. The Ministry of Health should continue with the development of a Transport Unit. The head of the Transport Unit should have the authority he needs to coordinate Ministry vehicles.
- b. The Ministry should give high priority to the rehabilitation of its broken-down vehicles. The head of the Transport Unit should develop an action plan to accomplish this rehabilitation.
- c. The Ministry should implement the other recommendations made by the transportation consultant in his January 1982 report, including those on driver behavior, operating policies and procedures, and preventive maintenance.

5. Communication System. Work has been carried out in two parts of this system: (a) two-way radio system, and (b) general communication for primary health care. With assistance from USAID, a two-way radio (TWR) system was established by the Ministry for medex posted at isolated health facilities. A network of ten medex stations and one base station was established in 1979 as a pilot project. Short-term technical assistance was provided through the University of Hawaii contract to implement and assess the two-way radio system. Among the functional objectives of the TWR system were the provision of medical consultation, emergency communication (e.g., for patient evacuation), continuing education (e.g., radio conferences), the provision of management support and administrative back-up, and morale boosting in what are extremely isolated posts. The utility and reliability of this pilot project was fully demonstrated. In early 1984, expansion of the system by 23 additional stations (some portable) began. When this is completed, the TWR network will be one of the largest in Guyana.

The pilot project also experimented with various power sources, and determined that solar power is reliable and economical. Consequently, all TWRs, unless they have a reliable power source, are being provided with solar power.

The Ministry has begun to institutionalize the TWR system by arranging for technical support from the Guyana Telecommunication Corporation. Continuing procurement of consumables (especially battery replacement) and administrative support is essential, otherwise the network will deteriorate quickly.

Recommendations:

- a. A TWR hardware and a software evaluation should be done 6-12 months after the entire expanded network is operational.
- b. Commencing in 1985, provision in the Government Budget Estimates must include funds to maintain the TWR system, e.g., technical support by GTC and procurement of consumables.

Other recommendations derived from a 1983 survey of effectiveness of general communication for primary health care are that:

- a. Telephones should be installed in health facilities wherever possible.
- b. Telephone patches from the TWR system should be installed at each base station.
- c. Feedback on patients referred to doctors is needed.
- d. Ministry of Health communication policies should be formalized, documented and made available.

6. Regionalization. All management systems are designed to support the regional concept. The project provided assistance to help the Ministry achieve regionalization, including a) frequent consultations with the Manager of Regional Health Services to define the roles and responsibilities of various parties, and b) helping with the conceptual design of the Regional Supervisors of Health Centres plan.

Supervision is the critical link between central Ministry of Health officials and Primary Health Care programs at health centres and health posts. The supervisor provides leadership and supervision in motivation, education and guidance, technical assistance, communication, monitoring and control, evaluation, legitimation and role protection. In December 1982 the Policy Committee accepted recommendations for establishing this new type of worker -- a regional supervisor of health centres. Training and orientation programs have been designed for the regional supervisors, Regional Health Officers, central Office of Regional Health Services, and Medex Training Unit staff and health personnel in each region.

Recommendations:

- a. A full-time Medical Director of Regional Health Services should be appointed.
  - b. The organizational structure and communication linkages for regionalization should be strengthened.
  - c. Regional supervisors of health centres should be trained using the training materials developed under this contract, and should begin functioning as soon as possible. The supervisors should be qualified as medex and/or public health nurses.
  - d. Additional support staff is needed at the central level and should be appointed.
8. Other.

A major effort under this project was the development of the Health Centre Operations Manual. This reference manual, completed in June 1984, explains the policies and procedures at the health centre level for the supply, maintenance, transportation, communications, personnel, finance, health information, and management systems.

With initial assistance from the consultants, an Orientation Manual on Guyana's health services and Ministry of Health organization was prepared to help orient all levels of staff.

Some assistance was given to the Ministry in defining the roles and responsibilities of Regional Supervisors of Health Centres and others who are to provide continuing education for medex, public health nurses, and community health workers.

A course covering the management support systems was developed to train clerks. Sixteen clerks were trained in March 1984, and another sixteen in May 1984. The course will be held periodically in the future.

Some assistance was provided to arrange U.S. training in the use of microcomputers for one person from the Ministry in February 1984. The Ministry is considering acquisition and use of microcomputers to process health statistical data, financial management information system data, and data from other areas.

### III. MANPOWER DEVELOPMENT

During the nearly four years of the University of Hawaii contract, a training specialist was in Guyana for approximately two and a half years, working with the Medex Training Unit. In addition, the University provided occasional short-term assistance in specialized areas. The Medex Training Unit was established in 1977 and had graduated three classes of medex before the University training specialist arrived in Guyana. Assistance over the life of the contract was provided primarily to revise and develop the curriculum and teaching methodology, to train medex and their instructors, and to strengthen support for deployed medex.

#### 1. Support to Deployed Medex

The provision of adequate support and continuing education for deployed medex has always been an important concern of the Ministry, but as increasing numbers of medex have been graduated and deployed (a total of 129 as of June 1984) this issue has become all the more pressing.

It is expected that in the near future, responsibility for continuing education and supervision will fall to regional supervisors, though tutor-supervisors from the Medex Training Unit may organize seminars, prepare materials, and assist with regional continuing education programs. In the meantime, and until regional supervisors are in place, responsibility for supervision and administrative support is shared by the Medex Training Unit and the Office of Regional Health Services. Administrative support for deployed medex in the past four years has increasingly shifted to the Office of Regional Health Services.

Several measures to improve support for deployed medex have been taken over the years of the contract. An attempt has been made to more carefully plan and schedule supervisory site visits to deployed medex. Optimally several medex are seen on each trip, maximizing the value (in time, fuel costs, and vehicle use) of visits to a particular area. Site visit objectives have been reassessed and site visit booklets revised to make the visits less routine and inflexible, and more responsive to the continuing education needs and interests of individual medex. If possible, the medex to be visited are asked in advance what subjects they would like to review, in addition to subjects the tutor-supervisors want them to review.

A detailed formulary, listing all drugs medex are authorized to prescribe, was compiled and distributed to deployed medex. The formulary lists such information as adult and child dosages, side effects, indications, contraindications and alternatives. The formulary is particularly useful as a review for medex, and as an aid in determining alternative medications, when a first choice is unavailable owing to drug shortages or supply problems.

A longstanding problem for deployed medex has been the lack of feedback from physicians to whom they have referred patients. This has meant that questions about diagnosis, treatment given, and need for follow-up care have gone unanswered. Medex are urged to try and develop good working relationships with their referral physicians, which may lead to better feedback. But in addition, the Medex Training Unit designed a half-page referral form for medex to send with a referred patient, which is to be filled in and sent back with the patient. Although the Ministry approved use of the form, a shortage of paper has prevented institution of the procedure. It is hoped that this can be remedied.

Copies of David Werner's Where There is No Doctor and Primary Child Care by Maurice and Felicity King, and Soebagio Martodipoero, have been purchased as reference books for deployed medex, in accordance with a recommendation in the mid-project evaluation.

The whole issue of continuing education has been re-examined, and a sample of medex have been asked both what content and format they would prefer for continuing education. Plans have been made to revise and more frequently publish the medex newsletter, and to develop other effective means of continuing education.

Recommendations:

- a) Although medex of Classes I and II received their full back pay, reflecting salary adjustments due them since they completed training, medex of succeeding classes have not been given the back salary to which they are entitled. Some means should be found of providing this compensation to them.
- b) Adequate orientation of new Government Medical Officers to the health care system and the role of primary health care workers would improve their adjustment to rural hospital posts and their working relationships with other health personnel. This might best be accomplished by assigning new Government Medical Officers for a few months to rural hospitals like that at Aishalton rather than Georgetown Hospital before they are given their regular posting. In addition, of course, it would help to provide an orientation to the reorganized health delivery system using the orientation manual developed and revised over the last year.
- c) The means that exist to provide continuing education should be used to the fullest. In the last year the frequency of Saturday morning two-way-radio (TWR) conferences has drastically declined despite reports that medex looked forward to and enjoyed them. These should be increased. If sufficient resources are available, the medex newsletter could be issued more often too. Both TWR and the newsletter

provide a means of educating, uniting, and cheering medex who often work in great isolation from their colleagues.

- d) The distinctive blue jackets of the medex help to identify them and facilitate their acceptance by the community. Apparently it has been difficult for medex to have replaced jackets that are no longer usable. Replacements should be provided to those who need them.
- e) Some medex are away from post for a long time as they must travel quite far to collect their salaries. Some means should be found to provide their pay in the districts where they work.
- f) There is a continuing urgent need for medex housing to be constructed. Originally forty-one houses were to be built under the Rural Health Systems Project. This was reduced after long delays to twenty-three, six of which had been built by June 1984. Priority should be given to constructing houses at Brothers, Baramita, Hog Island, and Ibini, as the lack of housing at each of these sites prevents not only the deployment of medex but the installation of two-way radios intended for these locations.

## 2. MEDEX Training Unit

As mentioned above, the MEDEX Training Unit had been in operation for about three years when the University of Hawaii contract began in August 1980. The prototype medex curriculum had been adapted to Guyana, tutors had been selected from among student medex, and three classes of medex had been graduated. Short-term consultant assistance had been provided by the University to help with this process; once the long-term management and training specialists arrived, short-term consultancies were naturally fewer.

One of the MEDEX Training Unit's strengths is the staff's regular self-assessment and adaptation to changing needs of deployed medex and each class of students. Resourcefulness and ingenuity are required from staff, students, and deployed medex in a time of financial constraints and shortages. These qualities have been practiced by the staff, and they have attempted to encourage them in the student medex and deployed medex.

Among the specific accomplishments and changes in the MEDEX Training Unit during the life of the project are the following.

Sixty-seven medex have been graduated from three classes, bringing the total number of medex trained to one-hundred and twenty-nine. These medex are now deployed throughout the country, most in the hinterland or other remote areas, providing health care services to rural populations.

The curriculum has been revised periodically. Simple compounding was introduced beginning with Class IV, because in many cases drugs and equipment used by dispensers are still at medex deployment sites. If they can prepare some medications on site, problems of supply and transportation of drugs (with much of the weight being water) can be alleviated. A module on health education was added, giving the subject a more prominent position in the curriculum. Medex take part in community field work at the beginning of the fifteen-month course, so that their orientation toward preventive health care and community service is encouraged early. From Class IV, medex have also received early and regular practical clinical experience, mainly at Georgetown Hospital.

The teaching methodology has been modified. Instructors have shifted from a lecture approach to a participative way of teaching, encouraging interaction among students and instructors. Discussion, role play, and student presentations have increased. The tutors have taken on greater responsibility for teaching. Student medex have been divided into groups of four or five. A tutor has been assigned to each small group, and he or she provides an on-going evaluation for each student.

Recommendations:

- a) The MEDEX Training Unit has been understaffed since September 1983. At that time, there were plans for the tutors to take time for regular clinical practice to refresh their own skills. These plans had to be put aside when one tutor resigned and another emigrated shortly thereafter. Staffing should be increased to a level that will permit tutors to have periodic clinical practice.
- b) Medex training should continue for the foreseeable future, with classes of between fifteen and twenty students. This will allow a continued extension of health care services in the country, and a replacement of the three to five medex who can be expected to resign when the five year bonding period of each class is up.
- c) Medex should be increasingly involved in the training and supervision of community health workers. They should be prepared for this role in the course of their training, with units on supervision and teaching methodology.
- d) Supervisors of health workers should receive periodic continuing education in the areas of supervision and continuing education for others.

#### IV. CONCLUSION

In the four years of University of Hawaii technical assistance to the Ministry of Health in Guyana, considerable progress has been made toward the attainment of a functioning nationwide rural primary health care delivery system.

Sixty-seven medex have graduated from three classes, all but reaching the target of seventy-two. This brings the total number of medex trained under the IDRC and AID contracts to 129. Changes have been made in both the medex curriculum and teaching methodology to encourage active and independent learning, and to prepare medex to function with considerable self-sufficiency and resourcefulness at isolated posts. Support for deployed medex has been strengthened, with renewed attention to supportive supervision and continuing education. The Medex Training Unit is clearly well-established and "institutionalized." The Ministry of Health decision to continue training medex, with Class VII scheduled to start in September 1984, gives recognition to the excellence of the training program and to the essential role that medex play in Guyana's effort to provide primary health care throughout the country.

During the four years of University of Hawaii technical assistance, significant changes have also been made in the organization of the Ministry of Health and its managerial systems that support deployed primary health care workers. Systems have been redesigned and strengthened to improve their efficiency and to bring them in line with the government-wide regionalization policy. In this area, there was little prior technical assistance from the University of Hawaii under the IDRC contract, although several management systems had been analyzed before the start of the Rural Health Systems Project by Pan American Health Organization (PAHO) or International Development Bank (IDB) consultants. Under this project, the Ministry of Health and the UH team assessed and redesigned the programming and budgeting system, the financial management information systems, the systems of supplies, drug supplies, transportation, and communications, and did similar work in the areas of supervision, continuing education, and regionalization. Operations manuals were written for the management systems, and training in how to use the systems was provided.

In brief, the efforts of Ministry of Health personnel, assisted by long and short-term specialists brought in under the contract, have resulted in achievements of which all those involved can be proud.

Sixty-seven new medex are now deployed and providing basic preventive, promotive, and curative care to rural populations in Guyana. These medex will continue to be trained by the Ministry of Health for the foreseeable future, at a training center that is well-staffed and that has graduated six classes of medex since 1977. The management systems that support these and other primary health care workers have been strengthened and extended to more effectively meet their needs.

The Ministry of Health's primary health care personnel and health management staff are as a result better able to meet the needs of Guyana's people for equitable health care.

## V. SHORT-TERM CONSULTATIONS - AUGUST 1980-JUNE 1984

January 1981 (2 person-weeks)	Tom Coles, Joyce Lyons, Sunil Mehra, John Rich	Curriculum Redesign and Development assistance to Yvonne Alonzo and Ken Davis in Honolulu
March 1981 (4 weeks)	Joyce Lyons	Educational system design and development of CHW curriculum
March 1981 (2 weeks)	Sherry Erzinger	Revision of community health materials
May 1981 (3 weeks)	Albert Neill	Manpower Analysis and Planning
May 1981 (3 weeks)	Sunil Mehra	Review and development of community education materials
May-June 1981 (3 weeks)	Joyce Lyons	Development of medex curriculum materials re community health
May-June 1981 (2 weeks)	Stan Burns	Two-way Radio System Design
May-June 1981 (2 weeks)	Heather Hudson	Communication Systems Planning (Two-Way Radio software)
August-October 1981 (6 weeks)	David Crichton	Assessment and redesign of Transportation System (Part I)
January-February 1982 (4 weeks)	Robert Mack	Design of Primary Health Care Program Evaluation
January-February 1982 (4 weeks)	David Crichton	Assessment and redesign of Transportation System (Part II)
October-December 1982 (8 weeks)	Louis Connick	Village Income Generation for Community Health Worker Support
January 1983 (2½ weeks)	Stan Burns	Two-Way Radio System Extension

May-June 1983  
(8 person-weeks)

Tom Coles,  
Greg Miles

Development of Ministry of  
Health Orientation Manual;  
Continuing Education and  
Supervision for Medex

June-July 1983  
(3 weeks)

Albert Neill

Design of Programming and  
Budgeting Process

July 1983  
(3 weeks)

Pat Dougherty

Supervisory Training Design  
for Regional Supervisors

VI. RURAL HEALTH SYSTEMS PROJECT  
 AID/LAC-C-1397  
 BUDGET SUMMARY THROUGH JULY 31, 1984

Expenditures Listed By Major Category & RCUH Category Number	3-Year Budget Sept.80-Aug.83	Cumulative & Anticipated Expenditures Thru Jul 31/84	Budget Balance
Salaries, Home Office	\$116,067	\$147,354	\$(31,287)
Salaries, In-Country	271,476	274,121	(2,645)
Salaries, Local Hire	28,089	31,293	(3,204)
Fringe Benefits, U.S.	77,509	77,556	(47)
Fringe Benefits, Local	1,643	5,948	(4,305)
DBA Insurance	27,409	10,468	16,941
Post Differential	24,255	50,095	(25,840)
Consultant Fees	87,450	31,451	55,999
Travel, HMDS & Net.	35,588	19,683	15,905
Travel & Transport.	143,860	79,440	64,420
Travel, Local	27,814	1,555	26,259
Allowances	120,834	86,815	34,019
Per Diem, HMDS & Net.	40,300	21,207	19,093
Per Diem, Contract, Cons. & Counterparts	67,502	43,680	23,822
Equipment		6,507	
	25,237		13,961
Materials & Supplies		4,769	
Vehicle Purchase	6,380	6,382	(2)
Other Direct Costs	62,820	59,877	2,943
Overhead	170,319	150,444	19,875
TOTALS	\$1,334,552	\$1,108,645	\$225,907